Good Practice in Peer-Facilitated Community Mental Health Support Groups: a Review of the Literature

May 2015

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Abstract

Purpose

St Mungo's Broadway, in partnership with Creativity Works and Sirona Community Health, is a voluntary sector provider of community-based support groups for people living with mental health problems. This partnership group commissioned the University of the West of England (UWE) to conduct a literature review exploring peer leadership and peer involvement in community support groups.

The review develops an understanding of how such groups support inclusion and recovery and how they are run, and draws learning from existing good practice to inform further community group development.

The literature review also forms the introduction to a participatory action inquiry into a range of peer-facilitated community support hosted by St.Mungo's in Bath and North-East Somerset, United Kingdom.

Method

A review of published journal articles concerning peer-facilitated community support groups was undertaken and the main themes were extracted from this body of literature.

Findings

In successful support groups peer-facilitation fosters mutually supportive, reciprocal relationships capable of inspiring hope among group members. These processes promote recovery, social inclusion and personal growth. Successful groups were based on principles of co-production in terms of shared aims, negotiated agendas, clear communication, and engagement with the wider community. Development of individuals' roles and support for peer support workers were also important factors. Overall, a group's success was seen in terms of growth in members' self-esteem, empowerment, and optimism.

Implications/value

This review develops understanding of a rapidly growing phenomenon in community-based mental health care and will directly inform an action inquiry-based exploration of how such groups work in practice.

Keywords

Community groups, peer support, recovery, social inclusion.

Overall Project Aim

St Mungo's Broadway, in partnership with Creativity Works and Sirona Community Health, oversee a diverse network of community groups for people affected by mental health difficulties living in Bath and North-East Somerset (BANES), in the United Kingdom. Within this network varying degrees and types of peer involvement in the groups have evolved. The overall project described in this report had two aims:

   i.   to develop an understanding of what was working well in terms of peer involvement and leadership in those groups

   ii. to inform the work of St. Mungo's Broadway and partners in further developing the community group network and in influencing the local commissioning of such services

Two inter-related inquiry processes

In order to meet the above aims St. Mungo's and partners commissioned the University of the West of England (UWE) to conduct two inter-related forms of inquiry:

1. **a participatory action inquiry** into the characteristics of those BANES groups deemed to be most 'successful'.

2. **a review of the literature** on peer leadership and involvement in community groups in order to inform and complement the participatory action inquiry.

The participatory action inquiry is presented in a separate report by Parmenter and Fieldhouse (2015, currently in press). What follows here is a report on the literature review.

A Review of the Literature

Peer support is increasingly recognised as a feature of mental health service users' recovery (Slade, 2013). Repper and Carter's (2011) literature review of seven randomised control trials involving support groups showed that peer support was at least as effective as professional support.

Effectiveness in terms of hard outcomes is difficult to prove because peer support is an individual *subjective* experience and not easily quantifiable. However, work by Repper and Carter (2011) and Faulkner and Kalathil (2012) indicates that peer support is felt to offer more person-to-person care, instil hope, improve self-confidence and promote self-belief.

The Challenge of Defining Peer support

Peer (or mutual) support has become widespread within mental health services but a precise typology is hard to create (Faulkner and Kalathil, 2012). The literature describes various forms it can take, ranging from informal (or naturally occurring) support, to peer-led programmes, to 'intentional' or 'formal' support where peers are employed to provide services or support within existing services (Davidson et al., 1999). Indeed, peer support workers are now employed in the United States, Australia, New Zealand and the UK (Repper and Carter, 2011).

Developing a more precise typology is likely to become more important because stating how peer support is defined and characterised can have an impact on funding (Seebohm, Munn-Giddings and Brewer, 2010). Faulkner and Kalathil (2012) recognised that definition is challenging because the contexts in which the support is offered are so multifarious, but they have identified a number of shared characteristics associated with the term 'peer', such as mutual or reciprocal support, shared experiences of mental distress and commitment to the values and ethos underpinning peer support.

To guide its exploration of peer involvement and leadership across this diverse and rapidly developing landscape, this review draws on the work of Slay and Stephens (2013). Their review of co-production in mental health service provision argues that the relationship between the service provider and the service user is crucial. They suggest that service types

can be broadly categorised according to the extent to which services are designed and delivered by professionals or by service users, or both. See Table 1 below.

	Who designs the service?		
Who delivers the service?	**Professionals**	**Professionals and People Using Services**	**People Using Services**
Professionals	Traditional statutory services, for example the National Health Service		
Professionals and People Using Services	Professionally designed with users employed (or volunteering) to deliver an aspect of care – eg. peer support workers	Co-produced services	
People Using Services	Professionally designed with users employed or volunteering to deliver services e.g. peer support workers, Expert patient programmes		User led organisation Consumer operated services

Table 1: Types of Mental Health Service Delivery (from Slay and Stephens, 2013)

This table should be considered in relation to St.Mungo's 'ladder of involvement (Box 1) from the St.Mungo's *Client Involvement Toolkit* (see mungosbroadway.org.uk), which

identifies five degrees of service user involvement. It is used by St.Mungo's to plan their support for involving service users in the running of their services.

> **Control –** Service users control decision-making at the highest level
>
> **Partnership –** Service users share decisions/responsibility, influencing and determining outcomes
>
> **Participation –** Service users can make suggestions and influence outcomes
>
> **Consultation –** Service users are asked what they think but have limited influence
>
> **Information –** Services users are told what is happening but have no influence.

Box 1: Degrees of Involvement (from St Mungo's Client Involvement Tool Kit)

With these degrees of involvement in mind, and in order to contextualise and make sense of the findings of this review, some working definitions of key concepts that emerged from it (*social inclusion*, *recovery*, and *co-production*) are now provided.

Social inclusion has been defined as an individual's participation in the key activities of the society in which they live (Burchardt, Le Grand and Piachaud, 2002). The social inclusion agenda (ODPM, 2004) and the recovery paradigm (Slade, 2013) have emerged as strong drivers of mental health policy and practice in the 21st century.

Recovery is "a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness" (Anthony, 1995, p.7).

Co-production has no single definition but key features of co-production initiatives have been identified (SCIE, 2015) and are presented in Box 2 overleaf.

- defining people who use services as assets with skills

- breaking down the barriers between people who use services and professionals

- building on people's existing capabilities

- Including reciprocity (where people get something back for having done something for others) and mutuality (people working together to pursue their shared interests)

- working with peer and personal support networks alongside professional networks

- facilitating services by helping organisations to become agents of change rather than just being service providers

Box 2: Key Features of Co-production (from SCIE, 2015)

Approaching the Literature

The over-arching question behind this review was:

What works well in community groups that involve peer support workers?

Pursuing this inquiry revealed two inter-woven strands or types of literature:

1. literature exploring the impact of peer leadership, where people affected by mental health problems (including carers) have a direct paid or unpaid role in leading a community group or groups

2. Literature exploring the impact of active 'participation' and working in 'partnership'.

It is recognised that these participatory and/or partnership roles are hard to define and will vary according to the group context. Consequently, a broad range of search terms was used to permit a degree of fluidity so the report could be as inclusive as possible, capturing a range of perspectives on peer involvement and leadership. The over-arching question (above) was broken down into the five sub-questions presented in the left-hand column of Table 2 overleaf. The right-hand column of Table 2 summarises how the literature answers each question, as presented more fully in the *Findings* section of this report (pps. 14-26)

Q1: In a successful group what is peer involvement/leadership?	1.1. The peer support worker role is defined flexibly but is characterised as inspiring hope 1.2. The peer support worker role promotes mutually supportive, reciprocal relations within the group
Q2: In a successful group what supports recovery?	2.1. Principles of social inclusion and equality 2.2. Personal control and personal growth
Q3: What helps successful community groups get started?	3.1. A meaningful common aim or purpose that may or may not focus on mental health 3.2. A jointly agreed agenda (between peer support workers and members) which is flexible and open to review 3.3. Environmental factors influence the success of support groups 3.4. A common language, engagement in conversation and a sharing of experiential wisdom
Q4: What helps successful community groups to develop?	4.1. Accessing wider communities 4.2. Opportunities for progression and transition within and beyond the group 4.3. Assistance to peer support workers
Q5: How is 'success' measured in successful community groups?	5.1. Self-esteem 5.2. Empowerment 5.3. Optimism

Table 2: A summary of findings from the literature

Method of Review

The review has analysed and synthesised published literature derived from formal data-base searching. It has sought to identify key themes, emerging theories, and current debates in

order to develop an understanding of a rapidly developing aspect of community-based mental health care.

Maintaining the inter-relatedness of both components of this overall project – that is, the participatory action inquiry and the literature review (see p.4) – has been a paramount concern of the UWE project team.

Participatory action inquiry is an approach to evaluating complex social phenomena. It draws on the principles of participatory action research, which is "critical research dealing with real-life problems, involving collaboration, dialogue, mutual learning, and producing tangible results" (Denzin and Lincoln, 2008, p.557). It is based on the principles of social justice (Mertens, 2007 and 2012), whereby the input of all participants is seen to have parity.

Participatory methods were chosen because they allow the voice of those participating in the various community groups to have an equal weight to the voices of the St.Mungo's/Creativity Works/Sirona hosts and the UWE inquirers and an active role in any possible future actions arising from the project as a whole (Reason, 1994)

Accordingly, in recognition of the subjective nature of 'support' (which, if effective, is usually something *felt*) and of the value of an authentic service user voice in describing the characteristics of support, the review has deliberately included papers that may otherwise have been omitted from more traditional systematic reviews. For example, experiential testimony of positive support group provision (from a peer support worker's perspective) has been included (see Hodge, 2005). Similarly, preliminary searching of support group literature revealed a preponderance of primary research conducted within statutory services and these articles were also omitted due to there being little transferability to the voluntary sector.

