School of Psychology
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A meta-ethnography of non-peer experiences of peer mentors, and a grounded theory analysis exploring the processes of integrating peer mentors into mental health teams

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PREFACE

Employing people with lived experience of mental health difficulties, otherwise known as peer mentors, has been increasing over the past 20 years. Several benefits have been found in relation to services, service users and peer mentors themselves. However, there have been challenges noted in the literature, including some of which are related to non-peer staff. 'Non-peer' as a term is used to describe all those professionals not employed due to their personal experiences of mental health difficulties, thus distinguishing from peer mentors. With continued challenges being linked to non-peers, and previous research demonstrating that non-peer staff and existing teams can influence how successful the integration of peer mentors would be into a service, it is important to consider non-peers' experiences particularly when thinking of clinical recommendations to ensure a smoother implementation. This thesis focuses on non-peer staff experiences in two ways: general experience of working with peer mentors, and specifically how non-peers adapt existing practice to integrate peer mentors, including the identification of the processes underlying integration.

Paper one presents a meta-synthesis focusing on qualitative research exploring non-peer experiences of peer mentors. Two meta-syntheses to date have focused on non-peer staff: one focusing on modifications of peer mentor roles, the other describing a meta-summary of peer, non-peer and service user experiences. In the meta-summary, positives were identified, however challenges included professional boundaries around the role and non-peer concerns of confidentiality. Through conducting a meta-ethnography, the current review aimed to provide new insights and a conceptual model of non-peer experiences of peer mentor roles which goes beyond the meta-syntheses in the area. A systematic literature search was conducted for both peer-reviewed and grey literature. A quality assessment was completed on all included studies, before studies were synthesised through conducting a meta-ethnography.

Seven core concepts were identified: *'Existing Team', 'Readiness', 'Integration', 'Shift in Power', 'Wider System Support', 'Value of Lived Experience'* and *'Services Embracing Recovery'.* A conceptual model of these themes is created through a line-of-argument, expressed in both diagrammatic and narrative form. This depicts the non-peer journey from before peer mentors joined the team to after integration. The findings whilst echoing those found in one previous review, go further by also demonstrating key time points such as pre-implementation and integration, and key aspects such as a shift in power, which impact non-peer experiences. These findings mirror research exploring both general service user and recovery-based initiatives. The findings have clinical implications for organisations, particularly recognising the need for organisations to prioritise and value peer mentor roles, and provide support throughout the process of implementation.

Paper 2 presents a grounded theory analysis exploring how non-peers modify or adapt their practice to integrate peer mentors into teams. Facilitators and challenges to integrating peer mentors have been well identified in the literature, demonstrating several factors which impact the relationship. Limitations of research which has focused specifically on integration processes have been linked to for example, transferability of findings across teams. Further, descriptive themes within the literature have been identified, but understanding the processes around integration are less known. The study aimed to understand and describe how non-peers working within statutory services and well-established teams, adapted their existing practice to integrate peer mentors into teams. Through using a social constructivist form of grounded theory, it aimed to ascertain the processes involved in the integration. Using theoretical sampling, eight non-peers participated. Nine core categories and theoretical concepts were identified: *'Team culture', 'Understanding Integration', 'Experiencing a sense of threat', 'How we all slot together', 'Finding commonalities and aligning values',*

'Observed change in service delivery', 'Reconnection with values', 'We need to keep [peer mentor] protected' and *'Wider influences'.* Non-peers identified multiple adaptations including engaging in more recovery-focused practice. Processes included identifying a need for change, which was an over-riding factor for moving non-peers towards an openness to explore how the peer mentor would 'fit'. Key relational processes were also identified including getting to know the 'person' behind the peer mentor role, which both supported non-peers to move from a place of threat to openness to the role, and was a catalyst for non-peers to reconnect with value-based working. Wider influences were recognised at various stages of the theoretical model. The findings echo previous understandings of processes at integration, but enhance understanding by specifically demonstrating non-peer experience. Relational and ecological models provide further understanding of the results. The findings have clinical implications for organisations, particularly the need to prioritise non-peers and peer mentors building relationships.

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PAPER 1

Non-peer staff experiences of peer mentors: A meta-synthesis of findings

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[3] This paper is prepared in accordance with the author guidelines for *Journal of Mental Health* (Appendix A). APA 7th formatting has been used throughout, in line with both DClinPsy submission and journal guidelines. For the purpose of thesis submission, the 8000 word limit has been used to ensure all relevant information has been included for the examiner. This is in place of the 6000 word limit set by the journal for review articles. Tables and Figures have also been embedded in the main body of the paper, however will be placed in supplementary information for journal submission.

ABSTRACT

As peer mentors are increasingly introduced into organisations, research recognises how non-peer staff can have an influential impact on how successful the role of a peer mentor could be within services. It is therefore important to understand non-peer experiences of peer mentors and to date, there has been no in-depth systematic review of findings. This review aimed to provide new insights and a conceptual model related to non-peer experiences of peer mentor roles. A systematic literature search was conducted of qualitative research exploring non-peer experiences of peer mentors. Twenty-eight studies met inclusion criteria, and were quality assessed. By conducting a meta-ethnography, the studies were synthesised identifying seven core concepts. It highlights the influential impact of the existing team; the complex factors associated with the point of integration; how the role becomes valued in services and how services come to embrace recovery. These findings support previous literature exploring power imbalances between professionals and service users, and role distinctiveness in inter-professional working. Recommendations for clinical practice identify the need for organisations to prepare existing teams for integration, and to disseminate the message that peer mentors can work alongside existing models of delivering mental health care.

Keywords: peer support; non-peer; recovery; expert by experience; qualitative; lived experience; mental health

INRODUCTION

There has been a marked growth in employing people with lived experience of mental health difficulties in the workplace – otherwise known as peer mentors. This has been supported by the first National Conference of Survivor Workers UK in 2000 (Snow, 2002), which provided guidance to employing 'experts by experience' and led to services recognising the place of people with lived experience within service delivery. Peer mentors are considered vital components of the recovery model (Cook, 2011; Drake & Latimer, 2012), which emphasises resilience, hope, self-efficacy and improved functioning (Bonney & Stickley, 2008; Davidson et al., 2005; Ramon et al., 2007). They have been increasingly involved in statutory services such as the National Health Service (NHS; Department of Health, 2009; 2011; 2012), with several benefits identified. These include their ability to role model recovery, provide service user perspective (Beales & Wilson, 2015; Bennetts et al., 2013; Fuhr et al., 2014; Repper & Carter, 2011) and enhance relationships with service users (Austin et al., 2014; Davidson et al., 2006; Moran et al., 2012). In addition, peer mentors may assist service uptake via reducing stigma and improving visibility of services (Campbell & Leaver, 2003; Davidson et al., 2012; Mowbray et al., 1998; Repper & Carter, 2011). However, challenges to incorporating peer mentors into services have also been identified, which have included prejudicial views of existing non-peer staff[4] and lack of role clarity (Ehrlich et al., 2020; Gates & Akabas, 2007; Gillard et al., 2015). For there to be successful integration and for peer mentors to be fully embraced in their roles, peer mentors need to be accepted as part of the wider team and organisation (Kemp & Henderson, 2012; Kern et al., 2013). Therefore, understanding the experience of non-peers may have important clinical implications for employing peer mentors into services.

[4] Following Gillard et al. (2013), the term 'non-peer' will be used to describe all staff not employed in peer mentor positions.

It is debateable how research and services measure the effectiveness of employing peer mentors. Randomised controlled trials (RCTs) suggest generally, that peer mentors do not make any difference to mental health outcomes of people using services (Repper & Carter, 2011). However, there have been several flaws found in the methodology of RCTs conducted including small sample size, varied use of control conditions, and difficulty in isolating the specific effects of peer mentor involvement (Goldberg et al., 2013; Kelly et al., 2014; Robinson-Whelen et al., 2007; Simpson et al., 2014). In addition, the outcome measures used have focused on reduction in symptoms and hospital admissions (Robinson-Whelen et al., 2007; Simpson, 2014), which has been argued to not adequately map onto the work of peer mentors and the recovery approach (Barbic et al., 2009).

As a consequence, a number of previous systematic reviews have suggested that there is generally a weak indication that peer support can have a positive impact on client outcomes, with evidence predominantly rated as low quality (Fuhr et al., 2014; Lloyd-Evans et al., 2014; Pitt et al. 2013). However, some recent reviews have reported more positive findings. White et al. (2020) have reported a 'modest, positive effect' on empowerment and self-reported recovery when exploring one-to-one peer support in mental health services. Huang et al. (2020) found a small-to-moderate beneficial effect on maternal mood in the short-term for levels of depression and incidence of post-natal depression. Both reviews are considered high quality, demonstrating clear consideration for risk of bias, independent review of extracted data and comprehensive search strategies. Similar to previous findings, White et al. found little or no effect on clinical outcomes such as symptoms or hospitalisation rates, and overall concluded that the quality of studies included in their meta-analysis remained low to moderate.

Huang et al. (2020) suggested in their review that qualitative methods may provide more in-depth insight into the experience of peer support. Such methods may assist in further

elucidating the mediating factors which contribute to success, and help identify appropriate outcomes to measure in quantitative studies. Synthesising findings of qualitative research can provide a range and depth of meanings, perspectives and experiences across contexts from various participant samples, and integrate the findings to develop new insights and conceptual models (Dixon-Woods et al., 2005; Hammarberg et al., 2016; Tong et al., 2012). Syntheses can further ensure that views and perspectives of particular groups of people such as patients and carers are incorporated into healthcare service development and delivery (Ring et al., 2011). This could also include differing multi-disciplinary professionals and differing levels of staff groups such as management. Qualitative methodology is argued to elicit insights into complex interventions (Cherry et al., 2017), therefore through collation of multiple study findings, a meta-synthesis can further inform service development.

Ibrahim et al. (2020) and Walker and Bryant (2013) have both conducted meta-syntheses of studies, which include data related to non-peer staff samples. Walker and Bryant in their review used a meta-summary approach and concluded that due to working with peer mentors, non-peer staff described an increase in empathy and understanding towards those in recovery. They further suggested non-peers experienced a sense of threat, commenting that non-peer staff fear that peer mentors might be considered a cheaper option thus leading to less non-peer positions. Walker and Bryant conducted a comprehensive search strategy to identify studies, however it is unclear the level of rigour around data extraction, particularly how potential author bias was managed in this process. Further, the reporting of non-peer experiences was limited in the paper due to the systematic review including data from non-peer, peer mentor and people using services.

In their recent systematic review, using narrative synthesis Ibrahim et al. (2020) identified influences which facilitated or were barriers to the implementation of peer support work in adult mental health settings. These included organisational culture, need for peer mentor role

definition and support for peer mentor wellbeing. Ibrahim et al. conducted a comprehensive search strategy to identify studies, including the involvement of an independent reviewer for data extraction. However, when considering the gap in understanding non-peer experiences, it is unclear from data extraction and the papers included, how embedded the influences identified are in non-peer experiences. Additionally, the strength of an influence was related to how many papers identified the influence. It is questionable whether this accurately captures the impact of an influence, in that some influences may have more impact however be discussed or identified in less papers. Lastly, the review provides less understanding of the mechanisms and potential overlap between influences.

The research discussed indicates that non-peer staff and existing teams can have an influential impact on the integration of peer mentors in services. Both previous reviews (Ibrahim et al., 2020; Walker & Bryant, 2013) suggest a need for a meta-synthesis which explores only non-peer experiences of paid peer mentors, using a methodology which goes beyond summarising experiences and considers how concepts identified in the literature may relate to each other. Through conducting a meta-ethnography, the current review aims to provide new insights and a conceptual model related solely to non-peer experiences of peer mentor roles. The review will include non-peer staff who have yet to work with peer mentors, as this provides further understanding of perspectives of those who have not yet been influenced by the establishment of the peer mentor role. Finally, through conducting a meta-ethnography, this review aims to provide recommendations for clinical practice in relation to integration and successful practice within teams.

METHOD

Protocol and registration

The protocol of this systematic review was developed in accordance with PRISMA guidelines (Moher et al., 2009) and registered on PROSPERO (International Prospective Register of Systematic Reviews) on 7th December, 2020 (Registration number: CRD42020224900; see Appendix B.).

Search strategy

The PICo (Population, Phenomenon of Interest, Context) tool was used due to its more appropriate use for qualitative research (Cherry et al., 2017). It supported the development of the review question, search strategy and inclusion/exclusion criteria (see Table 1.).

Table 1

PICo Tool

Review Question	What are non-peer staff's perceptions of working with peer mentors? A meta synthesis of qualitative findings
P	Non-peer staff working in mental health settings
I	Experiences of employed peer mentors in mental health settings.
Co	Settings which support people with mental health problems. Peer mentors may or may not be employed in the service at the time of the study.

The following sources were searched:

(1) Electronic bibliographic databases (n = 4) searched were Medline (via OVID), PsycINFO (via OVID), Scopus (via Elsevier), Cumulative Index of Nursing and Allied Health Literature (CINAHL; via EBSCO): searched October 2020 and January 2021.

(2) Google Scholar, OpenGREY and OpenDOAR: searched November 2020 and January 2021.

(3) EThos: searched December 2020 and January 2021.

(4) Experts within the peer development field were contacted for additional eligible publications.

(5) Backward citation searching through a hand-search of reference lists of included studies and forward citation searching on all included studies using Scopus and Google Scholar.

(6) Key journals were searched (n = 3), specifically Journal of Mental Health, International Journal of Mental Health Nursing and Community Mental Health Journal.

The date restriction of year 2000 onwards was applied. A movement in the 1990s parallels the roles of peer mentors currently in post however there was limited system-wide understanding or acknowledge of the role across services (Basset et al., 2010). The First National Conference of Survivor Workers UK in 2000 (Snow, 2002) provided a report considered "…essential reading for any individual or organisation that wants to develop

mental health peer support services" (Basset et al., 2010, p. 7.). With a growing number of service-user led organisations being set up in the 1990s/2000s, by 2010 there was a greater acceptance of the status 'experts by experience' and peer support roles (Basset et al., 2010). The inclusion of recent studies in the area is important to reflect the current involvement of peer mentors in services as it has evolved.

The search strategy was devised through a combination of strategies to maximise precision in identifying cases as suggested by Shaw (2004). It included consultation with experts in the area, scoping published articles for referred terms and identifying key words on publication databases. An information specialist was involved in devising the search strategy to ensure accuracy and adaptation for each bibliographic database. As agreed with the information specialist, qualitative research or specific qualitative methodology were not included in the search strategy. This was based on the number of studies returned, and the potential risk of missing data if the search strategy was focused further. Through abstract screening and full paper review, the reviewers were able to identify qualitative methodology. The search strategy was modified for each database (see appendix C.). Table 2. identifies search categories and relevant search terms, with Boolean operators used. It also includes an example of these operators being used in a database search string.

Table 2

Search terms, with an example of data base search strategy

Category	Search Terms with Boolean operators
Peer Mentor	Peer Mentor* OR Peer adj worker* OR Peer specialist* OR Consumer consultant* OR Peer relations/ OR Peers/
Mental Health Service	Exp Mental Health Services/ OR Exp Mental Health Personnel/ OR Mental Health Service* OR Mental Health Team* OR Psychiatric Service* OR Psychiatric Team*
Database	**Search Strategy**
MedLine	(“peer mentor*” OR “peer adj2 worker*” OR “peer specialist*” OR “consumer consultant*” or “Peer Relations/” OR “Peers/”) AND (“exp Mental Health Services/” OR “exp Mental Health Personnel/” OR “mental health service*” OR “mental health team*” OR “psychiatric service*” OR “psychiatric team*”)

Eligibility Criteria

To identify relevant studies, strict inclusion and exclusion criteria were applied (see table 3.). All citations returned through electronic searches were transferred into an Endnote Library and de-duplicated. Titles and abstracts were screened against the inclusion criteria independently by the first author. A second independent reviewer screened 10% of articles at this stage, with inter-rater agreement being 91%. The full text of all potentially relevant articles were reviewed to assess eligibility for inclusion against criteria by the first author.

The second independent reviewer screened 10% of articles at this stage, with inter-rater agreement being 83% (see Appendix D. for screening examples). Forward and backward citation searching was applied to all articles meeting inclusion criteria following full text assessment. Where there was ambiguity around terminology and samples used for both peer mentor and non-peer staff roles, authors were contacted. Those studies which conducted secondary analysis of primary studies were included if they provided nuanced findings not previously reported.

Table 3

Inclusion and Exclusion Criteria

Study Parameters	Inclusion	Exclusion
Methodology	Qualitative studies including focus groups, interviews, case studies, open-ended questionnaires (mixed-method studies could be included if qualitative data were extractable)	Quantitative Studies Mixed-Method studies where qualitative data was unable to be extracted
	Qualitative raw data extractable	No qualitative raw data included

Study Parameters	Inclusion	Exclusion
Study type	Peer reviewed journal, unpublished thesis, non-peer reviewed journals, grey literature	Studies which are not primary empirical research (e.g., systematic reviews, books) Reflective, commentary or discussion pieces
Language	Studies written in English or have a translated version in English	Studies not written in English
Participants	Non-peer staff (any discipline). Studies which recruit both peer mentors and non-peer staff may be included if non-peer staff data is clearly extractable from peer mentors. Non-peer staff may or may not be directly working with peer mentors at the time of the study. Adults 18+	Peer Mentors (including those in management/peer-led organisation positions) Service Users

Study Parameters	Inclusion	Exclusion
Study Setting	Study based in an adult mental health setting When referring to peer mentor positions, roles need to be formally employed not only involved in own care decisions (e.g., consumer participation refers to service users making decisions in own care but are not employed by teams into formal peer mentor roles to support others)	Study based in a child/adolescent setting (i.e., peer mentors or non-peer staff work with children or adolescents, <18) Non-peer staff not working within a mental health setting (e.g., setting is primarily related to physical health conditions, education, offending)

Quality appraisal process

Research quality was graded using the Critical Appraisal Skills Programme (CASP) for qualitative studies (CASP, 2018). The CASP checklist was chosen as it is widely used for quality appraisal in health-related, qualitative syntheses (Long et al., 2020). It has also been used in other meta-syntheses within the literature of peer mentors (Charles et al., 2020; Ibrahim et al., 2020; MacLellan, et al., 2015; Walker & Bryant, 2013). There is no assigned scoring system with the CASP checklists, thus a scoring system was applied similar to previous systematic reviews in the area (Charles et al., 2020; Ibrahim et al., 2020). For each CASP question rated as ‘yes’, one point was scored and for each CASP question rated as

'no', zero points were scored. In line with other meta-ethnographies (Toye et al., 2014), if CASP questions were partially met and rated as 'can't tell', they were also scored and for this review, received half a point. Although the CASP checklist includes ten questions, only nine are scored in this review. Question ten does not require scoring, however it does support the reviewer to think about how valuable the research is by considering its contribution to current understanding, future research and generalisability to wider populations.

The first author and second independent reviewer quality assessed all the included studies independently (see appendix E. for CASP quality assessment examples). Inter-rater agreement was 76%**,** and any disagreements were discussed comparing the paper to the CASP question until 100% agreement was reached between both reviewers. Each paper was awarded a total score out of nine, and in line with other meta-syntheses (Fox et al., 2015; Graham et al., 2020; Kowlessar et al., 2014), studies were graded from A to C to indicate their methodological quality based on their score. Table 4. outlines the classification system.

Table 4

Classification System for Quality Appraisal Process

Grade	Likelihood of methodological flaws	Scoring on CASP
A	Low	Eight and a half or higher
B	Moderate	Five to eight
C	High	Less than five

Records were not excluded based on a low-quality score, as recommended by Atkins et al. (2008), with a view that these research studies can still add to the literature and should not be discarded due to their 'surface' omissions in their write-up (Dixon-Woods et al., 2005). A critique of the articles was included within this review, with low scoring considered during synthesis.

Data Synthesis

The synthesis of qualitative research goes beyond the descriptive and summarising of data, and involves reinterpretation or innovation of published findings, resulting in conceptual development (Britten et al., 2002; Campbell et al., 2011). Meta-ethnography is argued to be the most widely used method of qualitative synthesis (Hannes & Macaitis, 2012; Toye et al., 2014). It is an inductive approach, allowing the reviewer to take an interpretative stance, preserving the context of the findings whilst also devising a holistic understanding of the area under review (Walsh & Downe, 2005). Although non-peer experiences have been previously summarised, an in-depth understanding going beyond a descriptive summary was considered important. Therefore, meta-ethnography was the chosen method of synthesising the included qualitative studies, following Noblit and Hare (1988) seven stages (see table 5.), with supportive guidance from Britten et al. (2002), Walsh and Downe (2005), and Toye et al. (2014). It is important to note that the seven stages of synthesis described below are not discrete and can overlap. Repeated reading and attention to study detail continues throughout the process (Toye et al., 2014), particularly when utilising a constant comparison method (Charmaz et al., 2014). Schütz (1962) notion of first and second-order constructs was used in this synthesis. First-order constructs relate to the participant's understanding of their experience, and second-order constructs refer to the researcher's understanding of the

participant's interpretation of the experience. Qualitative synthesisers aim to then develop third-order constructs, which are the reviewer's synthesis of first and second-order constructs into a theoretical understanding. A reflexive journal was kept throughout the process and the second author was involved in discussions at each stage of synthesis to enhance reflexivity and credibility.

Table 5

Process in current review of meta-ethnography (Noblit & Hare, 1988)

Phase	Description	Process in current review
1	Getting Started	Identifying a research area of interest – Non-peer experiences of peer mentors
2	Deciding what is relevant to the initial interest	Developing a search strategy including Boolean terms to be used, determining strict inclusion and exclusion criteria and identifying relevant studies. The use of a PICo table supported phase one and two. (Table 1., Table 2., Table 3., Figure 1. Appendix C., Appendix D.)
3	Reading the Studies	Repeated reading of the studies, extracting relevant study information (e.g., non-peer characteristics). Beginning to note key concepts from studies included. The synthesis was registered on PROSPERO (see Appendix B.). Due to number of studies included, this stage is particularly important to ensure familiarity with the studies. Quality appraisal process provided opportunity to read studies in-depth, adding to familiarity.

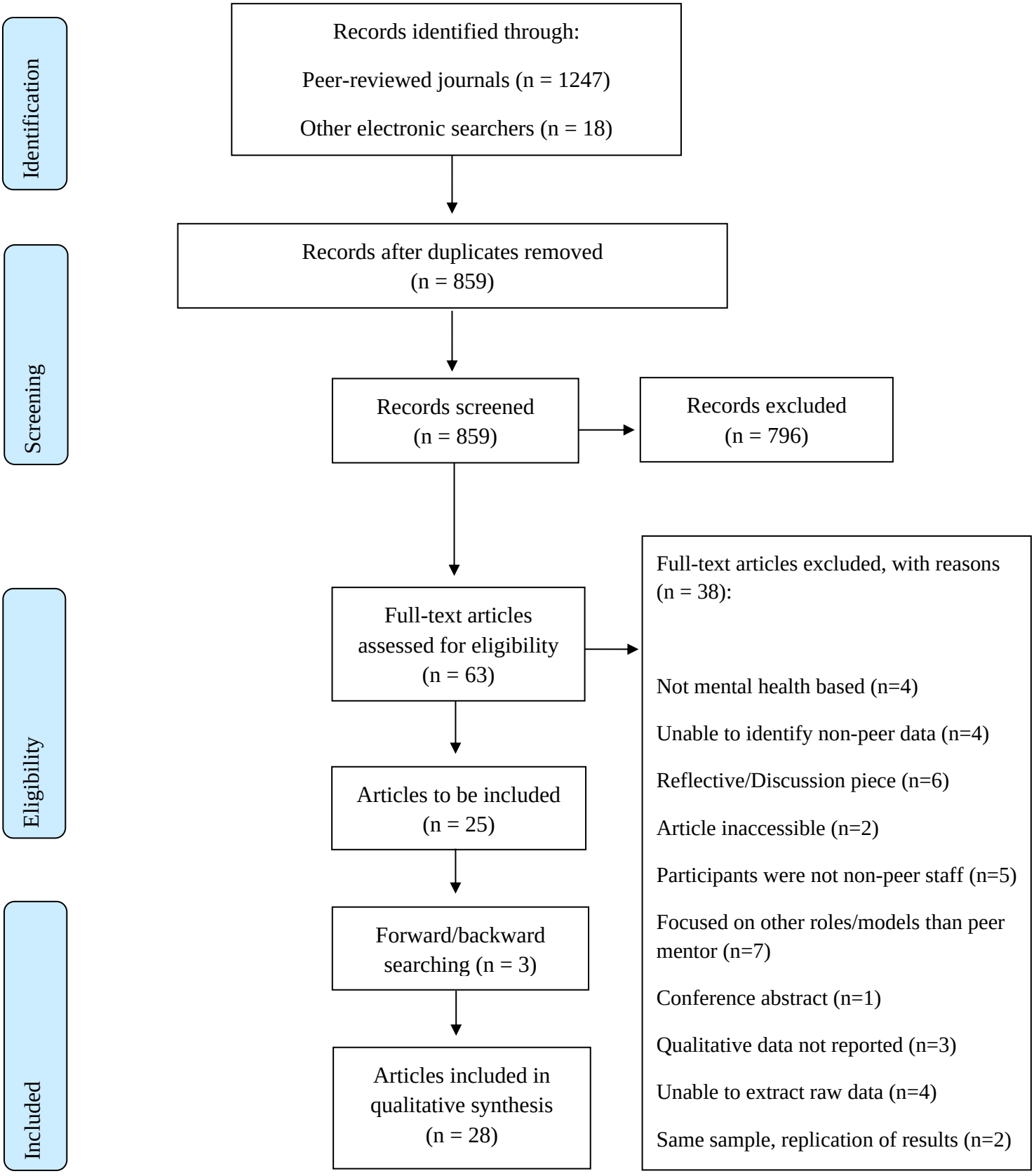
Phase	Description	Process in current review
4	Determining how the studies are related	The second-order concepts from each study were tabulated (see Appendix F.). First and second authors explored 10% of the studies together to ensure concepts extracted were relevant to the research question and fully grounded in the original studies. Using NVivo 12 Software (QSR International, 2018), these key concepts were extracted to begin constant comparison that stayed grounded in the data. Key concepts were explored to see whether they were related, discordant or providing a nuanced understanding. Concept maps were used to support this stage of determining relationships (see Appendix G. for examples).
5	Translating the studies into each other	A constant comparative method allowed for translation across studies. Researchers aimed to identify, understand and explain reciprocal translations (similar concepts) and refutational translations (contradictory concepts). Due to the emerging roles of peer mentors, this was completed in chronological order to explore any emergent processes over time (Toye et al., 2014). There were no refutational translations identified, thus reciprocal translations were used (see Appendix H. for translation example).
6	Synthesising Translations	Creating a line of argument through integrating the translations into a conceptual model. To ensure the emerging line of argument is grounded in the original articles, constant comparative methods were used (see Appendix I. for an example)
7	Expressing the Synthesis	The findings of this synthesis were expressed in written form, supported by an illustrative figure demonstrating the conceptual model (figure 2.). First order exemplars are used to support the conceptual parts of the line of argument.

RESULTS

The study selection process is demonstrated in Figure 1., following an adapted version of the PRISMA method (Moher et al., 2009). The search of electronic bibliographic databases yielded 1247 records, with an additional 18 records from google scholar and searching key journals. No records were identified through OpenGREY, OpenDOAR, EThos or experts within the field. Removal of duplicates resulted in 859 records. Following the application of inclusion and exclusion criteria, 25 articles were identified. Backward and forward citation searching was conducted on these articles, and three more articles were identified, resulting in 28 articles being included in this review.

Figure 1

PRISMA Flow Diagram demonstrating Systematic Search Process for Studies including Non-Peer Staff Experiences of Peer Mentors (Moher et al., 2009)



Study characteristics

Studies included a total of 601 - 609 participants, with one study being unable to provide an exact number of participants in focus groups (Otte et al., 2020). Non-peer staff participation ranged between 2-93 participants in each study (M = 21.46 – 21.75). There was variation in the reporting of sample demographics such as gender and job role, with some studies not reporting any. All but one study was conducted in a Western culture. Terminology regarding peer mentors was mixed within the studies (see table 6.). All included some non-peer participants who had experience of working with peer mentors, with six studies also including participants who had no experience of working with peer mentors. Twenty studies included additional data from service users and/or carers. These data were excluded from this review. Twenty-five studies were qualitative and three were mixed-methods where qualitative data could be extracted. Data collection varied across studies, with semi-structured interviews being the predominant method. Data analysis also varied, with approaches informed by thematic analysis and grounded theory being the most common methods of analysis.

Twenty-four studies were primary qualitative studies. Byrne et al. (2019) conducted a secondary analysis of data in an included paper (Byrne et al., 2018). Further, Gillard et al. (2013) conducted a secondary analysis of data of an excluded study (Gillard et al., 2012). The excluded study did not initially focus on this review question. Two more studies (Holley et al., 2015; Oborn et al., 2019) conducted secondary analysis of an included study (Gillard et al., 2015). All studies which completed secondary analysis were included due to nuanced examination of the data, including differing aims and analysis.

All but one study explored experiences of peer mentors in adult mental health settings, with one exploring experiences in an older adult mental health setting (Coates et al., 2018).

Recruitment of samples included statutory services, government funded mental health teams and third sector charities. Studies predominantly focused on samples within general mental health teams, apart from Barr et al. (2020) who recruited from services for people diagnosed with borderline personality disorder, and Weir et al. (2019) who recruited from veteran mental health services. Table 6. provides further details of the characteristics of the included studies.

Table 6

Outline of Included Study Characteristics[5]

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
1.	Aguey-Zinsou et al. (2018)	Staff Attitudes Towards Consumer Participation And Peer Worker roles in a Community Mental Health Service	Australia	"What are staff attitudes towards consumer participation and peer workers in community mental health teams?" (p. 84)	Public community mental health teams including case management and rehabilitation teams	82 Community mental health staff including adult case management and rehabilitation teams. Teams included nurses, social workers, psychologists and occupational therapist. No demographics included.	New employed paid peer worker positions were being established. 16 hours per week. No demographics included.	Cross-sectional survey design, with open-ended questions included.	Thematic analysis of open-ended questions (Braun & Clarke, 2006)	6.5 (B)

[5] Terminology included is used in original study. Study setting and data collection methods differed for non-peer and peer mentor thus tables only refer to non-peer recruitment.