Search Strategy

Search Terms

The search terms and synonyms in Table 3 (created by truncations designated by *) were developed from preliminary searches of relevant literature and appropriate references lists.

These search terms were combined using the Boolean operators 'AND' / 'OR' to search the following six databases (See also Appendix 1):

1. Assia (via ProQuest)
2. AMED (via EBSCO)
3. Cinahl (via EBSCO)
4. Psychinfo (via EBSCO)
5. Social Policy and Practice (via Ovid)
6. Social Services Abstracts (via ProQuest)

	Concept 1	And	Concept 2	And	Concept 3
OR	'Mental health'		Peer-led		'Community Group*'
			'Peer leader*'		'Support group*'
	Psychiat*		Peer involve*		Group*
			'Peer support'		
	Recovery		User-led		
			'User involve*'		
	'Experts by experience'		'Participant-led'		
			'Participant involve*'		
	'Mental illness'		'Member involve*'		
			Consumer-led		
			Client-led		
			'Client involve*'		
			Co production		

Table 3: Search Terms Used for Data Base Searching

Inclusion and Exclusion Criteria

Table 4 (overleaf) shows the inclusion / exclusion criteria that were applied to focus the review on non-statutory (that is, voluntary sector) support groups involving peer support workers.

Within these criteria there was a particular focus on support groups for working age adults (18-67 years) and on groups involving those who have lived experience of mental health difficulties. See also Appendix 2 for a matrix depicting the search method.

Inclusion	Exclusion	Rationale
Literature from 2004 to 2014 (inclusive)	Literature pre 2004	To maintain a contemporary perspective on a rapidly evolving aspect of practice
Peer-reviewed papers	Non peer-reviewed papers unless the paper discusses personal experiences of those accessing groups or being peer supporters.	To maximise the quality of the literature reviewed
Community-based services	Work focused on statutory in-patient services	To investigate community groups as commissioned by St. Mungo's and partners
Literature where peers are involved as members, volunteers and paid workers in community based groups	Groups run by professionals with no clear user involvement, or those with peer involvement/leadership, but in in-patient settings	To focus on the impact of peer involvement in community settings
Literature explicitly exploring the phenomenon of peer involvement/leadership	Studies of groups without peer involvement/leadership	To maintain a focus on the impact of peer involvement/leadership
Literature exploring groups where peers offer support to others impacted by mental health issues	Literature exploring groups where peers are involved in non-co-productive activities	To focus on the impact of peer involvement/ leadership in recovery
Literature focused on exploring what works well in relation to peer involvement/leadership in mental health based community groups	Literature where the focus is a global commentary and too unspecific to have relevance to the question	To keep the focus on the primary inquiry

Table 4: Inclusion and Exclusion Criteria Used in the Literature Search

Findings

Searching generated 110 potential articles by scanning abstracts for relevance. In total 35 papers were selected for this literature review (See Appendix 2). This included two literature reviews (Repper and Carter, 2011; Walker and Bryant, 2013), 11 commentaries or reflective pieces (Alberta, Ploski, and Carlson, 2012; Bradstreet, 2006; Clifton *et al.*, 2013; Davidson *et al.,* 2012); Davies, Gray and Webb, 2014; Duffield, 2009; Repper and Watson, 2012; Singer, 2011; Solomon, 2004; Swarbrick, 2013; Swarbrick, Bates and Roberts, 2009), and two case studies (Hodge, 2005; Newton *et al.*, 2013). The remaining literature was primary research using qualitative methods (Berry, Hayward and Chandler, 2001; Connor and Wilson, 2006; Kemp, 2010; Kemp and Henderson, 2012; Swarbrick and Ellis, 2009; Van Draanen *et al., 2013*), a mixed methodology (Brown *et al.,* 2008; Crepaz-Keay and Cyhlarova, 2013; Fukui *et al.,* 2010; Jonikas *et al.,* 2010; Ley, Roberts and Willis, 2010; Moran, Russinova and Stepas, 2012; Rose, Fleischmann and Schofield, 2010; Swarbrick, 2009; Swarbrick, 2009; Tanenbaum, 2011), and quantitative methods (Salzer *et al.,* 2013; Verhaeghe, Bracke and Bruynooghe, 2008), including randomised control trials (Cook *et al.,* 2012; Jonikas *et al., 2013;* Pickett *et al.,* 2012).

The articles retrieved by this method covered a number of aspects of peer-facilitated mental health support groups, such as: exploration of different models of group, examination of the effectiveness of specific interventions, analysis of the 'support worker' role, consideration of the impact that group membership had on individual members' mental health, and reflection on the best ways of involving peers.

The articles reviewed were examined closely in terms of how they answered the five key questions presented in Table 4 (p.12). What now follows (on pps. 14-27) is some reflection on the significance of the findings in relation to those five questions – that is, as a response to each question – in order to develop an understanding of how the literature has addressed the over-arching question presented on page 8.

1.1 The peer support worker role is defined flexibly but is characterised as inspiring hope

Despite the growing body of literature on peer support there is no consensus on a definition for the peer support worker role, as noted by Faulkner *et al.* (2013). For example, the terms *peer mentor*, *peer worker* or *peer lead* are all used (Repper and Watson, 2012).

However, naming such roles is seen to be important in creating a sense of achievement and purpose in successful support groups (Singer, 2011). This report uses the term *peer support worker* throughout (Repper and Watson, 2012).

An important aspect of the peer support worker was assisting group members to develop their social identity (Newton *et al,* 2013). This process could begin with the peer support worker having a shared 'service user' identity with the group member or having had similar experiences of assisting someone with mental health difficulties as a non-professional (Faulkner and Kalathil, 2011). The key outcome was the instillation of hope (Davies *et al.*, 2014). This was generally achieved by the peer support worker assisting the group member to extend their range of social activities (Clifton *et al.*, 2013) rather than purely learning ways to reduce distress associated with the symptoms of a particular mental health problem (Hodge, 2005).

1.2 The peer support worker role promotes mutually supportive, reciprocal relations within the group

Peer support work is characterised by *mutuality* (Swarbrick and Ellis, 2009) which is an attunement to, and responsiveness to, a person or group regarding their subjective frame of reference of being a service user (Solomon, 2004). *Reciprocity* was also a recurring quality, described as the exchange of mutually beneficial knowledge and/or accounts of personal experience (Repper and Carter, 2011).

This focus on mutuality and reciprocity suggests that a sense of equality in the relationship between the giver and receiver of support is important (Repper and Watson, 2012). This is seen to be distinct from support provided by statutory services where a clinician may request information from a service user without sharing their own personal narratives

(Korsbek, 2013). However this 'equal' relationship was seen to exist on a spectrum ranging from structured and boundaried relationships (which defined the support offered) to those relationships that seemed more like friendships (Bradstreet, 2006; Bradstreet and Pratt, 2010; Kemp and Henderson, 2012; Alberta *et al.,* 2012).

A number of issues were raised through consideration of relationships at different points along this spectrum. For example, where a peer support worker had a specifically *therapeutic* remit there might be a clearer understanding between them and other group members about the purpose of the relationship and thus concerning issues of confidentiality (Duffield, 2009). In contrast, this clarity might be absent in relationships that leaned more towards friendship but a sense of camaraderie and affiliation might better assist the social integration and personal growth of the group member (Alberta *et al.,* 2012).

Above all, the majority of the articles indicated that reciprocity underpinned the sharing of experience and the building of viable collaborative relationships (Crepaz-Keay and Cyhlarova, 2012; Newton *et al.,* 2013; Swarbrick, 2013). However, a significant cluster of articles focused less on such relationships and more on the dissemination of self-management techniques, presenting the benefits of this for individual service users (Fukui *et al.,* 2010; Jonikas *et al.,* 2013).

Having outlined the diverse range of peer support worker roles, the following quotation from Mead (2003) is offered because it encapsulates the findings as a whole in terms of describing how a peer support worker role can support a successful community group;

> *"Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others whom they feel are "like" them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to "be" with each other without the constraints of traditional (expert/patient) relationships. Further, as trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves re-enacting old roles. This allows members of the peer*

community to try out new behaviours with one another and move beyond previously

held self-concepts built on disability, diagnosis, and trauma worldview."

(Mead, 2003, p. 1)

Question 2: In a successful group what supports recovery?

There is much debate about the definition of recovery given its multi-faceted nature (Pilgrim, 2011). This has meant that different articles have placed comparatively different emphases on the extent to which a community group's focus is *recovery* or *social inclusion*.

2.1 Principles of social inclusion and equality

Some articles suggested social inclusion is a principle of recovery, and would therefore be a group's overall goal (Clifton *et al.,* 2013; Repper and Watson, 2012). Social inclusion within community groups is characterised as all participants having equal opportunity to be included in aspects of facilitating the group (Clifton *et al.,* 2013). This meant that all members felt valued and respected as individuals (Singer, 2011) and that, overall, there was a focus on collaboratively addressing the day-to-day challenges of living with a mental health problem (Clifton *et al.,* 2013) and to build on positive experiences of this learning (Rose, Fleischmann and Schofield, 2009).