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
2.	Barr et al. (2020)	Using peer workers with lived experience to support the treatment of borderline personality disorder: a qualitative study of consumer, carer and clinician perspectives	Australia	"…to determine possible models and recommend-dations of peer support for BPD." (p.3.).	Organisations which support people diagnosed with Borderline Personality Disorder (BPD), or the carers of individuals diagnosed with BPD.	12 mental health professionals who had experience working with consumers with BPD and consumer peer workers or carer peer workers. Female (n=7), Nurse (n=3), Occupational therapist (n=1), Psychiatrist (n=1), Psychologist (n=5), Social Worker (n=2).	Consumer peer worker (n=7, all female) with BPD. Carer peer worker (n=6, all female). Paid roles.	Semi-structured interview	Interpretative Phenomenological Analysis to ensure preconceptions 'bracketed' (Smith & Flowers, 2009). 'Reflexive thematic analysis' of the data was performed (Braun et al., 2019)	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
3.	Berry et al. (2011)	Another rather than other: experiences of peer support specialist workers and their managers working in mental health services	UK	"…to use qualitative methodology to further explore the integration of peer support workers into existing mental health teams in the UK." (p. 239.).	Mental health and social services within an NHS trust in South England.	Two managers of peer specialists. No demographics included.	Peer Support Specialists occupied substantive paid positions within NHS trust for less than six months. No demographics included.	Semi-structured interview	Thematic Analysis (Braun & Clarke, 2006)	6.5 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
4.	Byrne et al. (2018)	Taking a Gamble for High Rewards? Management Perspectives on the Value of Mental Health Peer Workers	Australia	"…Explores the perceived value and limitations of peer roles from the perspectives of people employed in management roles and […] identifies strategies to support and maximise the benefits of employing peers." (p. 2).	Charity and public mental health services	16 non-peer staff within not-for-profit organisations. 13 non-peer staff within government organisations. Roles were categorised as traditional executive, senior management or designated peer executive roles.	Differing levels of peer employment ranging from no peer roles to significant number of roles. Peer roles included advocacy, education and training, and peer support workers.	Semi-structured interview and one focus group	Grounded Theory (Strauss & Corbin, 1998)	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
5.	Byrne et al. (2019)	'You don't know what you don't know': The essential role of management exposure, understanding and commitment in peer workforce development	Australia	"[…] to gain insight into how these key decision-makers[*managers]* view the growing workforce. This paper explores the workplace cultural considerations that impact on peer roles and the critical role of management in setting the cultural 'tone'." (p. 573.).	Charity and public mental health services	16 non-peer staff within not-for-profit organisations. 13 non-peer staff within government organisations. Roles were categorised as traditional executive, senior management or designated peer executive roles.	Differing levels of peer employment ranging from no peer roles to significant number of roles. Peer roles included advocacy, education and training, and peer support workers.	Semi-structured interview and one focus group	Grounded Theory (Strauss & Corbin, 1998)	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
6.	Cabral et al. (2014)	Clarifying the role of the mental health peer specialist in Massachusetts USA: insights from peer specialists, supervisors and clients	USA	"…to add to the growing body of published literature on the similarities and differences in these groups' perspectives on the role." (p. 106.).	Various mental health agencies employ-ing peer specialists	14 supervisory staff, selected based on current supervision of peer specialists across different service types: community-based services, programme for Assertive Community Treatment and emergency services.	All completed Certified Peer Specialist Training and were employed into various settings.	Two focus groups (n = 7 in both groups).	"A systematic And rigorous process was used to conduct qualitative analysis of all interview and focus group data (Liamputtong & Ezzy, 2005).". (p. 107.).	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
7.	Coates et al. (2018)	The development and implementation of a peer support model for a specialist mental health service for older people: lessons learned	Australia	"…to guide others embarking on the development of a peer work model for older people, by outlining our specific learnings for each component of the model (recruitment, the role of peer workers, training and supervision and governance)." (p. 2.).	Specialist mental health service for older adults	Eight steering committee members, 16 multi-disciplinary clinicians, two project managers.	Employed by a non-government organisation. Role includes one-to-one support, group work and broader mental health promotional activities. Paid and voluntary positions	Focus groups	Thematic Analysis (Braun & Clarke, 2006)	5.5 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
8.	Collins et al. (2016)	"Very much evolving": a qualitative study of the views of psychiatrists about peer support workers	UK	"…to explore the views and attitudes of a sample of psychiatrists specifically towards PSWs [Peer Support Workers]." (p. 279.).	General adult services, older adults, forensic, early intervention learning disabilities and CAMHS	11 Psychiatrists – Average 15 years experience in psychiatry. Female (n=7), male (n=4). Six had direct experience, three had no direct experience, two did not disclose experience.	No characteristics provided. PSW defined as "…have personal experience of a mental health condition and are employed with the aim of sharing their recovery journey to motivate and encourage others." (p. 278.).	Semi-Structured interview	Thematic Analysis (Braun and Clarke, 2006)	7.5 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
9.	Doherty et al. (2004)	The consumer-employee as a member of a Mental Health Assertive Outreach Team. II. Impressions of consumer-employees and other team members.	UK	"…to provide a first hand account of the experience of being a consumer-employee within an assertive outreach team. […]investigated whether similar [non-peer staff] concerns would be found in an inner London assertive outreach team…". (p. 73.).	Assertive Outreach Team	10 staff members: case managers (all psychiatric nurses), associate specialist psychiatrist, consultant psychiatrist.	Service Users employed as healthcare assistants (HCAs). Work alongside case managers focusing on activities of daily living and engaging clients in community facilities to increase social networks.	Mixed Methods – Question-naire and semi-structured interview	Content Analysis (Berelson, 1952)	6 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
10.	Ehrlich et al., (2020)	What happens when peer support workers are introduced as members of community-based clinical mental health service delivery teams: a qualitative study.	Australia	Sought to answer: "(1) "How is peer support work constructed in an interprofessional clinical care team?" and (2) "How do interprofessional mental health clinical care teams respond to the inclusion of PSWs as team members?" (p. 108.).	Newly deployed inter professional clinical care team.	Three non-clinical support roles, 16 clinicians (clinicians included registered nurse, OT, psychiatrist, social workers and pharmacist).	PSWs employed in team. Roles included advocacy, sharing personal stories and assisting clients reach goals. PSWs employed specifically to support services become more culturally appropriate .	Semi-structured interview	Coding process (Bazeley, 2013; Glaser & Strauss, 1995).	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
11.	Gates & Akabas (2007)	Developing Strategies to Integrate Peer Providers into the Staff of Mental Health Agencies	USA	"… goal was to generate an in-depth understanding of the circumstances that allow peers to be effective in their designated roles, and experience improved integration into the organization." (p. 295).	Social work agencies, which provide mental health services	27 executive directors, 18 HR representatives, 22 supervisors of peer mentors and 26 line staff. Currently or in the past, employed peer mentors, or have not employed peer mentors currently or in the past.	Paid positions. Have completed pre-employment training through the Howie the Harp Peer Advocacy Center. No description of roles. Those agencies with no peer mentor will recruit a peer mentor in the future.	Semi-Structured Interview	Inductive approach (Strauss & Corbin, 1990; Miles & Huberman, 1994)	7.5 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
12.	Gillard et al. (2013)	Introducing peer worker roles into UK mental health service teams: a qualitative analysis of the organis-ational benefits and challenges.	UK	"(1) To describe the emergence of Peer Worker roles in Mental health services in England […]; (2) to describe in detail the organisational benefits and challenges of introducing Peer Worker roles into existing mental health service teams." (p. 2.).	Four English mental health NHS Trusts – innovative intervention providing support for self-care to service users, all of which include PSW.	Four managers, nine non-peer staff.	Peer workers paid employees of the Trust, part-time, contracted staff. Completed eight session training and received ongoing training and supervision. Roles include group co-facilitators and support in creating 'Wellness Recovery Action Plan'.	Semi-Structured Interview	Grounded Theory Approach (Strauss & Corbin, 1998)	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
13.	Gillard et al. (2015)	Introducing New Peer Worker Roles into Mental Health Services in England: Comparative Case Study Research Across a Range of Organisational Contexts	UK	"…to establish whether organisational conditions supporting adoption of new peer worker roles in England apply across all mental health providers (or provider partnerships), or whether there are implementation issues that are specific to particular organisational contexts." (p. 3.).	UK NHS Trusts, voluntary sector service providers, and partnerships between NHS and voluntary sector.	24 non-peer staff from statutory and non-peer led partnership programmes. Peer-led voluntary agencies and partnerships were excluded.	PW employed into various roles, paid and unpaid, in psychiatric inpatient settings, CMHTs, Black and minority ethnic specific services. Role included advocacy work, co-leading services such as groups, individual support, supporting in social aspects of service user lives.	Structured interview question-naire	Thematic and framework approach, then pattern matching (Yin, 2004), deductive in nature	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
14.	Gordon & Bradstreet (2015)	So if we like the idea of peer workers, why aren't we seeing more?	UK	"…to explore the views of individuals with responsibility […] for making decision on the design or development of mental health services and recovery initiatives." (p. 162-163.).	Two Scottish health boards: one recruited peer workers and the other had not.	19 NHS, council and third sector staff. Senior roles including strategic planning and commissioning, director or clinical lead for mental health and service managers.	Not specifically identified within healthboard. However, definition provided "… people who have personal experience of mental health problems who are trained and employed to work in a formalised role in support of others recovery.". (p. 161).	Semi-structured interview and focus group	Informed by 'framework' (Ritchie & Spencer, 1994).	5.5 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
15.	Gray et al. (2017)	Finding the right connections: Peer support within a community-based mental health service	Australia	"…to better understand the workplace environment into which peer support workers were expected to integrate." (p. 188.).	Non-government organisation, rural community mental health services.	16 caseworker and managers.	Two peer mentors, recently employed. Roles included group activities and one-to-one work. Worked closely with caseworkers to support clients.	Semi-structured interview	Open coding process (Strauss & Corbin, 2008)	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
16.	Hamilton et al. (2015)	Implementation on of Consumer Providers into Mental Health Intensive Case Management Teams	USA	"…one key goal was to evaluate facilitators and challenges to implementation of [consumer providers] on Mental Health Intensive Case Management teams." (p. 2.).	Mental Health Intensive Case Management teams	Eight providers. Roles include psychiatrists, psychologists, social workers and nursing case managers.	Recently employed. Conducted case management with a focus on being supportive and encouraging, building hope, teaching skills, liaising to other providers and using own experiences in tasks. All undergone training.	Semi-structured interview	Coding process described (No reference)	6.5 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
17.	Holley et al. (2015)	Peer Worker Roles and Risk in Mental Health Services: A Qualitative Comparative Case Study	UK	"…explores either potential risks to peer workers and the people they support, or the challenges posed to peer working by existing risk management practice in mental health services." (p. 478.).	UK NHS Trusts, voluntary sector service providers, and partnerships between NHS and voluntary sector.	24 non-peer staff from statutory and non-peer led partnership programmes. Peer-led voluntary agencies and partnerships were excluded.	PW employed into various roles, paid and unpaid, in psychiatric inpatient settings, CMHTs, Black and minority ethnic specific services. Role included advocacy work, co-leading services such as groups, individual support, supporting in social aspects of service user lives.	Open-ended questions (inductive in nature)	Grounded Theory approach (Strauss & Corbin, 1998)	7 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
18.	Hurley et al. (2018)	Qualitative study of peer workers within the 'Partners in Recovery' programme in regional Australia	Australia	"…sought to respond to the following research questions: (1) What are the experiences of Peer Workers of their roles within [Partners in Recovery]? (2) What were other [Partners in Recovery] staffs' experience of the Peer Worker role" (p. 188.).	Peers In Recovery programme, national mental health programme currently linked to National Disability Insurance Scheme (Australia)	Four managers, 10 support facilitators. Support facilitators work at a system level to improve coordination and integration in support of consumer recovery.	Four peer workers, who are employed "…workers who have lived experience of mental health challenges […] and these works have a key role in driving recovery practices" (p. 188.).	Semi-structured interview	Thematic Analysis (Hsieh & Shannon, 2005a, b)	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
19.	Kilpatrick et al. (2017)	Tokenistic or genuinely effective? Exploring the views of voluntary sector staff regarding the emerging peer support worker role in mental health	UK	"…to explore the views of voluntary sector staff regarding the emerging role of PSWs in mental health services, identify challenges and potential solutions to more successful role integration."	Voluntary mental health organis-ations	10 participants: Chief Executives, Employment Support Workers, Service Managers and Volunteer officers. Nine female, one male. Not currently working with peer mentor but experience of role.	None employed in study settings. Role understood as "…the intentional employment of service users to support others." (p. 504.).	Semi structured interview	COREQ checklist (Tong et al., 2007) and Miles & Hubermans (1984) method of data analysis employed.	8.5 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
20.	Mancini (2018)	An Exploration of Factors that Effect the Implementation of Peer Support Services in Community Mental Health Settings	USA	"(1) How do peers describe their experiences working in traditional mental health agencies and what factors enhance and hinder their ability to integrate their practice in these settings? (2) How do non-peer […] describe their experiences working with and supervising peers? (3) What do each of these groups describe as the most important factors guiding integration of peers […] ?" (p. 128.).	Four community mental health centers serving persons with psychiatric disabilities.	11 non-peer mental health workers. Must have had experience working directly with peer workers I either co-worker or supervisory role.	Certified peer specialists. Worked at 10 out of the 13 agencies involved in the study.	Semi-structured interview	Thematic Analysis methods (Boyatzis, 1998)	6 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
21.	McLean et al. (2009)	Evaluation of the Delivering for Mental Health Peer Support Worker Pilot Scheme	UK	"…to assess the impact of the peer support pilot on service users, peer support workers and the wider service system as well as assessing the process of implementation at national and local levels." (p. i.).	Community and inpatient mental health services	12 trained peer support supervisors. 12 wider service system individuals who could provide an informed perspective on the local implementation of the approach and its impact on the wider service system, including referrers and local service providers.	15 peer support workers – required to have a lived experience of a mental health difficulty and be in recovery. Employed into various services and geographical settings.	Interview	Stage content process (No reference)	7 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
22.	Moll et al. (2009)	Work transitions for peer support providers in traditional mental health programs: Unique challenges and opportunities	Canada	"…focus of this paper is on the perceptions of both new and established peer providers, and ways in which their experience is shaped by key elements in their workplace environment." (p. 450.).	Six community-based agencies providing psychosocial rehabilitation and support services to individuals with "severe mental illness"	Six managers of peer support providers. No further demographics.	Six peer support providers (four males, two female). Part-time hours, employed into services with roles such as one-to-one support, group support, community visits, supports education and training. Paid roles.	Semi-structured interview	Thematic Analysis (Braun & Clarke, 2006)	7.5 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
23.	Moore et al. (2020)	More 'milk' than 'psychology or tablets': Mental health professionals' perspectives on the value of peer support workers	UK	"What is it that mental health professionals value about peer support, given the tensions and difficulties it potentially arouses?" (p.3.).	Recruited from range of mental health difficulties, including community, acute and specialist services.	Five practitioners – OT, psychologist, nurse, social worker and psychiatrist. Three female, two male. All over fifteen years post-qualification experience. All had experience of user involvement in the past six months.	Peer support workers employed into NHS trust, but not necessarily working with non-peers at time of the study. Work within the NHS trust included one-to-one, group and supporting others through e.g. advocacy roles.	Semi-structured interview	Foucauldian Discourse Analysis (Willig, 2008)	8 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
24.	Oborn et al. (2019)	Knowledge and expertise in care practices: the role of the peer worker in mental health teams	UK	"What forms of knowledge and expertise do PW's [peer worker] develop and how they do use them in enacting mental healthcare practices?" (p. 1306.).	10 contrasting UK NHS Trusts, voluntary sector service providers, and partnerships between NHS and voluntary sector.	24 non-peer staff from statutory and non-peer led partnership programmes. Peer-led voluntary agencies and partnerships were excluded.	PW employed into various roles, paid and unpaid, in psychiatric inpatient settings, CMHTs, Black and minority ethnic specific services. Role included advocacy work, co-leading services such as groups, individual support, supporting in social aspects of service user lives.	Semi-structured interview	Thematic and framework approach (Averill, 2002)	7 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
25.	Otte et al. (2020)	Beneficial effects of peer support in psychiatric hospitals. A critical reflection on the results of a qualitative interview and focus group study	Germany	"…to explore the integration of [peer support workers] into mental health care teams in psychiatric hospitals and to identify beneficial effects for patients and mental health professionals as well as challenges that occur during the implementation process." (p. 290.).	Five adult psychiatric hospitals	32-40 mental health professionals who worked alongside peer support workers.	Experienced mental health difficulties and currently in recovery. All passed one-year official training program in Germany. Paid work between 5-20 hours. Most worked on open wards in general psychiatry, and offered both one-to-one and group work.	Four focus groups (8-10 mental health profess-sionals in each)	Qualitative content analysis (Mayring, 2014)	7 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
26.	Tse et al. (2007)	A one-year longitudinal qualitative study of peer support services in a non-Western context: The perspectives of peer support workers, service users, and co-workers	Hong Kong	"[…] to identify the changes in the perceptions (concerning peer support services and their key ingredients) of PSWs among themselves, their co-workers […] and service users at different community-based mental healthcare centers in Hong Kong over a 12- month period." (p.28)	Integrated Community Centre for mental wellness and Halfway house	14 co-Workers. Professions: 12 social workers, one clinical psychologist, one OT. 12 women, two men. Worked with PSWs on daily basis.	All completed training course and employed either part/full-time in non-governmental organisations. Roles included talking with service users, co- leading recovery-oriented activities, sharing recovery journeys, accompanying professionals to appointments.	Semi-structured interview	Thematic Analysis (Braun & Clarke, 2006; Gibson & Brown, 2009)	8.5 (A)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
27.	Weir et al. (2019)	Military veteran engagement with mental health and well-being services: a qualitative study of the role of the peer support worker	UK	"…to inform [the] gap in the literature by exploring veterans, PSW and mental health clinicians thoughts, feelings and experiences of the PSW role in veteran engagement at a UK clinic…" (p. 648)	Specialist NHS veteran mental health and well-being clinic in Scotland.	Four clinicians participated. Aged between 25-44 years, two Male/two female and all had no military background. Three psychologists and one psychiatrist, with experience of role between 11 months – five years.	Four veterans at the clinic, aged between 35-54 years. Two male and Two female. All had served in the army and had experience in the role of between six months – three years.	Semi-structured interview	Thematic Analysis (Braun & Clarke, 2006)	7 (B)

Study	Authors	Title	Country	Aim	Study Setting	Non-peer characteristics	Peer mentor characteristics	Data collection	Method of data analysis	Quality Rating
28.	Zeng et al. (2020)	Organisational contexts and practice developments in mental health peer provision in Western Australia	Australia	"…aims to explore the organisational contexts where [peer providers] operates, covering both government health departments (PMHS) and other [Non-Governmental Organisations]." (p. 570).	Public, Non-governmental organisation and independent setting.	Two supervisors, four team managers, three peer support coordinators, three programme managers, two project officers.	None provided – "[...]. it was anticipated that there would be some differences between peer providers' work experiences" (p. 571).	Semi-structured interview	Hybrid approach of inductive and deductive coding (Fereday & Muir-cochrane, 2006)	7.5 (B)

Findings of quality appraisal

Studies were all within low to moderate likelihood of methodological flaws, meaning scores ranged from 5.5-8.5 on the CASP (2018) tool (M = 7.28). Studies predominantly scored no or partial points for reflexivity, lack of rationale of research design and lack of information regarding ethical considerations (see Appendix E. for examples of CASP scoring).

Table 7. outlines scoring for each question on the CASP (2018) tool, for all included studies. As question 10 does not require scoring, the prompts to consider are provided, with consideration of how the included studies met these prompts.

Table 7

Scoring of all included studies on CASP Quality Assessment Tool (2018)

Quality Appraisal Criteria (CASP tool)	1. Aguey-Zinsou et al. (2018)	2. Barr et al. (2020)	3. Berry et al. (2011)	4. Byrne et al. (2018)	5. Byrne et al. (2019)	6. Cabral et al. (2014)	7. Coates et al. (2018)	8. Collins et al. (2016)	9. Doherty et al. (2004)
1. Was there a clear statement of the aims of the research?	1	1	1	1	1	1	1	1	1
2. Is qualitative methodology appropriate?	1	1	1	1	1	1	1	1	1
3. Was the research design appropriate to address the aims of the research?	1	1	0.5	1	1	1	0.5	0.5	1
4. Was the recruitment strategy appropriate to the aims of the research?	1	1	0.5	1	1	1	0.5	1	1
5. Was the data collected in a way that address the research issue?	1	1	0.5	1	1	1	1	1	0.5
6. Has the relationship between researcher and participants been adequately considered?	0	0	1	0	0	0	0	1	0

Quality Appraisal Criteria (CASP tool)	1. Aguey-Zinsou et al. (2018)	2. Barr et al. (2020)	3. Berry et al. (2011)	4. Byrne et al. (2018)	5. Byrne et al. (2019)	6. Cabral et al. (2014)	7. Coates et al. (2018)	8. Collins et al. (2016)	9. Doherty et al. (2004)
7. Have ethical issues been taken into consideration?	0.5	1	0.5	1	1	1	1	0	0
8. Was the data analysis sufficiently rigorous?	0.5	1	0.5	1	1	1	0.5	1	0.5
9. Is there a clear statement of findings?	0.5	1	1	1	1	1	0	1	1
10. How valuable is the research?									
10a) Do the researchers discuss the contribution the study makes to existing knowledge or understanding?	✓	✓	✓	✓	✓	✓	✓	✓	✓
10b) Do the researchers identify new areas where research is necessary?	✓	✓	**X**	✓	✓	✓	**X**	**X**	✓
10c) Do the researchers discuss whether or how the findings can be transferred to other populations or considered other ways the research may be used?	✓	✓	✓	✓	✓	✓	**X**	✓	**X**
CASP total (out of 9) with CASP quality rating	6.5 (B)	8 (A)	6.5 (B)	8 (A)	8 (A)	8 (A)	5.5 (B)	7.5 (B)	6 (B)

Quality Appraisal Criteria (CASP tool)	10. Ehrlich et al. (2020)	11. Gates & Akabas (2007)	12. Gillard et al. (2013)	13. Gillard et al. (2015)	14. Gordon & Bradstreet (2015)	15. Gray et al. (2017)	16. Hamilton et al. (2015)	17. Holley et al. (2015)	18. Hurley et al. (2018)
1. Was there a clear statement of the aims of the research?	1	1	1	1	1	1	1	1	1
2. Is qualitative methodology appropriate?	1	1	1	1	1	1	1	1	1
3. Was the research design appropriate to address the aims of the research?	1	1	1	1	0.5	1	1	1	1
4. Was the recruitment strategy appropriate to the aims of the research?	1	0.5	1	1	1	1	0.5	1	0.5
5. Was the data collected in a way that address the research issue?	1	1	1	1	1	1	1	1	1
6. Has the relationship between researcher and participants been adequately considered?	0	0	0	1	0	0	0	0	0.5
7. Have ethical issues been taken into consideration?	1	1	1	0	1	1	0	0	1
8. Was the data analysis sufficiently rigorous?	1	1	1	1	1	1	1	1	1
9. Is there a clear statement of findings?	1	1	1	1	0.5	1	1	1	1

Quality Appraisal Criteria (CASP tool)	10. Ehrlich et al. (2020)	11. Gates & Akabas (2007)	12. Gillard et al. (2013)	13. Gillard et al. (2015)	14. Gordon & Bradstreet (2015)	15. Gray et al. (2017)	16. Hamilton et al. (2015)	17. Holley et al. (2015)	18. Hurley et al. (2018)
10. How valuable is the research?									
10a) Do the researchers discuss the contribution the study makes to existing knowledge or understanding?	✓	✓	✓	✓	✓	✓	✓	✓	✓
10b) Do the researchers identify new areas where research is necessary?	✓	✓	✓	✓	✓	✓	✓	✓	✓
10c) Do the researchers discuss whether or how the findings can be transferred to other populations or considered other ways the research may be used?	✓	✓	✓	✓	**X**	✓	✓	✓	✓
CASP total (out of 9) with CASP quality rating	8 (A)	7.5 (B)	8 (A)	8 (A)	7 (B)	8 (A)	6.5 (B)	7 (B)	8 (A)

Quality Appraisal Criteria (CASP tool)	19. Kilpatrick et al. (2017)	20. Mancini (2018)	21. McLean et al. (2009)	22. Moll (2009)	23. Moore & Zeeman (2020)	24. Oborn et al. (2019)	25. Otte et al. (2020)	26. Tse et al. (2017)	27. Weir et al. (2019)	28. Zeng et al. (2020)
1. Was there a clear statement of the aims of the research?	1	1	1	1	1	1	1	1	1	1
2. Is qualitative methodology appropriate?	1	1	1	1	1	1	1	1	1	1
3. Was the research design appropriate to address the aims of the research?	0.5	0.5	1	1	1	0.5	0.5	1	0.5	1
4. Was the recruitment strategy appropriate to the aims of the research?	1	0.5	1	1	0.5	0.5	0.5	1	0.5	1
5. Was the data collected in a way that address the research issue?	1	1	1	1	1	1	1	1	1	1
6. Has the relationship between researcher and participants been adequately considered?	1	0	0	0	1	0	0	0.5	0	0
7. Have ethical issues been taken into consideration?	1	0	0.5	0.5	0.5	1	1	1	1	0.5

Quality Appraisal Criteria (CASP tool)	19. Kilpatrick et al. (2017)	20. Mancini (2018)	21. McLean et al. (2009)	22. Moll (2009)	23. Moore & Zeeman (2020)	24. Oborn et al. (2019)	25. Otte et al. (2020)	26. Tse et al. (2017)	27. Weir et al. (2019)	28. Zeng et al. (2020)
8. Was the data analysis sufficiently rigorous?	1	1	0.5	1	1	1	1	1	1	1
9. Is there a clear statement of findings?	1	1	1	1	1	1	1	1	1	1
10. How valuable is the research?										
10a) Do the researchers discuss the contribution the study makes to existing knowledge or understanding?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10b) Do the researchers identify new areas where research is necessary?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10c) Do the researchers discuss whether or how the findings can be transferred to other populations or considered other ways the research may be used?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CASP total (out of 9) with CASP quality rating	8.5 (A)	6 (B)	7 (B)	7.5 (B)	8 (A)	7 (B)	7 (B)	8.5 (A)	7 (B)	7.5 (B)

Findings of meta-ethnography

Following Noblit and Hare (1988), the meta-ethnography identified seven over-arching core concepts that demonstrate non-peer experiences of working with peer mentors: *'The existing team', 'Wider System Support, 'Readiness', 'Shift in Power', 'Integration', 'Value of lived experience'* and *'Services embracing recovery'*. These core concepts encompassed 18 sub-concepts, all of which are described in the written narrative below. These over-arching core concepts are considered inter-linked rather than distinct, and describe a journey of non-peer experience from before to after peer mentors were integrated into teams.

Twenty studies reported both peer and non-peer experiences. Some of these were limited in reporting, for example Cabral et al. (2014) and Coates et al. (2018). These studies supported the least concepts. However, when comparing data across all studies, data was considered rich enough to go beyond descriptive understanding, devising third order interpretations of the data. The significant overlap across studies (as shown in table 8.) suggests poorer quality rated studies did not negatively impact the findings. No emergent processes were apparent over time, suggesting concepts were found across the timespan of studies.

Table 8

Identified core concepts and sub-concepts from meta-synthesis

Identified concepts		Total	1. Aguey-Zinsou et al. (2018)	2. Barr et al. (2020)	3. Berry et al. (2011)	4. Byrne et al. (2018)	5. Byrne et al. (2019)	6. Cabral et al. (2014)	7. Coates et al. (2018)	8. Collins et al. (2016)	9. Doherty et al., (2004)
Quality Rating			6.5 (B)	8 (A)	6.5 (B)	8 (A)	8 (A)	8 (A)	5.5 (B)	7.5 (B)	6 (B)
The Existing Team	Existing organisational culture	10		✓	✓	✓	✓				
	Previous exposure to peers	5				✓	✓			✓	
	Non-peer attitudes	13	✓		✓	✓			✓	✓	
Wider System Support		20	✓	✓	✓	✓	✓	✓		✓	✓
Readiness	Role Clarification	15	✓	✓	✓			✓		✓	
	Shared Expectations	10			✓					✓	
	Preparation	11				✓	✓		✓		
	Needing more than lived Experience	12	✓	✓	✓	✓					

	Identified concepts	Total	1. Aguey-Zinsou et al. (2018)	2. Barr et al. (2020)	3. Berry et al. (2011)	4. Byrne et al. (2018)	5. Byrne et al. (2019)	6. Cabral et al. (2014)	7. Coates et al. (2018)	8. Collins et al. (2016)	9. Doherty et al., (2004)
Shift in power	Power imbalances	12	✓	✓	✓	✓	✓				
	Peer mentor as a 'challenger'	8			✓					✓	
Integration	Transition from service user to peer	14	✓		✓					✓	✓
	Flexibility around the role	9			✓	✓					
	Role in existing practice	7	✓	✓							
	The role and peer well-being	13		✓	✓	✓				✓	

Identified concepts		Total	1. Aguey-Zinsou et al. (2018)	2. Barr et al. (2020)	3. Berry et al. (2011)	4. Byrne et al. (2018)	5. Byrne et al. (2019)	6. Cabral et al. (2014)	7. Coates et al. (2018)	8. Collins et al. (2016)	9. Doherty et al., (2004)
Value of lived experience	Peers complement non-peers	24	✓	✓	✓	✓	✓		✓	✓	✓
	Differing relationships	18	✓		✓	✓			✓	✓	✓
	Measuring value	7		✓		✓	✓			✓	
Services embracing recovery		12	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Identified concepts	10. Ehrlich et al. (2020)	11. Gates & Akabas (2007)	12. Gillard et al. (2013)	13. Gillard et al. (2015)	14. Gordon & Bradstreet (2015)	15. Gray et al. (2017)	16. Hamilton et al. (2015)	17. Holley et al. (2015)	18. Hurley et al. (2018)
Quality Rating		8 (A)	7.5 (B)	8 (A)	8 (A)	5.5 (B)	8 (A)	6.5 (B)	7 (B)	8 (A)
The Existing Team	Existing organisational culture		✓		✓	✓			✓	
	Previous exposure to peers					✓	✓			
	Non-peer attitudes		✓	✓	✓			✓		
Wider System Support			✓	✓	✓	✓	✓		✓	
Readiness	Role Clarification	✓	✓		✓			✓		✓
	Shared Expectations		✓	✓	✓			✓		
	Preparation		✓		✓	✓		✓	✓	
	Needing more than lived experience	✓	✓	✓						✓
Shift in power	Power imbalances	✓		✓				✓		
	Peer mentor as a ‘challenger’			✓	✓				✓	

	Identified concepts	10. Ehrlich et al. (2020)	11. Gates & Akabas (2007)	12. Gillard et al. (2013)	13. Gillard et al. (2015)	14. Gordon & Bradstreet (2015)	15. Gray et al. (2017)	16. Hamilton et al. (2015)	17. Holley et al. (2015)	18. Hurley et al. (2018)
Integration	Transition from service user to peer		✓	✓	✓		✓	✓	✓	
	Flexibility around the role		✓					✓		✓
	Role in existing practice		✓						✓	
	The role and peer well-being			✓			✓		✓	✓
Value of lived experience	Peers complement non-peers	✓	✓	✓	✓		✓	✓	✓	✓
	Differing relationships	✓	✓		✓		✓	✓		
	Measuring value		✓			✓				
Services embracing recovery										