2.2 Personal control and personal growth

Most of the articles regarded social inclusion as the continuation of a personal growth process and saw this growth as the goal (Alberta, Ploski and Carlson, 2012; Clifton *et al*., 2013; Davies, Gray and Webb, 2014; Kemp and Henderson, 2012; Repper and Carter, 2011; Rose, Fleischmann and Schofield, 2010; Singer, 2011; Tanebaum, 2011; Verhaeghe, Bracke and Bruynooghe, 2008).

However, when looking at successful support groups, the two issues – *recovery* and *social inclusion* – are woven together in the way they each assisted individuals to have equality of access to meaningful economic, social and cultural relevant activities and supported them in

developing a sense of personal control over their life, promoting hope and cultivating personal identity (Brown *et al.,* 2008; Clifton *et al.,* 2013).

<table>
<tr><td>Question 3: What helps successful groups get started?</td></tr>
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3.1 A meaningful common aim or purpose that may or may not focus on mental health

A key characteristic of successful community groups is collective action (Faulkner e*t al.,* 2013; Swarbrick*, Bates and Roberts,* 2009). This is when people come together with a common aim or purpose and with a shared or mutually understood perspective of the world (Clifton *et al.,* 2013; Crepaz-Keay and Cyhlarova, 2012; Kuo, 2013).

Cook *et al.* (2012) and Fukui *et al.* (2010) suggested that this might be achieved through the creation of structured groups focusing on recovery principles and starting with the aim of either understanding psychiatric symptoms or reducing the distress associated with them. These learning processes appeared to relate to self-management, with various degrees of specialisation. For example, some groups focused on medication management (Cook et al., 2012), while others acquired more profound spiritual understanding of personal recovery (Straughan and Buckenham, 2006). However, whilst this learning may have been supportive of personal recovery and/or social inclusion and an expansion of individuals' life choices (Cook *et al.,* 2012; Fukui *et al.,* 2010; Pickett *et al.,* 2012), there was little evidence that this personal process assisted community groups to work better overall.

A successful community group was meaningful to all its participants (Van Draanen *et al.,* 2013). Usually this sprang from a shared experience of living with mental health difficulties (Berry, Hayward and Chandler,2011); be that as a current service user (Singer, 2011), a former service user (Repper and Watson, 2012), a carer (Davidson *et al.,* 2012), or as a family member or friend of a service user (Alberta, Ploski and Carlson, 2012, Moran, Russinova and Stepas, 2012).

'Success' could have different connotations for individuals, ranging from learning how to gain more from statutory services (such as being signposted towards therapy services) (Jonikas *et al.,* 2013), to getting support for self-advocacy (Pickett *et al.,* 2012), to

developing the confidence for activism (Van Draanen *et al.*, 2013), which might begin from a standpoint of dissatisfaction with statutory care (Rose*,* Fleischmann and Schofield, 2010). This could involve working with statutory services to develop provision, assisting service users to access care, or informing the public about resourcing (Davies *et al.,* 2014; Solomon, 2004; Tanenbaum, 2011).

Davies, Gray and Webb, (2014) considered equality of involvement in a group as an issue of social justice. More widely, the importance of non-hierarchical processes (compared with the asymmetrical service provider/service user dynamic associated with statutory services) was emphasised, whereby all views and opinions could be equally respected (Dunfield, 2009; Hodge, 2005; Verhaeghe, Bracke and Bruynooghe, 2008). However, Kemp (2010) argued that for some particular cultural groups there may be less of a wish to socialise with others due to mistrust and/or the experience of discrimination. Indeed, cultural awareness on the part of peer support workers was noted as an important aspect of successful group facilitation by Jonikas *et al.* (2010) and Newton *et al.* (2013), particularly where the social exclusion associated with living with mental health problems was compounded by other societal prejudices such as racism (Kemp and Henderson, 2010; Ley, Roberts and Willis, 2010; Verhaeghe, Bracke and Bruynooghe, 2008).

Given the overall prime motivation of wanting to engage with a supportive social milieu (Moran, Russinova and Stepas, 2012), service users' participation in community groups took many different forms such as vocational activities to improve employment possibilities (Swarbrick, 2009a; Swarbrick, Bates and Roberts, 2009), leisure activities (Fukui *et al.,* 2010), participation in sporting activities (Clifton *et al.,* 2013), going on trips (Swarbrick, 2009b), and sharing hobbies and artistic expression such as painting, writing and performance art (Brown, *et al.,* 2008, Clifton, *et al.,* 2013, Swarbrick, 2013).

3.2   A jointly agreed agenda (between peer support workers and members) which is flexible and open to review

Successful community groups are characterised by co-production (Solomon, 2004) whereby group members and peer support workers jointly agree the agenda for how support is provided (Clifton *et al.*, 2013).

In the reviewed literature co-production negotiations occurred in relation to ground rules for maintaining individuals' dignity, for example (Crepaz-Keay and Cyhlarova, 2012), for establishing roles and operational policies regarding confidentiality (Connor and Wilson, 2006), and for discussion about risk management and the nature of the support offered (Kemp and Henderson, 2012). Sometimes, however, there was a more laissez-faire approach which allowed ideas to emerge over time (Alberta, Ploski and Carlson, 2012). Also, in some groups not all group members liked the expectation that they *should* become involved in such planning, though generally they wanted to retain the flexibility to become involved if they chose to in their own time (Rose, Fleischmann and Schofield, 2010).

Sharing information is an important issue in community groups (Moran, Russinova and Stepas, 2012) and various methods are discussed including the use of information technology and regular open discussion forums. Attention to this need is seen to promote cohesiveness, consistency and understanding, all of which contribute towards a community group's success (Davies, Gray and Webb 2014; Kemp and Henderson, 2012).

Several articles highlighted the importance of training for peer support workers (Newton *et al.,* 2013; Salzer *et al.,* 2013), particularly in terms of developing their ability to demonstrate empathy with service users on the basis of a shared experience of living with mental health problems (Brown *et al.,* 2008; Repper and Carter, 2011). Other papers showed that learning particular recovery-orientated interventions – such as Wellness Recovery Action Planning (WRAP) (Copeland, 1995; Jonikas *et al*., 2013) or the BRIDGES programme (Cook *et al*., 2012) – can be useful as part of a pragmatic, assisted self-management approach.

Other important abilities to develop included cultural awareness (Jonikas *et al.,* 2010), problem solving (Cook *et al.,* 2012; Pickett *et al.,* 2012), coaching and looking after oneself (Davidson *et al*., 2012; Duffield, 2009; Singer, 2011; Swarbrick, 2013; Walker and Bryant, 2013). This latter issue acknowledged the stress placed on peer support workers of adopting a care provider role. This will be discussed further when considering the literature regarding support for peer support workers.

Peer support workers feeling part of a peer support *team* was seen as an important aspect of a group's success (Moran, Russinova and Stepas, 2012; Salzer *et al.,* 2013; Swarbrick, 2013, Van Draanen *et al.,* 2013). There was also a suggestion that peer support workers

could have a more formal induction into the role (including certification and an information booklet), which would help to build their confidence (Clifton *et al.,* 2013; Repper and Watson, 2012; Salzer *et al.,* 2013). Other articles discussed further developing peer support roles through co-production of employment specifications (Davidson *et al.,* 2012) such as sickness policies and financial benefits for peer support workers (Davidson *et al.,* 2012; Singer, 2011). There was also consideration of a comprehensive interview process to select peer support workers which would establish, for example, applicants' awareness of social inclusion issues (Clifton *et al.*, 2013, Repper and Watson, 2012). Other desirable credentials included personal experience of mental health problems, experience of community group facilitation (Repper and Watson, 2012) and awareness of societal issues that added to the stress of living with mental health problems (Kemp, 2010).

The benefits of retaining experienced peer support workers who understood the multifaceted nature of supporting people within a community group were acknowledged (Repper and Carter, 2011; Walker and Bryant, 2013). Additionally, Bradstreet (2006) argued a case for career development for such peer support workers, which may lead to a change in how their leadership role is defined (Faulkner and Kalathil, 2012). For example, some articles referred to *peer leads* (Moran, Russinova and Stepas, 2012; Rose*,* Fleischmann and Schofield, 2010) and there was recognition of the need for further training for such positions (Newton *et al.,* 2013; Van Draanen *et al.,* 2013). However, there was also a contrasting perspective that such positions should be developed through experiential learning over time (Pickett *et al.,* 2012; Swarbrick, 2013). Alberta, Ploski and Carlson (2012) raised a concern that peer support workers remaining in a leadership position for too long might limit development opportunities for other people and impede equality in the group.

There was also acknowledgement that successful community groups owed their success to input from members who did not want to commit to a specific 'leadership' role (Bradstreet, 2006) but preferred to help in an ad hoc way such as by engaging people in conversation, helping people with travel, cooking skills or budgeting, and by helping to provide refreshments (such as by making drinks) at group meetings (Davidson *et al.,* 2012; Newton *et al.,* 2013).

Understanding the needs of the community or population that a group sought to support was an important factor in a group's success. Although this 'community' may, arguably, be defined by its members' use of statutory services (Walker and Bryant, 2013), it was noted that not everyone will want to meet with other people. Some research suggested demographic analysis as a prelude to offering support (Cook *et al.,* 2012; Repper and Watson, 2012), while other articles recommended using community leaders who were attuned to the specific needs of a locality in order to establish relationships and determine local need (Ley, Roberts and Willis, 2010; Verhaeghe, Bracke and Bruynooghe, 2008).

3.3 Environmental factors influence the success of support groups

Unsurprisingly, the location of a support group was a contributory factor in its success, particularly its proximity to public transport and other amenities, and its accessibility for those with physical disabilities (Swarbrick, Bates and Roberts, 2009; Van Draanen *et al.,* 2013).

A number of articles examining environmental factors (Moran, Russinova and Stepas, 2012; Swarbrick, 2009; Swarbrick and Ellis, 2009) indicated that successful support groups required areas for communal activity (with seating and furniture arranged to promote conversation) and appropriate equipment and furniture to support specific activities (Moran, Russinova and Stepas, 2012). It was also shown that private space for confidential support was important (Swarbrick and Ellis, 2009). Clifton *et al.* (2013) highlighted that where an environment is designed through a co-production approach (for example, with group members and peer support workers decorating the premises together) this can promote inclusiveness in many ways such as by including culturally specific murals or by allowing group members to contribute their own do-it-yourself skills (Clifton *et al.,* 2013).

3.4 A common language, engagement in conversation and a sharing of experiential wisdom

Duffield (2009) highlighted the importance of using simple, de-jargonsied language within community groups. It was also acknowledged that certain words can have different connotations across different communities and/or cultural groups (Hodge, 2005; Moran, Russinova and Stepas, 2012; Rose*,* Fleischmann and Schofield, 2010) such as in street slang,

for example. Additionally, the power dynamics of communication should be taken into account, particularly in relation to how information is shared (Hodge, 2005; Duffield, 2009). Poor sharing of information was linked to poorly planned community groups (Berry, Hayward and Chandler, 2011, Duffield, 2009; Kemp and Henderson, 2012). In short, the sharing of knowledge increased collective understanding of what was occurring within a group and this supported successful functioning (Clifton *et al.,* 2013).

Question 4: What helps successful groups develop?

The majority of the findings regarding what helps groups to get started are equally applicable to groups' successful continuation and development. 'Development' in this context means becoming sustainable over time. This may require adaptation in relation to the ever changing socio-political climate regarding mental health provision but also in relation to deepening understandings of what is experienced as supportive, particularly as the demographics of those accessing groups may change overtime (Clifton *et al.,* 2013; Swarbrick, Bates and Roberts, 2009).

4.1 Accessing wider communities enables groups to develop

Kemp (2010) and Ley, Roberts and Willis (2010) have discussed the need to engage with wider, non-mental health-orientated communities; that is, going beyond the immediate boundaries of the community group itself. This was summarised as a process of networking with other statutory or voluntary organisations. For example, the benefits of attending public forum meetings about developing a city's artistic expression – such as through carnivals, public street art, or other artistic performances – enabled a community group to work with new partners (Clifton *et al.,* 2013; Kemp, 2010; Kemp and Henderson, 2012). The ability to communicate with potential partners while respecting the confidentiality of community group members was the key to success (Clifton *et al*., 2013; Van Draanen *et al.,* 2013; Repper and Carter, 2011).

Networking in this way could increase a group's sustainability in several ways, such as by increasing public awareness and support for the group (Kemp, 2005; Verhaeghe, Bracke and Bruynooghe, 2008), through co-production between community group members and other communities creating opportunities for social inclusion of group members (Clifton *et al.,* 2013; Connor and Wilson, 2006). Again, this partnership working worked best when based on shared interests rather than on mental health problems as such (Hodge, 2005).

4.2) Opportunities for progression and transition within and beyond the group can assist sustainability

 Bradstreet (2006), Bradstreet and Pratt (2010), Newton *et al.* (2013), and Van Draanen (2013) considered transitional opportunities for community group members to increase the cohesiveness within a community group. They suggested a cyclical process whereby new participants (who may initially join primarily for their own support) later have the opportunity to become more involved as a peer support worker. However it was unclear how this process would work when there were already people holding such positions.

Bradstreet and Pratt (2010) suggested there may be a new role beyond the immediate group for those who have been peer support workers for a time, or those individuals may be assisted with employment opportunities (Repper and Carter, 2011; Singer, 2011; Solomon, 2004). This would create opportunities for new members to become peer support workers (Solomon 2004), and also present the peer support worker role itself as a potential step towards social inclusion (Clifton *et al*., 2013; Repper and Watson, 2011).

4.3) Assisting peer support workers supports the development of a group

Davidson *et al.* (2012), Duffield (2009), Repper and Watson (2012), Singer (2011), and Walker and Bryant (2013) considered the kind of assistance required by peer support workers themselves. For example, supervision was seen as a way to support someone face the challenges of working within a community group, to maximise their learning, and to build their confidence (Repper and Watson, 2012; Singer, 2011). Generally, the focus of the supervision was the peer support worker's own personal growth and their capacity to assist

others (Davidson *et al.,* 2012, Singer, 2011; Swarbrick, 2013) rather than management issues.

Other supportive features included having opportunities for timely, ad hoc discussions to address the day-to-day emotional challenges associated with helping others (Duffield, 2009; Singer, 2011), particularly where that helping role evoked the peer support worker's memories of their own mental distress (Singer, 2011). Indeed, Rose*,* Fleischmann and Schofield (2010) suggested that being a peer support worker involved modelling ways of accepting support and that witnessing this may empower group members to also seek support when it was required.

As noted earlier (in section 3.2 on p.18), regarding agreements and policies, several articles highlighted the need to appreciate peer support workers' vulnerability to a relapse of their own mental health problems (Davidson et al., 2012; Singer, 2011) and the importance of supporting that person's recovery and return to the role when they felt able to do so (Singer, 2011; Kemp and Henderson, 2012). Singer (2011) discussed the supportiveness of regular visits while the person was in hospital and/or recovering at home. There was also recognition of the need to reduce the anxiety of the peer support worker regarding any expectation they might feel to complete tasks when relapsing (Singer, 2011; Ley, Roberts and Willis, 2010; Walker and Bryant, 2013) and to ensure group members were kept informed if someone was absent (Singer, 2011).

5) How is success measured in community groups?

This literature review found various methods for evaluating groups. Co-production of measures (including input from the host organisation, its peer support workers and group members) was seen as a way of gauging a group's development in a relevant and meaningful way for all (Clifton *et al*., 2013; Davidson *et al*., 2012; Singer, 2011; Solomon, 2004). Some authors suggested using standardised outcome measures also to maximise rigour, which may be an important consideration (Brown *et al.,* 2008; Cook *et al.,* 2012; Fukui *et al.,* 2010; Jonikas *et al.,* 2010; Pickett *et al.,* 2012; Swarbrick, 2009).

5.1) Measurement of self-esteem

A recurring phenomenon as a focus for group evaluation was group members' *self-esteem*, based on the premise that this was enhanced by engagement in more socially inclusive activities and – hence – was a proxy indicator of an effective support group (Fukui *et al.,* 2010; Newton *et al.,* 2013; Verhaeghe, Bracke and Bruynooghe, 2008). There was widespread use of the Rosenberg (1965) Self-Esteem Scale to this end. For this tool to work effectively, however, baseline measures would need to be taken of all those involved due to multiple variables such as age, ethnicity, education, employment and relationship status (Sinclair *et al.,* 2010).

5.2) Measurement of empowerment

Another outcome measure, described by Jonikas *et al.* (2010) and Picket *et al.* (2012), was Rogers *et al.'s* (1997) Empowerment Scale, which enabled measurement of the outcomes recommended by several authors cited in this review, such as individuals' activism, their sense of empowerment and their optimism.

5.3) Measurement of optimism and hope

Cook *et al.* (2012) and Jonikas *et al.* (2013) also considered measures of optimism and hope, particularly Snyder's (1995) State of Hope Scale which offers a brief self-report measure of on-going goal-directed thinking based on an individual's sense of personal agency – that is, their belief in their own capacity to initiate and persevere with actions in adverse conditions.

Other outcome measures considered included Ryff and Singer's (2006) Psychological Well-Being Scale and the Recovery Assessment Scale (Giffort *et al.,* 1995), both observed by Moran, Russinova and Stepas (2012), for example. The majority of mixed methodology or quantitative research papers highlighted the importance of measuring psychiatric symptoms using Derogatis' (1993) Brief Symptom Inventory (Cook *et al.,* 2012; Jonikas *et al.,* 2013; Verhaeghe, Bracke and Bruynooghe, 2008). However using such an instrument may depend

on how a support group wishes to demonstrate success overtime because, as this review has highlighted, 'success' is not generally considered in terms of symptom alleviation.

Discussion: creating a learning culture

As a conceptual framework for further discussion of the qualities of successful peer-facilitated community groups this review uses certain principles of *learning organisations* (see Small and Irvine, 2006 and Skok, 2013) on the basis that successful organisations and successful community groups are characterised by a culture of ongoing learning and adaptation, and by a collective commitment and shared vision across all stakeholders. It can be argued, therefore, that the essence of a successful community group using peer support workers is the development of its culture to become a *learning* culture (Cooper, 2014).