Identified concepts		19. Kilpatrick et al. (2017)	20. Mancini (2018)	21. McLean et al. (2009)	22. Moll (2009)	23. Moore & Zeeman (2020)	24. Oborn et al. (2019)	25. Otte et al. (2020)	26. Tse et al. (2017)	27. Weir et al. (2019)	28. Zeng et al. (2020)
Quality Rating		8.5 (A)	6 (B)	7 (B)	7.5 (B)	8 (A)	7 (B)	7 (B)	8.5 (A)	7 (B)	7.5 (B)
The Existing Team	Existing organisational culture	✓									✓
	Previous exposure to peers										
	Non-peer attitudes	✓		✓	✓						✓
Wider System Support		✓	✓	✓	✓				✓		✓
Readiness	Role Clarification	✓	✓	✓				✓	✓		
	Shared Expectations		✓	✓					✓	✓	
	Preparation	✓	✓	✓							
	Needing more than lived Experience	✓		✓			✓			✓	
Shift in power	Power imbalances	✓	✓	✓		✓					
	Peer mentor as a ‘challenger’	✓	✓			✓					

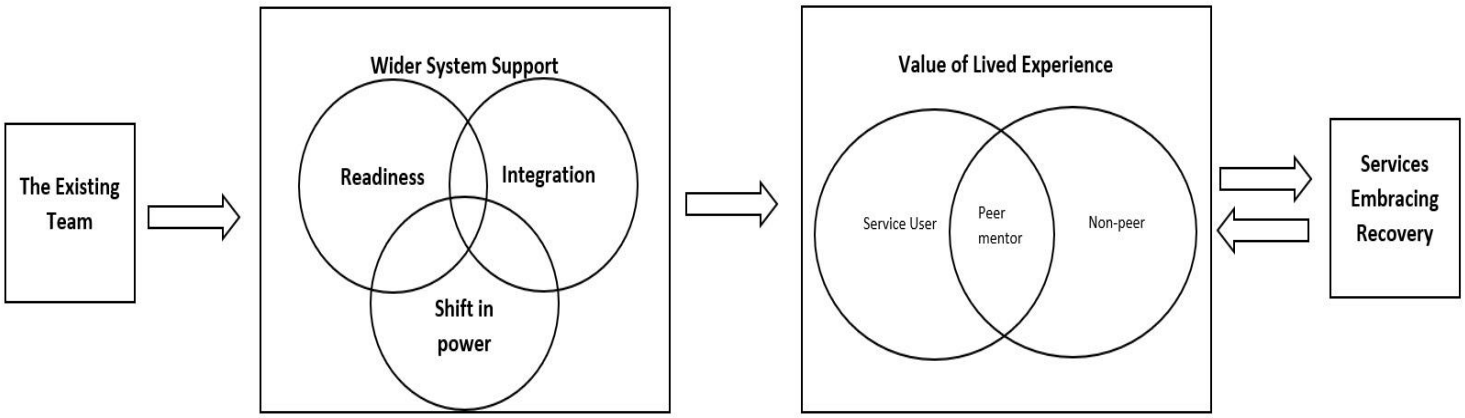
Identified concepts		19. Kilpatrick et al. (2017)	20. Mancini (2018)	21. McLean et al. (2009)	22. Moll (2009)	23. Moore & Zeeman (2020)	24. Oborn et al. (2019)	25. Otte et al. (2020)	26. Tse et al. (2017)	27. Weir et al. (2019)	28. Zeng et al. (2020)
Integration	Transition from service user to peer	✓	✓		✓				✓		
	Flexibility around the role	✓	✓	✓							✓
	Role in existing practice			✓	✓			✓			
	The role and peer well-being	✓		✓	✓				✓		✓
Value of lived experience	Peers complement non-peers	✓		✓	✓	✓	✓	✓	✓	✓	
	Differing relationships	✓		✓		✓	✓	✓	✓	✓	
	Measuring value			✓							
Services embracing recovery				✓					✓		✓

A diagrammatic summary of themes is presented in Figure 2., followed by a written narrative below. The written narrative will follow the journey of the experience, discussing core concepts and sub-concepts.

The line of argument proposes that existing teams are influenced by organisational cultures, previous exposure to peer work and non-peer attitudes such as prejudices towards people with lived experience. This influence either means non-peers are open to peer mentor roles, or they demonstrate resistance and defensiveness to the role. Organisations which show no prioritisation or value towards the peer mentor role, can result in a lack of readiness of non-peers for the integration. Alternatively, organisational value and prioritisation of the role often links with adequate planning around the integration, supporting a smooth implementation. Overlapping both readiness and integration is a shift in power, where traditional ways of working and power dynamics become more balanced. Existing teams which are open to, and prepared for, peer mentors are less likely to experience this as a disruptive or challenging shift. With wider system support and reduced resistance and defensiveness, non-peers can come to value and recognise how peer mentors can fill a gap in current service delivery. Through role modelling, offering a bridge between non-peer and service users, and offering a relationship built on mutuality which non-peers are unable to provide, non-peers described peer mentors as complementing and enhancing their own service delivery. If teams recognise the complementing and enhancing role, services will be open and embrace recovery-focused practice. Permanent changes are seen for example, in the language used by non-peers. The more services embrace recovery, the more value is placed on peer mentors within services.

Figure 2

Diagrammatic summary of concepts identified in the meta-synthesis



The Existing Team

This core concept depicts non-peer understanding and experiences of peer mentors prior to them being employed into a team. It considers both organisational and individual level concepts, specifically the *'existing organisational culture', 'previous exposure to peers'* and *'non-peer attitudes'*. Together, these sub-concepts result in an existing non-peer team which either demonstrates openness or resistance towards peer mentor employment. It is an important part of non-peer experiences, as it is the foundation for which they will move into the integration phase.

Existing organisational culture. The existing organisational culture was discussed in 10 of the included studies. Traditional, highly structured, risk adverse organisational environments were considered to adversely impact the potential employment and growth of the peer mentor role. If the organisation was considered to undervalue the peer mentor role, peer mentors were perceived as tokenistic and "cheap labour" by non-peers. This links with

'non-peer attitudes' as it may enhance non-peer ambivalence towards the role. However, organisations which had missions and agendas promoting recovery and empowerment tended to have non-peers with more positive attitudes towards peer mentors:

> *''Peers enrich the lives of clients and facilitate the transition to independence, the same as our mission.''* (Manager; Gates & Akabas, 2007, p. 297)

Previous exposure to peer work. Five studies referred to previous exposure to peer mentor working, three of which had participants who had little or no exposure to peer mentor roles. Apart from one non-peer, all those who had been exposed previously to the role held positive views and showed commitment to the role. One study contained participants who had less exposure but could consider what the role may entail and its potential benefits. Overall though, organisations or teams which had not been exposed to peer mentor working were less likely to demonstrate awareness, value or need for the role:

> *"[…] perhaps it's something [employing peers] we just haven't considered, or it hasn't been raised as something that we should be striving towards, maybe we don't have a lot of awareness about the value a person with lived experience [peer] can bring to a role or a program"* (Manager; Byrne et al., 2019, p. 575)

Non-peer attitudes. Non-peer attitudes towards peer support were referred to in 13 studies. Participants reported prejudicial and ambivalent attitudes towards peer mentors prior to them being employed, including concerns around peer mentor stability and ability to keep confidentiality. Participants reported feeling that peer mentors may pose a threat to existing,

non-peer staff roles. This was particularly evident when non-peers were unaware of what the role would entail, thus linking with a lack of *'previous exposure to peer work'*.

Wider System Support

The second core concept is key to non-peer experiences of working with peer mentors. Recognising the role organisations and non-peer colleagues play in the transition to a team that includes peer mentors, was a strong feature within 20 of the studies reviewed. This core concept impacts whether non-peers reduce defensiveness and resistance, and how non-peers come to value peer mentors and their lived experience. Non-peer supervision and management were both identified as key in supporting non-peers and peer mentors, demonstrating how non-peer management who prioritised and supported the role, led to smoother implementation of the role. Whole organisational support was also considered important. Non-peers voiced concerns about who would be accountable for risk, and organisational support, if something were to 'go wrong'. Without this, non-peers may find it difficult to embrace a peer mentor role which challenges risk adverse cultures:

> *"[…] It would be comforting to know that the Trust would support us if something went wrong […] But if something goes wrong […] there's a terrible sort of scurrying round […] and a general sense of, um, 'Oh dear, what will the papers say?'"* (Non-peer staff; Holley et al., 2015, p. 483)

Readiness

This core concept is encompassed within *'wider system support'* and overlaps with *'integration'* and *'shift in power'*. It refers to the 'getting ready' of non-peers and peer mentors for the integration, and the important processes identified by non-peers as being key

to feeling ready. It includes the sub-concepts *'Role Clarification', 'Shared Expectations', 'Preparation'* and *'Needing more than lived experience'*.

Role clarification. Role clarification was referred to in 15 studies. Non-peers described feelings of uncertainty and ambiguity of what the role would look like in practice. In the absence of clarification, participants spoke of mis-utilisation or no utilisation of the role after integration, questioning what the role brings to the non-peer team that is different to other current roles in the team:

> *"Like I say it's very new and I think probably the challenge is working out what the role of PSWs is going to be within the teams […] what is it that they should be doing that is different from a normal support worker or should they be the same as a support worker.[…]"* (Psychiatrist; Collins et al., 2016, p.281)

By clarifying the purpose and extent of the peer mentor role, non-peers felt able to understand and value the role more, whilst also reducing any initial resistance.

Shared Expectation. Ten studies referred to the need for there to be aligned expectations between non-peer staff and peer mentors. '*Wider system support'* was suggested to assist with aligning non-peer expectations. Without shared expectations, peer mentors were suggested to potentially fulfil a role which was unreasonable or exceeded expectations, for example non-peers expecting peer mentors to lead on culture change in the workplace. This links with *'the role and peer mentor wellbeing'* in *'integration'* where non-peers recognised how overwhelmed peers could be when expectations were considered unreasonable:

> *"[…] The peer support workers are definitely not paid enough money to go in and culture change statutory organisations and if I started putting that stress onto any of the peers it would be unacceptable."* (Supervisor; McLean et al., 2009, p. 41)

Preparation. Adequate planning, training for both peer mentors and non-peer staff and clear job descriptions were discussed as part of preparation in 11 of the studies. This preparation for the role, particularly training of peer mentors, was said to reduce non-peer concerns and increase non-peer confidence in the peer mentor role.

Needing more than lived experience. Non-peer staff described the need to recruit someone with more than just lived experience. Guidance on what other attributes may be helpful was suggested in 12 of the studies, as a way of reducing potential challenges following integration. Skills in communication, demonstrating compassion, navigating complicated situations and an understanding of recovery were considered to be needed alongside lived experience. Further, the need for qualifications was highlighted, as well as additional training in the role. For non-peers, this suggested that peer mentors could then compete with their roles and be more successful in the peer mentor role.

Shift in Power

This core concept refers to the difference in power dynamics due to the employment of peer mentors. It includes the sub-concepts *'Power imbalances'* and *'Peer mentor as a 'Challenger''.* It overlaps *'readiness'* and *'integration'* as power dynamics may shift through these key time points.

Power Imbalances. This sub-concept, identified in 12 studies, refers to power imbalances between service user and professional, and peer mentor and non-peer. Non-peers reported peer mentors challenging the power imbalance often experienced between service users and professionals. Non-peers experienced this as a reduction in perceived tokenism of the peer mentor role and noticed the increased equality in relationships with service users:

> *"There's a reciprocal respect that comes from that (peer support) where there's not a power differential that I think is often existing in the clinical relationship"* (Non-peer staff; Barr et al., 2020, p. 4)

Non-peers had mixed experiences in relation to the integration of peer mentors and their own power. Some non-peers described a loss of power through peer mentors challenging existing ways of delivery in mental health services, thus exacerbating the feeling of threat some non-peers experienced prior to integration. Some non-peers were reported to position peer mentors as 'second-class professionals', potentially impacting their ability to positively challenge practice. However, this was not the experience of all non-peers, with some describing embracing peer mentors as 'equal' colleagues.

Peer mentor as a 'challenger'. Eight studies described peer mentors as a 'challenger', particularly in relation to culture, practice, prejudicial attitudes and power imbalances. Some non-peers described an expectation that peer mentors would be 'challengers' by virtue of being employed as a peer mentor. However even with this expectation and sometimes welcomed approach, some non-peers noted continued feelings of being uncomfortable or defensive to this part of the role:

> *"A part of your job here is to call us out when we're not being sensitive…when we're falling into stereotyping…And we're telling you that's part of your job, but then we get sort of defensive when you actually do it."* (Non-peer staff; Mancini et al., 2018, p. 134)

Integration

This core concept refers to the processes involved at the point of integration, specifically including *'Transition from service user to peer', 'Needing more than lived experience', 'Flexibility around the role', 'Role in existing practices'* and *'The role and peer wellbeing'*.

Transition from service user to peer. The transition from service user to peer mentor was referred to in 14 of the studies. Some non-peers described peer mentors having a conflicted identity of 'lived experience' and one of 'professionalism'. This led to some non-peers positioning peer mentors outside both staff and service user. Non-peers suggested this confusion and uncertainty could lead to them finding it difficult to leave the 'professional-service user' relationship behind, closely linking with *'power imbalances'*. One way to manage this was holding peer mentors to the same professional standards as non-peers, which could sometimes mean the peer mentor's work was interpreted as 'unprofessional', and/or it over-formalised the role, diluting the unique and core qualities of a peer mentor role:

> *"… the whole point about peer workers is having this not being so much part of the establishment, but by professionalising it … we actually make people part of an establishment."* (Non-peer staff; Gillard et al., 2015, common issues across organisational contexts section)

Flexibility around the role. Flexibility around the role of peer mentors was suggested in nine studies. Non-peers suggested that each peer mentor role may differ in terms of how the role may work in each team. Flexibility around reasonable adjustments was also discussed, with conflicting views as to whether these should be unique to peer mentors or embraced as a whole service approach. There were concerns that offering reasonable adjustments to only peer mentors suggested peer mentors were being treated differently to non-peers, and thus exacerbating the tension between the roles. However, where organisations adopted whole system approaches, there was a reduction in *'power imbalances'*, with mental health difficulties being normalised within the service.

Role in existing practices. Seven studies discussed how peer mentors could be involved in existing team practices such as note sharing and viewing medical notes. The inclusion of peer mentors in note sharing allowed non-peers to have stronger communication with peer mentors, spread the responsibility of risk and increased non-peer understanding of what service users were experiencing. When non-peers were uncertain of the 'fit' of peer mentors into existing teams, they sometimes involved peer mentors in meetings or delivering training which reduced peer mentor's capacity to engage in work which was considered valuable in relation to their role:

> *"I just think it was because we were trying to probably be too over-inclusive actually and as a result of that we tagged her up with other things to do which is not really ultimately what we wanted her to do like attend meetings and stuff like that."*
> (Supervisor; McLean et al., 2009, p. 46)

The role and peer mentor wellbeing. Thirteen studies highlighted non-peer concerns

in relation to the impact of the demands and expectations of the role on peer mentor wellbeing. Non-peers demonstrated an awareness of the toll that might come with sharing lived experience and how parts of the job may feel triggering. Participants described how peer mentors becoming unwell may impact service delivery, particularly work with clients. Non-peers also described a sense of responsibility towards peer mentors to ensure their wellbeing did not suffer:

> *"[…] We didn't realise at the time and [he] was becoming quite ill and quite psychotic at times [...] but we kind of missed the early signs and we all felt terrible because we should have known, working in mental health, about what was happening to him […]"* (Non-peer staff; Gillard et al., 2013, p. 8)

Some non-peers also spoke about the resilience demonstrated by peer mentors due to their lived experience, and felt peer mentors had a better capacity to manage their wellbeing than non-peer staff.