Facilitative leadership

Training for all stake holders

Flexibility and scope to try out different roles

Mission statement emphasising partnership

Co-production

Career development

Employment assistance

Networking and sharing knowledge with other communities

1. Culture of learning

2. Culture of continual development

4. Culture of support and supervision

3. Culture of clear communication

Open meetings to discuss group progression

Sharing knowledge through different media

Regular supervision and support

Transparency of information and clear expression shared vision

Defining roles for peer support workers

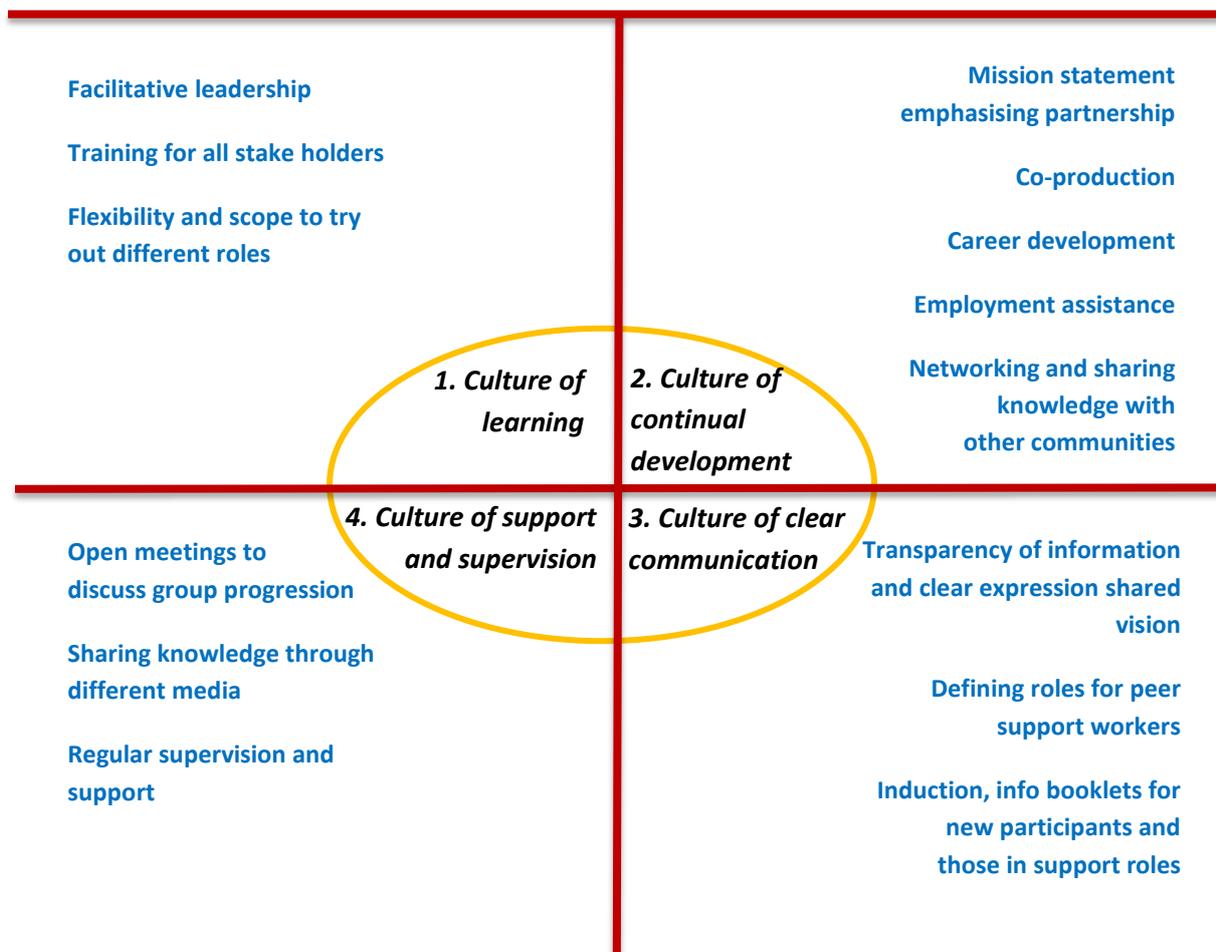**Induction, info booklets for new participants and those in support roles**

Fig 1: Four elements of a learning organisational culture present in successful peer-facilitated community support groups (from Milway and Saxton 2011)

Accordingly, aspects of the organisational culture (Büschgens, Bausche and Balkin 2013) of peer-facilitated community groups which foster mutual learning are highlighted here. They include the accessibility of the group's premises and location (Moran, Russinova and Stepas, 2012; Swarbrick and Ellis, 2009; Swarbrick, Bates and Roberts, 2009; Van Draanen *et al.,* 2013), the training and support given to peer support workers (Repper and Watson, 2012; Singer, 2011; Swarbrick, 2013), challenging asymmetrical power dynamics (Hodge, 2005; Dunfield, 2009), using straightforward language (Dunfield, 2009), transparency in information-sharing (Morgan et al., 2012), maintaining habits of communication focused on shared inquiry rather than being instructional (Duffield, 2009; Hodge, 2005; Verhaeghe, Bracke and Bruynooghe, 2008) and – perhaps most pertinently – collective *adaptation* to promote sustainability.

This focus on learning and adaptation underlines the suitability of action learning as a methodology for further developing the network of peer-facilitated groups hosted by St. Mungo's Broadway and partners, as indicated on page 4. The *appreciative inquiry* approach (Cooperrider and Whitney, 2005) adopted by the UWE project team focuses specifically on adaptive potential by exploring, in 'the thick of the action', what makes human social and organisational systems operate at their best and works on the premise that dialogue about strengths is a transformational process for the groups that engage in it. The emphasis on collective commitment across all stakeholders in a learning organisational culture also reflects the ethos of co-production that has emerged strongly as a feature of successful community groups in this literature review.

Figure 1 (on p.26), adapted from Milway and Saxton (2011), summarises some of the main points established in this review and their relevance to the four elements of a learning organisational culture.

Summary

The findings of this review indicate that, whilst successful community groups have diverse characteristics, a common feature of *successful* groups is a culture of close partnership-working between a host organisation, peer support workers and the members themselves. Other specific components of good organisational development include, for example, aspects of recruitment, training, peer certification and supervision for peer support workers.

An over-arching theme regarding individuals' engagement with such groups was the benefits of being with, and doing things with, other people with whom there was a sense of affiliation. This connection was not necessarily expressed through overt, explicit discussion of mental health difficulties as such but primarily through shared interests and activities, or simply through a willingness to engage with each other socially.

The population accessing support groups was also considered. There was broad acknowledgement that stigma and exclusion were challenges facing a wider range of people than simply those with a mental health problem. Additionally, there was recognition of the need for greater awareness of the needs of people from distinct and diverse cultural backgrounds who might access support groups.

Overall, successful support groups focused on group members' social identity beyond that of 'service user' and beyond diagnostic frameworks.

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Appendices

Appendix 1: Description of Data Bases

Databases were searched via the UWE Library Services and were selected to cover a wide range of published articles in the field of mental health and social care, complimentary health and social policy.

	Data base	Description (UWE 2015)
1.	Assia (via proquest)	ASSIA contains worldwide English language coverage of journal articles, conference papers and book reviews in the fields of applied social sciences and health.
2.	AMED (via Ebsco)	AMED is a unique bibliographic database produced by the Health Care Information Service of the British Library. It covers a selection of journals in 3 main subject areas: complementary medicine; palliative care; and professions allied to medicine.
3.	Cinahl (via Ebsco)	CINAHL® Plus covers more than 4,500 journals from the fields of nursing and allied health. Offering complete coverage of English-language nursing journals and publications from the National League for Nursing and the American Nurses' Association, CINAHL Plus covers nursing, biomedicine, health sciences librarianship, alternative/complementary medicine, consumer health and 17 allied health disciplines. It is produced in the US but has worldwide coverage.
4.	PsychINFO (via Ebsco)	The American Psychological Association's PsycINFO® database is the comprehensive international bibliographic database of psychology. It contains citations and summaries of peer-reviewed journal articles, book chapters, books, dissertations, and technical reports, all in the field of psychology and the psychological aspects of related disciplines, such as medicine, psychiatry, nursing, etc. Journal coverage, spanning 1806 to present. Over 80,000 records are added annually through weekly updates. More than 36 million references in over 870,000 journal articles, books, and book chapters; retrospective to 2001 and earlier, where available; more than 3.2 million references from 1920 to 2000.
5.	Social Policy and Practice (via Ovid)	Social Policy and Practice brings together data from 5 databases. The majority of the material originates from the UK but there is also European and US material. Some 50% of the references are to grey literature, including semi-published reports, working papers, local and central government reports, and material from the voluntary sector and charities. Databases included: Planex from IDOX; Acompline from the Greater London Authority; Social Care Online from the Social Care Institute for Excellence; AgeInfo - from the Centre for Policy on Ageing; ChildData from the National Children's Bureau. It contains over 300,000 bibliographic records dating back to 1981, with approximately 24,000 added per annum. Subjects covered include: Behavioral & Social Sciences; Social Work; Public Health.
6.	Social Services Abstracts (via Proquest)	SA Social Services Abstracts provides bibliographic coverage of current research focused on social work, human services, and related areas, including social welfare, social policy, and community development. The database abstracts and indexes over 1,300+ serials publications and includes abstracts of journal articles and dissertations, and citations to book reviews. Coverage dates back to 1979 and it includes over 147,000 records as of December 2010

Appendix 2: Inclusion Matrix

1. Articles exploring different models of group functioning: included papers

Article	Research	Measurements	Themes	Why included
Brown, L., Shepherd, M., Merkle, E., Wituk, S. and Meissen, G. (2008) Understanding how participation in a consumer-run organisation relates to recovery. *American Journal of Community Psychology* **42 167-178**	Self-defined, mixed methodology, inter comparability by splitting statistical analysis into 3 subject groups within each 3 groups are compared and contrasted for rigour. Tools used were adapted to suite need.	Empowerment scale (Segal et al. 1995), Group Support and Mutual Learning Scale, Intimacy and Sharing Scale (Mowbray and Tan 1993)	Self-help, social support, collective exercise, peer led, leadership, ground rules, problem solving through empowerment of hearing narratives of lived experience from peers	Though it's from the US, the aspect of social support is universal in western society; in addition this project is not about creating parity on sample size as noted in meta-analysis.
Bradstreet. S. (2006) Harnessing the 'lived experience': formalising peer support approaches to promote recovery. *Mental Health Review.* **11 (2) pp33-7.**	Commentary	N/A	Need mental health experience, training, accreditation, structure and education required.	Included due to commentary transferability to the UK
Repper, J. and Watson, E. (2012) A year of peer support in Nottingham: lessons learned. *The Journal of Mental Health Training, Education, and Practice.* **7(2) pp70-78.**	Commentary/reflective	N/A	Structure (a description of resources, administration and culture – and the changes in these structures as the project progressed), process (a description of the way the intervention – i.e. the peers – was introduced), and outcome (the perceived impact of the process and the extent to which project goals were achieved). Induction needs to be thorough and flexible, peer role modelling on recovery. Training and education, acceptance of challenges and processes not working as thorough as planned.	Very informative on process of setting up peer support hence used though within statuary services.
Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits and critical ingredients. *Psychiatric Rehabilitation Journal.* **27(4), 392–401.**	Commentary	N/A	Social support consisting of emotional and advice through personal experience. Needs awareness of statuary service provider as an issue is its accessibility with those distressed within community, or those wishing to leave while in hospital.	Though from the US, relevancy and themes are crossing between geographical locations (UK and US)
Swarbrick, M. and Ellis, J. (2009) Peer-operated self-help centers. *Occupational Therapy in Mental Health.* **25 (3-4) pp239-51.**	Participatory Action Research process to demonstrate development	Qualitative	Cost of service, measure of process, flexibility in leadership, strength model	Themes are transcontinental using the same principled research process. Guidance clear on setting up self-help centre is vital to question.
Tanenbaum. S. (2011) Characteristics associated with organizational independence in consumer-operated service organizations. *Psychiatric Rehabilitation Journal.* **34(3) pp248-51.**	Statistical Survey Method Research: • Small sample group appearing convenience to geography creates issues of external validity to US population let alone the UK • Cultural variants on service delivery means poor transferability • Poor probability on some noted outcomes, appears not to observe null hypothesis on these occasions	Survey	Flexibility of not being under control of state, more use not being under state, themes do require further UK investigation on comparable services.	If the study was systematic, this would not be included due to issues of rigour; however some of the themes may assist further investigation. Additionally the themes of flexibility increasing when funding is not under state control is relevant to the UK, for arguably the administration of monies is slower than being independent and trust maybe increased if service users recognise it to be a separate entity from state controlled services.

2. Articles exploring the effectiveness of specific interventions harnessed: included papers

Article	Research	Measurements	Themes	Why included
Cook, J., Steigman, P., Pickett, S., Diehl, S., Fox, A., Shipley, P., Macfarlane, R., Grey, D. and Burke-Miller, J. (2012) Randomized controlled trial of peer-led recovery education using Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES). *Schizophrenia Research*. 136 (1-3): 36-42.	RCT Single blind: Possible research bias on facts but sample was randomised Control and treatment group had probability significant numbers Possibly statuary funding bias	Recovery Assessment Scale (RAS) (Giffort et al., 1995) for self-perceived recovery, State Hope Scale (SHS) (Snyder et al., 1991) for hope, Brief Symptom Inventory (BSI) (Piersma et al., 1994) (may lack validity for the purpose of this question, but may demonstrate change in depressive symptoms, feeling lonely has relevance).	Led by peers, allowance for discussion that may be perceived anecdotal, increase in social networking, self-management may lead to less need to statuary services, which are arguably increasing such management to promote efficiency. Research needs facilitation of service users for arguable mutuality.	Study appears robust, though it's appreciated this is not systematic, important interventions were facilitated and measured by peers with support.
Crepaz-Keay. D and Cyhlarova. E. (2012) A new self-management intervention for people with severe psychiatric diagnoses. *The Journal of Mental Health Training, education and Practice.* 7 (2) pp. 89-93.	No salient points as not completed	Constructed questionnaire (no details) and 2 days of consultation (not described)	Social occasion. Peer led group facilitation originating from the original project, ground rules, mission, and self-management with goal setting. Not completed in isolation and is interactive in sharing with other community projects. Problem is its accessibility appears diagnoses led when under statuary services.	Generalizable in as far it being a UK sample group, common theme of self-management and socially valuable.
Fukui, S., Davidson, L. J., Holter, M. C., & Rapp, C. A. (2010). Pathways to Recovery (PTR): Impact of peer-led group participation on mental health recovery outcomes. *Psychiatric Rehabilitation Journal.* 34(1) pp42–48.	A single-group pre-test-post-test research design was applied. Statistical by the baseline of outcome measures before and after, convenience sample, no external validity.	The Rosenberg Self-Esteem Scale (Rosenberg, 1965; Blascovich & Tomaka, 1993), The General Self-Efficacy Scale (Schwarzer & Jerusalem, 1995), The Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988), The Spirituality Index of Well-Being (Frey, Daaleman, & Peyton, 2005), The Modified Colorado Symptom Index (Conrad et al., 2001)	Strength Model, personalisation and ownership, not structured like WRAP, socially supportive, based within community support.	As it was a peer run service with clearer guidelines on structure for a group to promote self-management with focus on Recovery principles. However a trend of self-management groups appears to be appearing.
Jonikas. J, Kiosk. S, Grey. D, Hamilton. M, McNulty. J and Cook. J. (2010) Cultural Competency in Peer-Run Programs: Results of a Web Survey and Implications for Future Practice. *Psychiatric Rehabilitation Journal.* 34 (2) pp121-9.	Mixed methods	Empowerment Scale (Rogers et al. 1997), self- advocacy scale (PSAS) (Brashers et al. 1999) adapted for validity as initially used for HIV suffers	Needs cultural competence: discouragement of the sharing of personal problems outside of one's family, lack of linguistic competence in many mental health settings, and enduring lack of diversity in the mental health workforce. Aspects for competency is training of peers, accessibility for diverse groups language, cultural relativity within ethical boundaries of UK societies, for example some aspects of cultural difference cannot be condoned such as genital mutilation etc. Creation of a manual and tool box for training was made, but not clear on items, however such a tool would need to consider demographic transferability between areas of Bristol let alone differences in cities and UK regions.	Though this study appeared led by statutory services, it considered peer led groups of a self-help variety, what is not clear if it is self-help that is the issue of cultural variance, for example collectivism Vs Individualism. The former are less keen for self-help and the latter are. However the aspect of cultural competency or indeed the work in New Zealand re cultural safety is pertinent here thus included as it assists with answering the question.

2   Articles exploring the effectiveness of specific interventions harnessed: included papers (*continued*)

Article	Research	Measurements	Themes	Why included
Pickett, S., Diehl, S., Steigman, P., Prater, J., Fox, A., Shipley, P., Grey, D., and Cook, J. (2012) Consumer Empowerment and Self-Advocacy Outcomes in a Randomized Study of Peer-Led Education. *Community Mental Health.* **48 (4) pp 420-30.**	RCT design randomisation with control and treatment group. Recruitment based on serious mental illness thus diagnostic, though participants were not biased to BRIDGES as part of the criteria was not having used it.	Empowerment Scale (Rogers et al. 1997), self- advocacy scale (PSAS) (Brashers et al. 1999) adapted for validity as initially used for HIV suffers	BRIDGES, peer instructors with back up either another peer or from service provider. Measurement self-created with Likert Scale approach, need for consistency of delivery. Flexibility of missing sessions students phoned and given details of what they missed. Promotion of self-advocacy re statutory service provision. Interactions with credible role models—BRIDGES peer instructors—may have increased intervention group participants' confidence in their ability to discuss treatment options and assert their opinions with their service providers.	Reiteration of BRIDGES as a programme to promote empowerment and now advocacy. Focus on peer leads and the social aspect as well as educational is adding to theme that such groups should have dual processes. BRIDGES may be transferable to the UK
Swarbrick. M. (2009) Collaborative Support Programmes of New Jersey. *Occupational Therapy in Mental Health.* **25 (3-4) pp224-38**	Mixed methodology with outcome measures and Participatory Action Research: Exploratory, descriptive research study was designed to measure factors related to the empowerment and satisfaction of participants involved in New Jersey peer-operated self-help centres. This study explored the association between a peer-operated self-help centre social environment (in terms of relationships, personal growth, and system maintenance and change dimensions) and two outcomes, participant empowerment and satisfaction outcome.	Self-Help Agency Satisfaction Scale (SHASS) (Segal et al., 2000), The Making Decisions Empowerment Scale (MDES), by a group of consumer activists and researchers to measure the personal construct of empowerment as defined by consumers of mental health services (Rogers et al., 1997). The Group Environment Scale (GES) (Moos, 1994, 2002).	Milieu, social networks, peer led research and peer facilitated structure. Increased satisfaction with expression, need for multicultural approach to promote access. Peer-operated self-help centres are planned, managed, and staffed by peers and designed to address the social and emotional needs of adult peers. They are considered not only as a complement to traditional mental health services, but also a possible alternative for people living with mental illness living in the community.	Self-help centres though may not be transferable in name as may appear to sound statuary, its premise is very relevant to the question. Balance is need between structure, purpose but also impulsivity and excitement.
Swarbrick. M, Bates. F and Roberts M. (2009) Peer Employment Support (PES): a model created through collaboration between a peer-operated service and university. *Occupational Therapy in Mental Health.* **25(3-4) pp325-34.**	Commentary	N/A	Peer support, peer facilitated, eligibility based on choice, preferences of employment, ongoing support which is flexible, geographical located groups not central, employment workshop with good links with employers, or create own sustainable groups that pay?	Transferability applicable to service users in the UK. Though commentary piece, the paper argues previously used research how employment may help, therefor peers assisting employment may assist also.
Swarbrick, M. (2013) Integrated care: wellness-oriented peer approaches: a key ingredient for integrated care. *Psychiatric Services.* **64 (8) pp723-6.**	Commentary	N/A	Self-help through the formularised process led by service user and coach, holistic health.	The reason for inclusion is the use of coaching rather than peer leading, this definition gives more purpose with role. Further it highlights the need for flexibility in delivery.