Value of Lived Experience

The value non-peers place on the lived experience of the peer mentor role is encompassed in this core concept. The sub-concepts identified are *'Peers complement non-peers', 'Differing relationships'* and *'Measuring value'*. Whether non-peers come to value the peer mentor role depends on the complex aspects of their experience prior to, and when, peer mentors are integrated into the team. This level of value also feeds into *'services embracing recovery'.* If peer mentor roles are considered valuable, then services are more likely to embrace recovery in practice.

Peers complement non-peers. Twenty-four studies recognised how peer mentors can provide a role, based on lived experience, which is unique and can work alongside non-peer work. They can influence work through education and training in recovery-focused practice; reduce stigma around mental health difficulties and bring insight and additional resources to the non-peer team. One of the key qualities of the peer mentor role was role modelling hope and recovery for both service users and non-peer staff. The other key quality was how peer mentors could be situated between non-peers and service users (as seen in figure 2.). Non-peers described this as 'bridging', as through peer mentors, non-peers were able to gain a better understanding of service users and service users were able to trust and engage with services more:

> *"[…] the biggest potential to me is that we now have this different access to the patients, we now have somehow a bridge between our two sides. […] now with our PSWs, they [the patients] see that it is okay to work with us, to be in a team with us. Now we can work together on their recovery."* (Non-peer staff; Otte et al., 2020, p. 292)

Differing relationship. This sub-concept was supported by 18 studies and overlaps with *'peers complement non-peers'.* It highlights how peer mentor's lived experience provides a uniqueness in relationships and interactions with service users: something which cannot be provided by non-peers. Non-peers recognised how peer mentors could offer something different to service users including more empathy due to mutuality in the relationship. This was a valued addition to non-peer practice, as peer mentors were seen to make more progress with service users who the non-peer team had made little progress with. Non-peers suggested service users were more likely to accept advice from a peer mentor

compared to a non-peer, recognising how peer mentor relationships with service users enhanced the service they provided.

Measuring value. Seven studies discussed how the value of peer mentor roles could be measured. Non-peers described difficulties in capturing the impact of the role such as comparing outcomes to when non-peers were not utilised. Qualitative feedback from service users was suggested to be positive and a way of demonstrating the value of the role. However, there were ongoing concerns regarding the cost-effectiveness of the role, particularly when considering funding a peer mentor role compared to a non-peer role.

Services embrace recovery

This core concept outlines those changes in services towards recovery-focused practice due to the employment of peer mentors. Twelve studies discussed permanent changes made in service delivery, both at a cultural and individual non-peer level. It follows the other core concepts, as a reduction in resistance allows non-peers to see the value of peer mentor roles, and for services to then come to embrace the recovery model. Embracing the recovery model was demonstrated through non-peer interactions with service users, where non-peers described being more compassionate and more effective in communication with service users. Non-peers described peer mentors being on-going reminders of recovery. This supported non-peers to use alternative language, which was suggested to increase inclusivity in the workplace and in service delivery:

> *". . . this is the function of peer support, so you know it is this person's job to make sure we've got consistent [recovery focused] language […]"* (Non-peer staff; Byrne et al., 2018, p. 5)

Service-wide changes were also recognised in the disclosure of non-peer mental health difficulties. Those studies where participants were not currently working with peer mentors demonstrated on-going concerns regarding non-peers sharing their lived experience compared to those participants who had worked with peer mentors. This demonstrates how peer mentor roles can be a catalyst for change in relation to how sharing non-peer lived experience is viewed in services.

DISCUSSION

This meta-ethnography aimed to build on previous systematic reviews (Ibrahim et al., 2020; Walker and Bryant, 2013), providing a further understanding and new insights related to non-peer experiences of working with peer mentors. The findings from this review echo those found in the previous reviews, such as the role of peer mentors as role models, decreasing stigma within teams and educating non-peers about recovery. Further, the previous and current reviews found a need for wider organisational support, whilst also recognising the tensions of 'professionalising' the role of peer mentors with the potential for this to diminish key qualities of the role. This review, however, goes further by highlighting other important processes voiced by non-peers including power imbalances, peers complementing non-peer practice and the explicit need for shared expectations. It demonstrates how all these concepts influence one another and subsequently impact non-peer experiences of working with peer mentors.

Despite the studies in this review spanning over 16 years, common challenges were discussed. Based on the non-peer experience, this review outlines two areas, power imbalances and role distinctiveness, which may highlight why tension is still experienced

between non-peer and peer mentor roles. Firstly, the notion of power implies a degree of interpersonal control and influence being present, which enforces the wants of a person or group of people to produce change in others (Bennetts et al., 2011). The history between professionals and service users demonstrates professionals asserting power and authority over service users (Felton & Stickley, 2004; Jacob, 2015; Lewis, 2014). There has been a contrast in the identities that 'service users' and 'professionals' hold, with professional identities within the medical model of care being constructed as 'experts', authoritarian and holding power (Schiff, 2004; Slade, 2009; Tse et al., 2012). As services embrace recovery and change the negative identity attached to being a service user to one of valued lived experience, non-peers have increasingly spoken out about their own mental health service use (Jhangiani & Vadeboncoeur, 2010). Professionals using services themselves has been said to challenge dominant discourses around mental distress (Adame, 2011), and therefore normalising lived experience. By normalising lived experience amongst non-peers and within organisations, there could be an increased acceptance and value for lived experience, thus equalising peer mentor and non-peer roles.

Secondly, Gillard et al. (2015) referred to role adoption literature in their study, highlighting that the lack of distinctiveness of a new role could mitigate the successful role adoption. Role adoption can be difficult when a new role is not supported by an established professional discipline (Currie et al., 2009), which is considered a vital facilitator to role adoption (Gillard et al., 2015). In the UK, The Implementing Recovery through Organisational Change (ImROC) strategy (Department of Health, 2011) has been established specifically to support the development of peer mentor roles, and has significantly contributed to the increase of peer mentor roles in statutory services (Repper, 2013). Referring to supportive strategies may provide clarity around the role for organisations and specific teams, thus reducing the

ambiguity around the role.

However, the culture of organisations can still threaten role distinctiveness, particularly as they can shape experiences of peer mentor roles (Watson, 2019a; 2019b). The current synthesis found those organisations considered bureaucratic and risk adverse can lead to non-peers moulding the peer mentor role to be like a non-peer role, thus diminishing its core qualities, as found in previous reviews (Repper & Carter, 2011). The process of individual recovery is influenced by people's expectations and attitudes, and often requires a well-organised system of support from people around the individual (Jacob, 2015). This parallels the introduction of peer mentors into teams, who are role models for the recovery approach in services. Embracing the recovery approach and the distinct qualities of peer mentor roles, requires organisations to demonstrate flexible and innovative ways of working which move away from traditional, symptom-focused service delivery (Jacob, 2015).

In this synthesis, organisations which demonstrated openness to change, equality and the recovery model were more likely to embrace peer mentors as a complementary addition to enhance service delivery. Beales and Wilson's (2015) review suggested lived experience can enhance clinical roles, however if a role can be done without lived experience, then the role is not a peer support role. This synthesis suggested the peer mentor role can complement non-peer clinical roles, through distinct qualities specific to the peer mentor role such as bridging the gap between service users and professionals. This synthesis would also suggest that peer mentors can be involved in existing processes such as note sharing and reading medical records. However, this is with the intention of better communication and learning between peer mentors and non-peers: not as a way of non-peers blurring the work of peer mentors. This idea of working alongside each other is supported by Moore et al. (2020) who suggested

shared training, supervision and reflective spaces would allow for non-peer and peer mentors to learn from each other, and maintain and develop their identities within the workplace.

Limitations and future research

All but one paper in this review were based in Western culture, thus caution should be given to a potential cultural bias. In relation to the samples included, there was a large disparity in relation to sample sizes, and those studies who recruited both non-peers and peer mentors reported less on non-peer experiences compared to those who only sampled non-peers. However, similar to Walker and Bryant (2013), in keeping with the principles of qualitative research, the quality of findings and what the paper added to the knowledge of the area was considered as important as sample size and level of data. As with all systematic reviews, the studies included are based on the terms used. Terms used to describe peer mentor roles differed, and it may be that non-western cultures use different terms not identified within this review. The first author attempted to clarify any ambiguity regarding terms used in studies. This allowed the inclusion of data which may have otherwise been excluded, and for all findings to be grounded in non-peer experiences. Future reviews could explore the use of roles which are similar to 'peer mentor' positions within non-western culture, to identify whether experiences differ.

Only one paper focused on an older adult mental health population, thus transferability of the results outside of adult mental health should be done with caution. It was beyond the scope of this review to explore different populations and their experiences of peer mentors. Gillard et al. (2015) included voluntary and partnership organisations in their sample, and described differences in experiences in terms of role confusion and openness. This data was excluded from this review unless the first author could confirm they were not peer-led organisations.

Future reviews may want to explore whether organisations not embedded in traditional narratives of service user-professional relationships such as some third-sector charities, would demonstrate similar experiences to those described in this synthesis.

Clinical Implications

The second aim of this systematic review was to provide clinical recommendations. Firstly, embracing recovery-based culture can begin before peer mentors are employed. Organisations should bring awareness to language being used in the workplace, and encourage an environment where non-peers feel comfortable disclosing their own lived experiences of mental health, therefore normalising mental health difficulties.

Secondly, organisational value and prioritisation of peer mentor roles needs to filter down to management and non-peers at all levels. Organisations need to recognise the limitations of current cultures and need to consider innovative ways to overcome these environments. Being guided by recovery-based principles is key, thus peer mentors should be a part of these conversations. Services should consider peer mentor management roles, thus demonstrating value and shared equality in peer mentor voices and reducing perceived tokenism of the role by non-peers.

Thirdly, organisations should disseminate the message that peer mentors can work alongside and complement traditional models of working, not ‘compete’ or ‘take over’. Non-peers should be encouraged to recognise their occupational knowledge is still valid, whilst also recognising the unique and distinct qualities of peer mentor roles which can enhance service delivery. Preparation such as guidance, training and exposure to services involving peer mentors will support this. Completing this before integration will support role clarification,

reduce prejudice and feelings of threat, and support a shared power across colleagues within services.

CONCLUSION

This meta-ethnography highlights the influential factors described by non-peers in relation to their experiences of working with peer mentors. Wider system value, prioritisation and support around peer mentor roles, as well as openness to change and embracing recovery-practice within organisational culture, were considered crucial to how accepted peer mentor roles were by non-peers. Shifts in power imbalances need to occur, supported by the surrounding organisation, for there to be an equality amongst non-peers and peer mentors. By overcoming the complex factors related to the point of integration, non-peers found value in the peer mentor roles and recognised how they enhanced existing service delivery.

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PAPER 2

Understanding how mental health teams integrate peer mentors: A grounded theory study

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[3] This paper is prepared in accordance with the author guidelines for *Journal of Mental Health* (Appendix A). APA 7th formatting has been used throughout, in line with both DClinPsy submission and journal guidelines. For the purpose of thesis submission, the 8000 word limit has been used to ensure all relevant information has been included for the examiner. This is in place of the 4000 word limit set by the journal for original research. Tables and Figures have also been embedded in the main body of the paper, however will be placed in supplementary information for journal submission.

ABSTRACT

In the United Kingdom, peer mentors are increasingly being involved in statutory services. Facilitators and challenges to integration of peer mentors have been clearly outlined, however previous research has identified a need to understand the changes occurring in existing non-peer teams which goes beyond descriptive themes. The current study aimed to understand and describe how non-peers in statutory services change existing practice to integrate peer mentors, including the processes underpinning integration. Eight non-peer staff who worked in existing teams prior to peer mentors being introduced, completed semi-structured interviews. Analysis of data was conducted using a constructivist grounded theory methodology. The emerging theoretical model described multiple changes to teams, including changes in approaches to service user care, which enhanced service delivery. Several key processes were found including getting to know the peer mentor as a 'person', which reduced experiences of threat and reconnected non-peers to value based working. Wider influences on various part of the model were identified, and how these supported or hindered the integration process. Recommendations for clinical practice are discussed, particularly the need for organisations to prioritise ways for peer mentors and non-peers to build and maintain relationships.

Keywords: peer mentor; non-peer; experts by experience; mental health; grounded theory; qualitative; recovery

INTRODUCTION

Over the past twenty years, there has been an increasing drive within mental health services in many countries to directly employ and/or collaborate with 'experts by experience' in the provision of peer mentors or commonly termed 'peer support workers' (PSWs; Department of Health, 2009; 2011; Faulkner & Kalathil, 2012; World Health Organisation, 2013). In the UK, this is also supported by a shift in mental health services to encompass a 'recovery model' of care alongside conventional ideas of clinical recovery (Department of Health, 2011; Shepherd et al., 2008; Slade, 2009). The recovery model places emphasis on maintaining functioning and self-efficacy, and on building hope and resilience, aside from symptom reduction (Bonney & Stickley, 2008; Davidson et al., 2005; Ramon et al., 2007). Whereas traditional models of mental health have tended to focus on symptom reduction, and 'management' of remission, recurrence and relapse, the recovery model arguably places greater emphasis on working with the whole person (Jacob, 2015). Researchers have discussed how these different approaches to mental health support may co-exist (Collins, 2019; Davidson et al., 2009; Frese et al., 2001; Mueser, 2012). Peer mentors are suggested to represent recovery (McLean et al., 2009), thus exploring the experiences of peer mentors and non-peer[4] colleagues can provide further understanding of how different approaches, including the recovery approach to mental health difficulties, can work together (Ehrlich et al., 2020; Oborn et al., 2019; Moore et al., 2020). Research has identified tension at the point of integration between non-peers and peer mentors (Berry et al., 2011; Gates & Akabas, 2007; Moll, 2009). It is therefore important to explore this key time point within research,

[4] Following Gillard et al. (2013), authors recognise non-peer staff may have lived experience which informs elements of their work. Non-peer will be used to describe all staff not employed into peer mentor positions.

and understand how non-peers come to integrate peer mentors who represent recovery, into their existing teams.

Several benefits to service users have been identified when introducing peer mentors into mental health teams, including a reported reduction in readmission rates and emergency and primary care use (Kelly et al., 2014; Simpson et al., 2014); reduction of depressive symptoms (Robinson-Whelen et al., 2007); increase in self-management behaviour (Chinman et al., 2015; Goldberg et al., 2013) and increased empowerment (Pickett et al., 2012). However, systematic reviews and meta-analyses of these quantitative research studies have identified quality being low to moderate, suggesting significant flaws in the research (Fuhr et al., 2014; Lloyd-Evans et al., 2014; Pitt et al., 2013; White et al., 2020).

By broadening the range of study designs, benefits to service users have also been found in promoting hope, belief in recovery and social engagement (Repper & Carter, 2011). In qualitative research, benefits have further been identified for peer mentors and non-peers. These include peer mentors being able to continue their recovery journey, create cultural change within teams, reduce stigma and support the development of non-peer staff skills (Berry et al., 2011; Kilpatrick et al., 2017; McLean et al., 2009; Walker & Bryant, 2013). Several challenges have also been identified which consistently relate to non-peer staff and the existing organisation, including non-peer staff holding stigmatising and discriminatory views of service users and/or peer mentors (Aguey-Zins et al., 2018; Collins et al., 2016; Doherty et al., 2004; Gillard et al., 2013; Marwaha et al., 2009; Shankar et al., 2014). Such views have been found to impact the successfulness of the integration of peer mentors (Berry et al., 2011; Gates & Akabas, 2007). Additionally, role confusion and lack of organisational support have been recognised as challenges, identifying the need for clearly defined roles (Berry et al., 2011; Byrne et al., 2018; Ehrlich et al., 2020; Gates & Akabas, 2007; Mancini, 2018; Moll, 2009), and organisational support around preparing non-peers for peer mentor

integration (Gates & Akabas, 2007; Gillard et al., 2013; Mancini, 2018; Moll, 2009). Qualitative research therefore provides a clearer holistic picture of the benefits, and challenges, of integrating peer mentors into teams.

Some of those challenges identified in the peer mentor literature mirror those found in research exploring general inter-professional working, including ambiguity around roles and power imbalances between different professions (Ashby et al., 2013; Belling et al., 2011; Brown et al., 2000; Donnison et al., 2009). Research has explored the impact of competing professional perspectives, including those which offer a different discourse to the traditional biomedical model of care, and how these may influence, and hinder, the engagement in profession-specific practices (Ashby et al., 2015; Lloyd et al., 2007; Scanlan et al., 2010). Applying this literature to the integration of peer mentors, the lived experience of peer mentors has been considered a unique and valuable aspect of the role (Barr et al., 2020; Beales & Wilson, 2015; Oborn et al., 2019). The subjective knowledge held by peer mentors through their lived experience has been suggested to work alongside that of the formally acquired knowledge of trained non-peers (Moore et al., 2020; Oborn et al., 2019). However, knowledge through lived experience also challenges conventional organisational hierarchies, particularly those that value and place power in qualified professional and medical perspectives (Gray et al., 2017). These organisational cultures may therefore prohibit the value of the peer mentor roles in teams (Gillard et al., 2015). This research demonstrates the importance of considering the perspectives of those working within existing organisations before peer mentors are introduced, as well as organisations which are traditionally built on hierarchical cultures, such as those found in statutory services.

The research conducted thus far exploring non-peer experiences has spanned across a variety of organisations, including statutory (Berry et al., 2011; McLean et al., 2009), tertiary (Kilpatrick et al., 2017) and a mixture of both tertiary, partnership and public/statutory mental

health services (Byrne et al., 2018; Byrne et al., 2019; Gillard et al., 2013; Gillard et al., 2015; Gordon & Bradstreet, 2015). In the UK, Gillard et al. (2015) found unique challenges to different organisations, and compared to voluntary organisations, statutory services often lacked shared expectations and clarity around the role. This was related to how 'new' the roles were within statutory services. Research within statutory services echo these findings (Mancini, 2018; McLean et al., 2009), highlighting the impact of these challenges on peer mentor integration in statutory services.

There are several limitations to the current literature which need to be considered when exploring integration from non-peer perspectives. Facilitators and challenges to integrating peer mentors has been well identified through identification of themes (e.g. Berry et al., 2011; Mancini, 2018; Moll et al., 2009). However, less is known regarding the processes that underpin non-peer experiences of integrating peer mentors, thus moving beyond theme identification. Those studies which have used methods to explore processes include Gillard et al. (2013) and Ehrlich et al. (2020), however it is unclear whether their findings can transfer across different settings and teams. Gillard et al., for example, explored the impact of an innovative intervention involving peer mentor roles as a core component. The integration of peer mentor roles are not always as clearly defined in terms of their position; thus it would be interesting to explore whether the findings also existed when peer mentors are integrated without a defined position. Ehrlich et al. explored experiences of having peer mentors in a newly formed community-based mental health team. They acknowledged that context was important in their study, and it should be considered whether the processes found are also present when conducting research with an established team where peer mentors potentially are the only new member.

The limitations and gaps identified in the current research demonstrate a reason to further explore non-peer experiences of peer mentor integration, moving beyond descriptive themes. In their study, Ehrlich et al. (2020) used inductive qualitative methodology (Bazeley, 2013; Glaser & Strauss, 1995, as cited in Ehrlich et al., 2020) and were able to provide an understanding of how peer mentors navigated their place within teams. However, their research also recognised the need to further explore the changes in interprofessional teams that include peer mentors. To date, no research has explored specifically how existing, non-peer teams adapt or change their practice so as to support and make use of peer mentor involvement in the delivery of services. To understand this, grounded theory is one such method which can support category identification and the relationships between them, to integrate them into a theory which describes the emerging processes (Willig, 2013). Therefore, this study aims to understand and describe how non-peers working within statutory services, adapt their existing practice so as to integrate peer mentors into the established team. More specifically, through using grounded theory, this study aims to ascertain the processes involved in integration, whether these replicate those previously found in newly formed teams, and their influence on ways of working for the existing teams.

METHOD

Design

Semi structured interviews were used to collect data, and analysed using the principles of grounded theory (Glaser & Strauss, 1967). For the current study, a constructivist grounded theory approach (Charmaz, 2014) was used, meaning categories and theories are constructed by the researcher through their interaction with participants and data analysis. This approach recognises there could be multiple perspectives or constructions of a given phenomenon of interest, usually embedded within local and contextual knowledge, allowing individuals to

make sense of and engage in that reality at an immediate level (Charmaz, 2014; Singh & Estefan, 2018). Using key components of grounded theory such as constant comparisons, theoretical sampling and theoretical coding, the author was able to develop a theoretical framework.

Peer mentors were consulted throughout the current study, including in study design and interpretation of the findings. This supported further questioning of the data, and was particularly important due to the sensitive nature around sampling and dissemination of the results. The lead researcher was also aware of her position as a non-peer, and thus peer mentor input further prevented any bias related to this positioning.

Recruitment

Six adult mental health teams were identified within an NHS Healthboard. All six teams were part of an NHS pilot project that was seeking to integrate peer mentors into existing mental health teams in Wales, supported by the Welsh Government (2020). An email advertisement was sent to all team leads within the services identified, to be disseminated to all non-peers within the services (see Appendix J.). Those who were interested were asked to contact the researcher via the information provided. The inclusion and exclusion criteria are described in Table 1. There was a requirement for non-peers to have worked with peer mentors for at least six months to ensure they understood the role of a peer mentor within the team.

Table 1

Study inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Non-peer staff over the age of 18	Peer development lead, who oversees peer mentor employment into the teams
Worked within service with peer mentors for at least 6 months	Peer mentors
Worked within service before peer mentors were employed in the service	
Working within mental health service	

Sixteen individuals self-selected to participate in the research. Eight participants were found not to be eligible as they were either not working in a mental health team (n=1), not working in a mental health team where peer mentors were embedded (n=1), had not worked in the service prior to the peer mentor being introduced (n=2), or were themselves in a peer mentor role (n=1). Three participants did not respond following interest. The remaining eight respondents all met the inclusion criteria and provided informed consent to participate in the study.

Participants

Participants were all resident in the UK and aged between 34 – 56 (mean = 44.42 years). Seven participants were female. Years of practice within the team the peer mentor was embedded ranged between 1 – 9 years (mean = 4 years, 6 months). Services were all community based services, including both generic and specialist mental health teams. Roles included occupational therapists, nurses, psychologists, therapists and administrators. Some participants also held service lead roles (n=3). Participants worked with peer mentors in different ways, including line managing the role, supervising the role and involving peer mentors in service user care to differing degrees.

Data collection and procedure

Data collection

Data was collected via semi-structured interviews. This allowed a balance of exploring participant constructions of the area of interest, and key emerging issues of interest (Bluff, 2005). Interviews were conducted virtually due to COVID-19 pandemic guidelines. Those who expressed an interest were provided with a participant information sheet (Appendix K.) outlining study aims and procedures, and ethical considerations such as confidentiality and right to withdraw from the study. Informed consent via written consent form (Appendix L.) was received from all participants prior to participation. All interviews were audio recorded, lasting between 23 and 56 minutes, and transcribed verbatim. Debrief forms were sent to all participants following participation (Appendix M.).

Interview Schedule

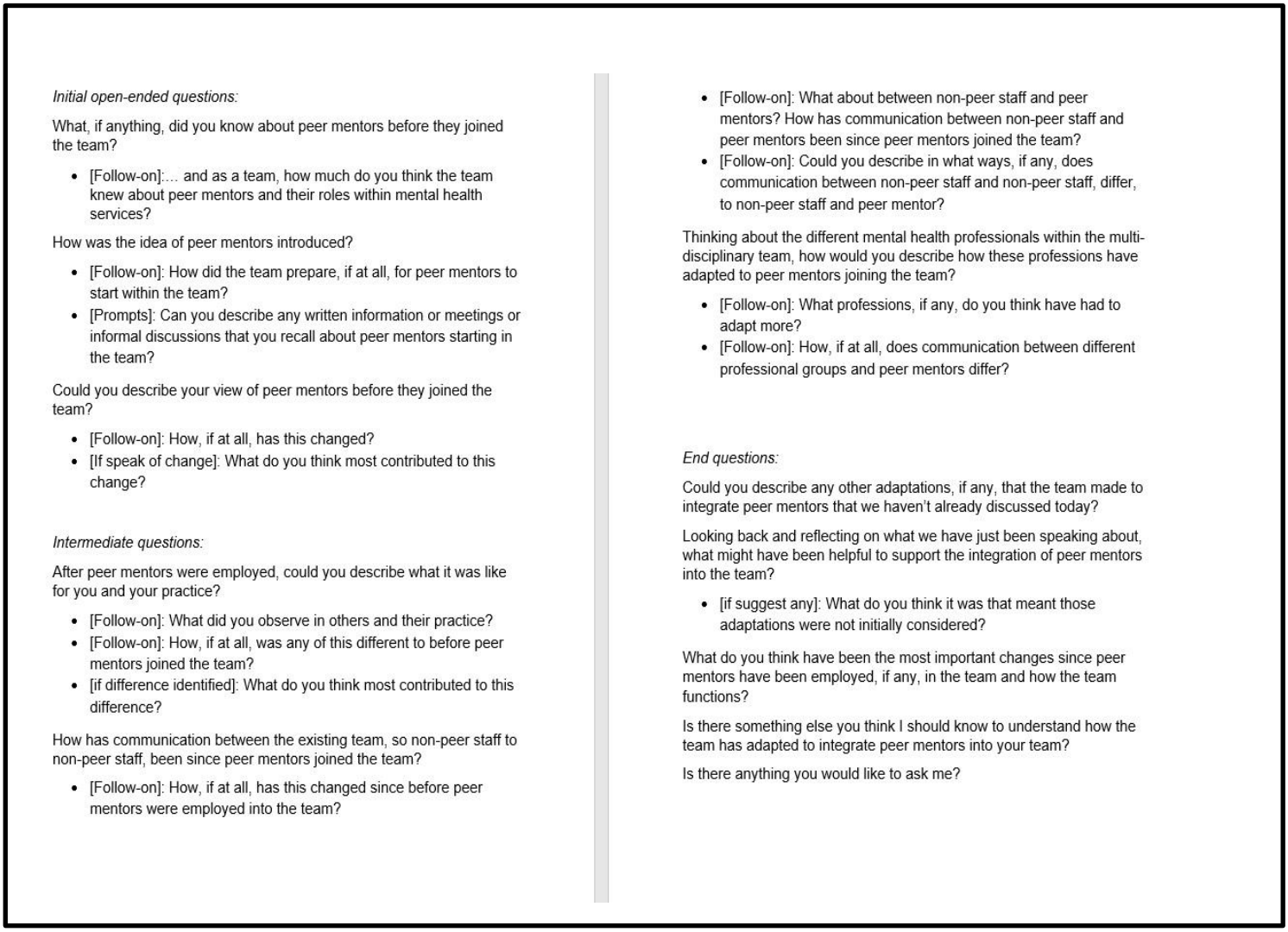
Based on Charmaz (2014), a semi-structured interview schedule was created to guide interviews (see Figure 1.). In line with a constructivist approach of engaging with literature

and being aware of own experience, the initial interview schedule was developed based on existing literature exploring the integration of peer mentors (e.g. Moll, 2009; Ehrlich et al., 2020; Gillard et al., 2013), with the wider research team who have expertise in working in mental health team settings and peer mentors. The collaborative nature of creating the interview schedule provided an opportunity to be reflexive about the nature of the questions and reduced researcher bias. The questions explored whether there were changes in for example, views of peer mentors, communication and team working practices, as well as consideration for what contributed to any identified changes.

Adapting the interview schedule allowed for constant comparison of subsequent data to previous data, supporting the processes of theory development (see further detail in theoretical sampling). Following preliminary analysis the interview schedule was altered on two occasions (following interview three and six) so as to allow for further exploration of emerging codes (see Appendix N. for the final version, with alterations highlighted).

Figure 1

Initial interview schedule



Initial open-ended questions:

What, if anything, did you know about peer mentors before they joined the team?

- [Follow-on]:… and as a team, how much do you think the team knew about peer mentors and their roles within mental health services?

How was the idea of peer mentors introduced?

- [Follow-on]: How did the team prepare, if at all, for peer mentors to start within the team?
- [Prompts]: Can you describe any written information or meetings or informal discussions that you recall about peer mentors starting in the team?

Could you describe your view of peer mentors before they joined the team?

- [Follow-on]: How, if at all, has this changed?
- [If speak of change]: What do you think most contributed to this change?

Intermediate questions:

After peer mentors were employed, could you describe what it was like for you and your practice?

- [Follow-on]: What did you observe in others and their practice?
- [Follow-on]: How, if at all, was any of this different to before peer mentors joined the team?
- [if difference identified]: What do you think most contributed to this difference?

How has communication between the existing team, so non-peer staff to non-peer staff, been since peer mentors joined the team?

- [Follow-on]: How, if at all, has this changed since before peer mentors were employed into the team?
- [Follow-on]: What about between non-peer staff and peer mentors? How has communication between non-peer staff and peer mentors been since peer mentors joined the team?
- [Follow-on]: Could you describe in what ways, if any, does communication between non-peer staff and non-peer staff, differ, to non-peer staff and peer mentor?

Thinking about the different mental health professionals within the multi-disciplinary team, how would you describe how these professions have adapted to peer mentors joining the team?

- [Follow-on]: What professions, if any, do you think have had to adapt more?
- [Follow-on]: How, if at all, does communication between different professional groups and peer mentors differ?

End questions:

Could you describe any other adaptations, if any, that the team made to integrate peer mentors that we haven't already discussed today?

Looking back and reflecting on what we have just been speaking about, what might have been helpful to support the integration of peer mentors into the team?

- [if suggest any]: What do you think it was that meant those adaptations were not initially considered?

What do you think have been the most important changes since peer mentors have been employed, if any, in the team and how the team functions?

Is there something else you think I should know to understand how the team has adapted to integrate peer mentors into your team?

Is there anything you would like to ask me?

Ethical considerations

Ethical approval was received from Cardiff University School of Psychology ethics board (reference EC.20.12.08.6176R; Appendix O.). Further approval for the research was granted through Health and Care Research Wales (HCRW; Appendix P.), and the recruiting healthboard (Appendix Q.).

Thompson and Russo (2012) outlined several ethical considerations when completing qualitative research and potential ways to overcome these. Those related to this research

include the difficulty in providing complete anonymity to participants, who provide detailed data through semi-structured interviews. This is particularly pertinent with the sample in the current study being professionals within services, who are discussing colleagues. The research team were sensitive to data storage and anonymisation (through use of pseudonyms and pronoun removal). Demographics were not presented in a way which would link categories together such as gender, age and years of service. Additionally, due to the nature of the area of interest, processual form of consent was sought. This was in the form of written and verbal consent prior to interview, a reminder that participants could withdraw from the study at any point, and a reminder that participants could 'pass' if they did not want to elaborate further on a point during the interview. Participants were also invited to review and consent to all quotes proposed to be used in the final write-up, to ensure level of anonymity of data. No changes were requested, and thus all quotes have been consented to be used within the current study.