3. Articles exploring being a support worker: included papers

Article	Research	Measurements	Themes	Why included
Moran. G, Russinova. Z and Stepas. K. (2012) Toward understanding the impact of occupational characteristics on the recovery and growth processes of peer providers. *Psychiatric Rehabilitation Journal.* 35(5) pp376-380	Mixed-methods study, recruitment already employed peer leads, bias?	1. Recovery Assessment Scale, a 24-item scale measuring perceptions of recovery from mental illness (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004) 2. Empowerment Scale (Rogers, Chamberlin, Ellison, & Crean, 1997), a 28-item scale measuring five dimensions of psychological empowerment; 3. Loyola Generativity Scale (LGS; McAdams & de St. Aubin, 1992; Ochse & Plug, 1986), a 20-item scale assessing generative concerns of promoting the development and well-being of others and future generations 4. Generative Behaviors Scale (Keyes & Ryff, 1998), an 8-item instrument consisting of two subscales measuring, respectively, provision of emotional support and provision of unpaid assistance to children, family, friends, or anyone else during the past month; 5. Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996), a 21-item scale assessing the growth in the aftermath of trauma experiences; and 6. Psychological Well-Being Scale (PWB; Ryff, 1989; Ryff & Singer, 2006), a 54-item instrument measuring autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance.	For peers, success maybe noted by having experience, being peers may empower the individual, occupation, as in doing activities (emotional support) is the link to empowerment rather than being at a centre for example just in case of need.	Included for it does assist with answering the question regarding 'being a peer', in this case showing that occupational activities is better than none, this suggests defining clear roles for those in peer positions.
Rose. D, Fleischmann. P and Schofield. P. (2010) Perceptions of user involvement: a user-led study. *Journal of Social Psychiatry.* 56 (4) pp 389-401	Mixed methodology, semi-structured interview schedule. The questionnaire consisted of mostly closed questions with some opportunities for participants to expand their answers. Sample lacks external validity.	N/A	Activism, about changing services though participants spoke of improvement over the last years. Activists appear more empowered with information about service user groups. If a user is articulate enough to participate in change management activities then they are not 'representative' of ordinary users. Ordinary users are not articulate (but they are satisfied). Activists cannot speak on behalf of ordinary users and ordinary users cannot speak for themselves. In such a discourse, no service user can have a voice. This may represent a need for teaching or training?	The research lacks rigour however this is the first paper that examines a service user as an activist, such social positions appears to empower the person to be more aware of provision and arguably if not exhibiting extreme militancy would make positive Peer role models.
Salzer. M, Darr. N, Calhoun. G, Boyer. W, Loss. R, Goessel. J, Schwenk. E and Brusilovskiy, E. (2013) Benefits of Working as a Certified Peer Specialist: Results From a Statewide Survey. *Psychiatric Rehabilitation Journal.* 36 (3) pp 219-21.	Quantitative survey, posted out to participants, sample determination is not clear suggesting convenient or purposeful, unclear response rate; suggested higher than 27%, issues of significance if return rate is below 40%	N/A	Increase in confidence and purpose to have certification.	The research is unclear on response, however this does add to theme that a sense of certification of being a peer adds to wellbeing, arguable identity with purpose.

3	Articles exploring being a support worker: Included Papers *Continued*				
Article	**Research**	**Measurements**	**Themes**	**Why included**
Singer (2011) Managing my life as a peer support worker *Psychiatric Rehabilitation Journal* **35(2) p49-50**	Reflective first person perspective	N/A	Policy and procedures need to be in place to support relapse with consideration on the peer's dignity and safety for the person and the group. Supervision is required to assist in stress reduction, recommendation is not managerial supervision assessing performance but perhaps in line of Hawkins and Sohet's (2006) 7 Eye Process Model as it considers a counselling approach	Included for it reflects the possibility of relapse of illness for peers.
Walker G. and Bryant, W. (2013) Peer support in adult mental health services: A meta-synthesis of qualitative findings. *Psychiatric Rehabilitation Journal,* **36(1)pp 28-34**	Meta synthesis using CASP to assess transferability of qualitative papers	CASP	Supervision needed, as well as regular pay and hours yet from the service user perspective this also requires flexibility.	Though the article did not come with new findings it again highlighted the need for peer supervision, pay and regular hours.

4   Articles exploring the impact on mental health: included papers

Article	Research	Measurements	Themes	Why included
Clifton, A., Repper, J., Banks, D. and Remnant, J. (2013) Co-producing social inclusion: the structure/agency conundrum. *Journal of psychiatric and mental health nursing.* **20(6) pp514-524.**	Commentary	N/A	Assists carers as well. Focus is on Social inclusion: giving advice, promote hope through positive social networks, make socially specific dependent on the community, include cultural aesthetics that is relevant (artistic occupation), be guided by communities rather than suppose need, no discrimination but consider also the ethical issues of cultural relativity, is all practices accepted? Those involved in groups need to be involved its economic running of the groups. Structure is important, clear induction, mentor flexi time and adapt physical environment. Ultimately this all adds to self-determination.	Included the paper gives further credence to already established themes, with more focus on social inclusion, further the authors are renowned for their UK speciality in this field.
Connor, S. and Wilson, R. (2006) It's important that they learn from us for mental health to progress. *Journal of Mental Health.* **15 (4)pp 461-74.**	Qualitative study, exploratory focus group, grounded theory, convenience/ purposeful sample. Informed consent Measurement: Grounded theory	See left	Group attenders addressed needs to be established, Require assessment that considers aspects other than why they access service provision. information not using medical language	Focus is on language having commonality, that those who may engage in 'activities' perhaps are assessed on aspects other than being a service user.
Davidson. L, Bellamy, C., Guy, K. and Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry.* **11(2) pp123–128.**	Theoretical commentator	N/A	1. A clear job description and role/ 2. Utilizing a cross section of mental health specialists (Statutory and non-statutory, with service users, carers and other community 'activists') in the hiring of peers with job description/ 3. Identifying and valuing the unique contributions that peers can make to the programs and settings where they will work/ 4. Starting with at least two peer staff within any program, team, or work unit to facilitate their transition to this new role and giving them the opportunity to share job experiences and provide mutual support to each other/ 5. Senior administrator is peer champion preferable a peer initially/ 6. Training that assists peers to share stories to assist others, not to focus purely on negative historic outcomes and reducing blame/ 7. Supervision/ 8. Training to none peers re relevant legislation/ 9. Share successes and learning	Paper gives clear policy guidance on peer mentorship.
Jonikas, J., Grey, D., Copeland, M., Razzano, L., Hamilton, M., Floyd, C., Hudson, W. and Cook, J. (2013) Improving Propensity for Patient Self-Advocacy Through Wellness Recovery Action Planning: Results of a Randomized Controlled Trial. *Community Mental Health Journal.* **49 (3) pp260-9**	RCT control and intervention group, many latent variables not considered.	Patient-Self-Advocacy Scale (PSAS) (Brashers et al. 1999), Hope Scale (Snyder et al. 1991), World Health Organization Quality of Life Brief Instrument (WHOQOL- BREF), (Skevington et al. 2004), Brief Symptom Inventory (BSI) (Derogatis 1993).	WRAP was focused on however it might have been the peer led group that also assisted, arguable bias towards WRAP.	Cautiously included as the study highlighted the importance of peer led groups on advocacy, it is impossible to state that the intervention's had bearing due to the study's design. For example there required a third intervention group of peer support without wrap. Additionally the measures may be useful.
Repper, J. and Carter, T. (2011) A review of the literature on Peer support in Mental Health. *Journal of Mental Health.* **20(4) pp392-411.**	Literature review. A pluralistic approach was adopted to include multiple sources of evidence and types of data. Published literature in the field consists largely of qualitative studies often with small sample sizes and descriptive cross-sectional or longitudinal designs.	See left	Defining peer support needs community relevance, empowerment, social support and social functioning, empathy and acceptance suggesting counselling type skills, involvement reduces stigma in finding work, hope for the future is developed	Included as it guides understanding on paying peers and how their roles may assist risk taking, which is a new theme including issues of accountability though mutuality in risk taking is noted with peer support.

4 Articles Exploring Impact on Mental Health: included papers (continued)

Article	Research	Measurements	Themes	Why included
Verhaeghe, M., Bracke, P. and Bruynooghe, K. (2008) Stigmatization and self-esteem of persons in recovery from mental illness: the role of peer support. *International Journal of Social Psychiatry.* 54 (3): 206-18.	Quantitative data analysis from questionnaires, sample is questionable, appears to study a population rather than a sample with external validity as all took place in Flanders, Belgium.	Dutch translation of Rosenberg's self-esteem scale (Brutsaert, 1993; Bruynooghe et al., 2003), Brief Symptom Inventory (Derogatis, 1993), this was used to assist stigma assessment as it is argued it is correlated with symptoms, however this may lack internal validity.	Peer contact is positively linked with clients' self-esteem. This is consistent with the view that perceived support from similar others bolsters the self (Thoits, 1985). Peer support could not attenuate the negative link between stigmatization and self-esteem. A possible explanation could be that stigmatization impedes the positive effect of social integration among peers. The shame of receiving professional help for psychological problems is possibly so strong that it obstructs group formation, however this may have latent variable issues, as the study occurred in Belgium aspects of 'shame' may differently perceived in communities let alone cities and countries.	Included as self-esteem work may be needed with those feeling stigmatized, however the article considers this to be due to receiving statutory treatment, this does not correlate with other themes and should not be considered as a cause and effect for participants to engage.

5 Articles exploring how to involve peers: included papers

Article	Research	Measurements	Themes	Why included
Alberta, A., Ploski, R. and Carlson, S. (2012) Addressing challenges to providing peer-based recovery support. *Journal of Behavioral Health Services & Research.* **39(4) pp 481-91.**	Commentary	N/A	The idea of a Recovery bank bundles of recovery based packages to assist peers and service users, regular meeting to discuss organizational culture/processes with all staff, that tasks are handed out with equality not based on the most experienced or who works with the governing organization, there needs to be clear demarcation between statutory services and peer run services to avoid hierarchal structures and inequality in power, skills are associated with life skills not severity or type of condition, no specifics on individual friendships, a service refers to those that attend as all our friends.	Included, though the piece lacks rigor with external validity, it hones on the specifics of giving those facilitating community group's support, whilst also reinforcing already observed themes.
Berry, C., Hayward, M. and Chandler, R. (2011) Another rather than other: experiences of peer support specialist workers and their managers working in mental health services. *Journal of Public Mental Health.* **10(4) pp238-49.**	Thematic analysis, no external validity and only interpretive	Interview	1. Professional identity, shared lived experience with difference from statutory professional. Role needs parity with job spec and interview. Persons needs to have or have been a service user/ 2. Role of using the strength model/ 3. Expectation: A sense of challenging and activism, awareness of recovery principles relevant to the community	Though this paper appeared to relate to statutory services, there is transferability with non-statutory workers, however there requires caution that only 4 people were interviewed.
Davies, K., Gray, M. and Webb, S. (2014) Putting the parity into service-user participation: an integrated model of social justice. *International Journal of Social Welfare.* **23, pp.119-127.**	Commentary	N/A	Fraser's (2001) model of parity of participation challenges undue emphasis on identity-focused approaches to participation, for example: Participation as social justice/parity of participation/ Capacity for individual and representative notions of participation/ Encompasses aspects of rights-based and consumerist approaches/ Recognises that single issue of homelessness or mental illness does not reflect full extent of exclusion/ Emphasises responsibility of authorities to change, rather than of service users to adapt/ Underestimates centrality of identity to service-user perceptions of disparity/Supports examination of complexities and interconnections between aspects such as poverty and participation/Needs further development to translate to meaningful/operational actions	Included for this opens up debate regarding identity which is not as succinct as may initially appear
Duffield, A. (2009) Putting the 'lunatics' in charge of the 'asylum'? Handing over the keys of power to peer support volunteers. *A Life in the Day.* **13 (3) pp41-3.**	Commentary piece on a pilot study by Mind Charity titles Working Together.	N/A	Motivation and persistence, anxiety management and training defined as: The peer support development group already established, then worked with Bromley Mind staff to develop a six-session introductory peer support training programme, which covered the following areas: Context and journeys through mental health services/ The role of peer support volunteer and diversity active listening/ Communication and confidentiality/Dealing with challenging behaviour and emergencies /Health and safety and supervision/Recovery and community signposting.	Included for it is a UK project highlighting how training has a positive effect on Peer involvement.
Hodge, S. (2005) Participation, discourse and power: a case study in service user involvement. *Critical Social Policy.* **25 (2) pp 164-79.**	Discourse analysis	See left	Power or the use of it may repeat hospitals for example when visited by officials. Requires clear separation from statuary services to allow freedom to thrive	Originally this article was to be omitted as it regards the interface of statuary services and service user forum, however the concept of reintroducing an institutional power processes is a very important aspect to consider and there requires clear equality in decision making and boundaries from statuary services, yet also have regular dialogue to develop care for all.

5 Articles Exploring How to Involve Peers: included papers (*continued*)

Article	Research	Measurements	Themes	Why included
Kemp, G. (2010) It's not what you know but who you know that's important: The influence of social networks on communities. *International Journal of Consumer Studies.* **34(3), pp.326-332.**	Interpretative Phenomenological Analysis (IPA). Sample is taken from Bristol showing high external validity regarding the question.	Interpretive	Interviewees have strong informal social networks; there is a strong sense of generalized reciprocity, for example a groups helps each other with child care, meals, financial and so forth. Diversity is limited within the social groupings, for example this may relate to various factors for example ethnicity and gender. Trust is deemed very important and the disconnection with state services means lack of trust.	Included as this gives further evidence that to involve groups there requires a need to be specific to their communities rather than setting up a service that caters for all.
Ley, A., Roberts, G. and Willis, D. (2010) How to support peer support: evaluating the first steps in a healthcare community. *Journal of Public Mental Health.* **9(1) pp 16-25.**	Limited information, Ethical issue is the funding came from the NHS, spread sample, researchers spilt to reduce bias for preference of design.	Quantitative by assessing numbers of people who attended workshop were engaging in peer support, and qualitative questionnaires	A need for thorough training with review prior to starting a group may increase involvement, by the original experience gaining social connections and understanding, inspiring hope for success, however it requires consistency and no false promises as isolation and not being able to practice causes detrimental and reverses possible hope.	Included for this was a localised study demonstrating the need for consistency after training and training itself.
Kemp, V. and Henderson, A. (2012) Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal.* **35(4), 2012, 337-340.**	Nominal group technique (NGT) is a group process involving problem identification, solution generation, and decision making.	Measurement: None but there is a process: 1.Introduction and explanation 2.Silent generation of ideas 3.Sharing ideas 4.Group discussion 5.Voting/ranking of votes	Using a Nominal Group technique may enhance decision making, it was written by Gustafson (1975). It assists by (1) Identify elements of a problem situation; (2) Identify elements of a solution; (3) Establish priorities	Included as it demonstrates manners of decision making and the need to clarify role to support peers.
Newton, A., Beales, A., Collins, D. and Basset, T. (2013) Service user leadership: training and development for service users to take the lead. *Journal of Mental Health Education and Practice.* **8(3) pp134-140**	Case Study	Choices if the peer wishes accreditation, to receive this, there was need to complete a reflective essay and learning log, with marking such assignments there would need to be clear guidance and learning outcomes that didn't purely focus on critical thinking, there would need to be flexibility in presentation, such as a poster	The training program is for 12 days and completed with a University, topics were equality, diversity, stigma, discrimination, self-esteem, confidence in situations of high expressed emotion, meeting skills to presentation skills and knowledge on the service user movement. Each day regarded skills, knowledge, expertise and personal experiences of the peer supporters running the session. Leadership consists of the following: • Giving guidance and solid advice to others in need, using learned experience and understanding. • Being a proactive member of society, leading by example, being a shepherd not a sheep. • Leading by example and guiding rather than pushing. • Facing your challenges head-on and feeling proud of your accomplishments. • Using your personal skills and experience to empower others and give them a voice. • Confidence, compassion and personal belief in change where change is needed. • Showing initiative.	Included as this literature review has not come across specifics on developing leadership skills and its link to supporting peers.
Van Draanen, J., Jeyaratnam, J., O'Campo, P., Hwang, S., Harriott, D., Koo, M. and Stergiopoulos, V. (2013) Meaningful inclusion of consumers in research and service delivery. *Psychiatric Rehabilitation Journal.* **36(3) pp180-186.**	Appears action based, little detail on philosophical underpinning	See left	1. Selection of participants should be purposeful, based on the skills required to perform specific tasks and should be communicated in advance. Direct service recipients should be included where possible/ 2. Once a group is selected purposefully, they should be made clearly aware of their role and expectations/ 3. A coordinating body to support engagement, meaningful inclusion, and problem solving is invaluable/ 4. Early involvement in a project to maximize potential contribution and impact is essential/ 5. Regular opportunities to discuss and facilitate the process of inclusion, from each partner's perspective, can be helpful/ 6. Motivation may lay with payment, or this maybe principled in some way/ 7. Apt environment increases access, for example depends how 'local' who goes and can people relate, similarly to people who may attend social networking functions regardless of illness/ 8. Leadership is very important to inspire direction, activism without personal agenda/ 9. Positive support to persist in action is required/ 10. The allowance of time, not over months but years to see growth and interest.	Included for it gives evidence to the need for policy to be clear on procedures, rewards or payments and a process to choose members that will inspire new comers