Data analysis

Data was contained within Nvivo Software (Version 12; QSR International, 2018) as this allowed the researcher to develop codes, categories and concepts from a vast amount of data. The analysis involved coding and categorisation, and subsequent theory development, with memo-writing used throughout to allow for the exploration of analytical ideas (Charmaz, 2014). By paralleling data collection and analysis, emerging ideas were used to inform future data collection. This allowed for both theoretical sampling and theoretical saturation, which supported the development of a substantive grounded theory (Sbaraini et al., 2011).

Coding

In line with Charmaz (2014), each transcript was initially coded line-by-line for action, meaning and processes, using gerunds. Following initial coding, 'focused coding' was then conducted which highlighted the most significant or frequent initial codes that made most analytical sense (Flick, 2014). Through exploring which codes best described the processes within the data, tentative conceptual categories and then descriptive concepts emerged (Flick, 2014; Willig, 2013). Theoretical coding was used to explore how categories and codes were related to each other, creating hypotheses which informed the theory development. Constant comparative methods were used throughout data analysis, including comparing groups of codes, categories, incidents and different participants from the same or different mental health teams. This ensured the theory development was grounded in the data. An example of the coding process can be seen in Table 2. and Appendix R.

Memo writing was also used throughout the research process (see Appendix S. for examples). This allowed for questions and ideas around data analysis, emerging concepts and relationships between codes and categories to be investigated. Further, it supported the process of raising focused codes into tentative conceptual categories.

Table 2

Example of coding process

Raw Interview extract (Jordan)	Initial coding	Focused coding	Category	Theoretical concept
(ROBIN)				
Yeah. I mean for the staff it was just a lot of kind of "oh well I don't want them to know what I'm doing. I don't want them to know this, I don't want them to hear me say this" or um, "how do I know that they're well enough to come and do this visit with me? How do I know they're well enough?". When actually that, that shouldn't be a question. Um, um, but yeah, it is- I just find it bonkers kind of knowing [profession] and knowing the amount of them that use services themselves. It's, it doesn't make sense.	Being secretive/ Excluding PM Holding back Questioning PM 'wellness'/ Seeking clarity/ Feeling apprehensive Disagreeing with colleagues/Treating everyone the same Feeling disbelief Normalising mental health service use Feeling disconnected from colleagues	Being guarded Feeling threat emotions Relating in the same way to everyone Normalising lived experience Wanting change	Protecting self and team Experiencing threat emotions Utilising relational qualities Identifying need for change	Experiencing a sense of threat 'How we all slot together' Understanding Integration

Theoretical Sampling

Through paralleling and analysing interview data, and using memo-writing, commonalities and gaps in the data were identified (see Appendix T. for theoretical sampling examples). Recruitment was paused following interview three, where initial coding and memo writing informed changes in the interview schedule and the need to sample participants from generic mental health teams. Recruitment paused following interview six, where initial coding, focused coding, evolving category development and memo writing informed changes in the interview schedule. No further changes were made as data supported developing categories and theoretical concepts.

Quality control

Several methods were used to enhance quality control. These are outlined in Table 3., using Elliot et al. (1999) guidelines for quality control of qualitative research.

Table 3

Methods used for quality control including credibility and validity of findings

Guideline for consideration (drawn from Elliot et al., 1999)	Method to meet guideline
Owning one's perspective	Potential for researcher bias, based on own experience and literature to impinge on the analysis of the data (see reflexivity section below). Using a reflective journal following interviews, commenting on when their own values or assumptions may be being placed on the data (Charmaz, 2014). Through discussions with the research team, times where researcher bias may be impacting the data were identified. This allowed for reflexivity to be bracketed out (Crotty, 1996).
Situating the sample	Due to ethical considerations related to healthcare staff discussing their colleagues within the same team, this was difficult. Sufficient characteristics have been provided to situate the sample, however removal of characteristics which may identify staff has been conducted due to risk of breaching anonymity. Discussions with research team regarding this supported decisions being made, ensuring ethical considerations were considered throughout.

Guideline for consideration (drawn from Elliot et al., 1999)	Method to meet guideline
Grounding in examples	Sufficient data is provided to support the development of focus codes, conceptual categories and descriptive concepts. Examples of theoretical sampling, reflective journals and memos are also included to demonstrate processes of data collection and analysis. Interview quotations provided to support researcher's interpretation with raw data. Information redacted where required, and pseudonyms used to ensure anonymity. Having participants review and consent to their own quotations being used to support findings, provided confirmation that researcher had ensured anonymity.
Providing credibility Checks	Second author to listen to first interview to review first author's interview style, ensuring no leading questions or responses in interview. Research team involved in reviewing data analysis and supporting data. Further, research team enhance bracketing of reflexivity. Reflective journal used throughout to provide an audit trail and allowing transparency of data collection and analysis process. Referred to in research supervision, particularly in relation to theoretical sampling processes. Memo writing documented the development of analytical ideas, proving an audit trail and space for reflexivity (Thompson & Harper, 2012).

Reflexivity

Reflexivity is the process of recognising and acknowledging constructs which may influence the research process (Guba & Lincoln, 2005). It therefore involves immediate, continuous, thoughtful and dynamic self-awareness throughout the process of the research (Engward & Davis, 2015; Finlay, 2002). The lead researcher is a trainee clinical psychologist who has experience of working alongside people with lived experience and roles similar to peer mentor roles, in both statutory and educational settings. She has witnessed both the benefits and the challenges of integrating service user initiatives. Further, she is aware of the models she relies on, which fit and value recovery-focused working and seeing the person holistically. She has also experienced benefits and challenges to inter-professional working, including introducing new initiatives within teams and how teams can react. All these experiences may impact assumptions or constructions of the data.

The research supervisors all have experience working with ‘experts by experience’, with the external supervisor having extensive experience of integrating peer mentors into teams. Further, they have all been involved in mental health service delivery, and the understanding of inter-professional working in these settings. These experiences may have influenced the initial research question, and research supervision discussions.

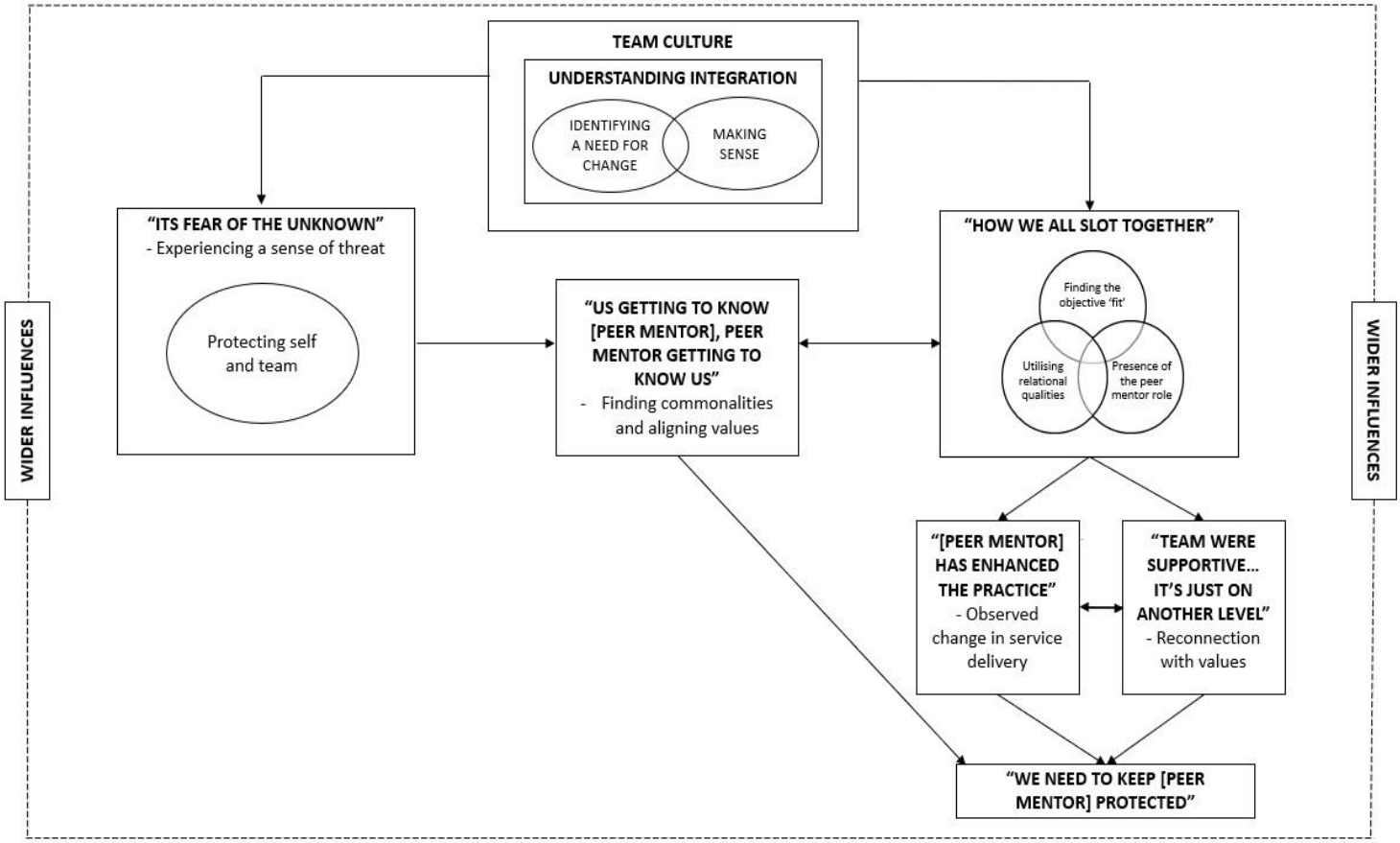
The use of a reflective journal and research supervision allowed for values and experiences of the lead researcher, and research team, to be bracketed out where possible. This ensures the developing theory was grounded in the data.

RESULTS

From the data, an interpretative theory was developed focusing on the processes involved when peer mentors are integrated into existing teams. The theory initially recognises the existing team culture around the non-peer, and it's influence on how the non-peer will make sense and react to the introduction of a peer mentor into the team. Within this culture, the individual non-peer goes through a process of self-reflection, making sense of the role and considering whether current service delivery meets service user needs and aligns with their own values of care delivery. Depending on this self-reflection process, non-peers will either experience a sense of threat, or feel open to exploring how the role will 'fit'. Getting to know the peer mentor as a 'person' reduces the protective strategies that non-peers use when feeling threatened, where values and focusing on the service user align. Through both objective (e.g. negotiating office space) and relational (e.g. utilising relational qualities) processes, non-peers are able to find the 'fit'. To differing degrees, non-peers change how services are provided and how they relate to themselves, others and service users, often reconnecting with values around person-centered and compassionate care. Once non-peers build a relationship with the peer mentor and understand the value of the role, there is a desire to protect the role due to wellbeing, and the risk of peer mentors becoming overstretched due to the value placed on the role. The wider influences identified within the data set impacted the theory at various points, including how teams made sense of the role and how teams were able to build a relationship with the peer mentor. A diagrammatic representation of this theoretical model is demonstrated in Figure 2.

Figure 2

Diagrammatic summary of the interpretative theory of understanding how non-peers integrate peer mentors into existing teams



Team Culture

This category encompasses descriptions of existing teams including references to the culture such as rigid, risk-adverse, hierarchical; team characteristics such as small, specialist, multi-professional; team qualities such as supportive and the types of service users that the team supports. It is within this team culture that the process of *'understanding integration'* takes place. An example of this is where team cultures are considered rigid, inflexible or not used to, or open to, change. This leads to non-peers finding it harder to, for example, identify a need for change.

Understanding Integration

Non-peers go through a process of self-reflection to understand the integration of peer mentors when peer mentors are introduced to the team. As suggested above, this is embedded within the team culture. There are two categories within this concept: '*identifying a need for change'* and *'making sense'*. Overall, those non-peers who could identify a need for change were more likely to feel open to the integration of peer mentors. Those who felt unprepared, lacked experience of the role and could not identify a need for change were likely to *'experience a sense of threat'*. However, if a non-peer felt unprepared and lacked experience, but could identify a need for change, they were more likely to be open to exploring how the role would fit once the peer mentor was introduced. Thus, '*identifying a need for change'* was the over-riding factor in understanding integration.

Identifying a need for change

Non-peers identified a need for change in two areas: a personal want and service delivery need for change. One interviewee acknowledged how the peer mentor could align the team to organisational agendas such as compassionate care. This linked with some interviewees describing wanting to further engage in value-based practice, particularly person-centered care, highlighting a personal want for change. Further, there was a recognition that service users may need something different to what was traditionally being offered in the existing team, identifying a service need to change:

> *"[…] the client base has changed […] and I think the service needs to change with it as well."* (Jordan)

Making sense

Alongside *'identifying a need for change',* non-peers also tried to make sense of the peer mentor role. This happened in several ways: previous experience of service user or peer mentor initiatives, knowing the peer mentor as a person beforehand and levels of preparation for the role. Three interviewees had previous experience and/or awareness of how peer mentor roles may integrate within teams. This was suggested to provide a clear understanding of the role, and increase positivity around the role being introduced. These three interviewees also knew the peer mentor personally, which was suggested to reduce the need to 'get to know' the peer mentor. Some participants described themselves or others knowing the peer mentors from when they previously used services. For one participant, this increased the desire to protect the peer mentor. This was also an interviewee who had previous experience of integrating service user initiatives and valued the benefits the roles provided prior to integration. However, other interviewees described colleagues as feeling more apprehensive of the role, linking with *'experiencing a sense of threat'*, due to previously supporting the peer mentors when using services:

> *"they could remember them when they were unwell. So there was that sort of* um *'how do we act around, these, these people'".* (Charlie)

Some non-peers had no previous experience of peer mentors. These participants were more likely to describe having little knowledge of the role and thus not knowing what to expect from the role. Having less of an understanding of the role often led to assumptions being made around the peer mentor integration, which were suggested to increase the likelihood of stigmatisation of the role.

There were differing levels of preparation for the teams. The Peer Mentor Development Team (PMDT) were involved to differing degrees, and for some participants, they felt well prepared for the introduction, whilst others described the peer mentors being introduced unexpectedly. Those interviewees who felt unprepared and lacked an introduction were more likely to describe teams which felt apprehensive about the role.

"It's fear of the unknown" (Robin) – Experiencing a sense of threat

This concept depicts the experience of apprehension, fear and worry that some non-peers experienced in relation to the integration. It is important to note that this category isn't solely related to non-peers experiencing a sense of threat from peer mentors, although participants suggested non-peer colleagues did experience this. It also encompasses those emotions which are linked with being in a 'threat mode' such as anxiety. Not *'identifying a need for change'* was suggested to be the key instigator for experiencing a sense of threat, as is recognised in the below quote suggesting teams can become comfortable in existing service delivery:

> *"I think its fear of the unknown, people get really comfortable in their roles. […] you like to feel good at your job don't you, and then as soon as something new comes in, you don't know it, so you're not going to feel comfortable."* (Robin)

Protecting self and team

This category is embedded within *'experiencing a sense of threat'* and refers to how non-peers describe themselves and/or colleagues managing the emotions they experienced. Some interviewees spoke about non-peer colleagues who would deliberately exclude the peer

mentor from clinical duties such as visiting service users and attending service user care meetings. Further, some non-peer colleagues avoided, or were reluctant to engage, with the peer mentor through conversation or clinical activity. However, for others, a lack of understanding meant they were apprehensive and thus hesitant to engage the role initially as they did not know how to:

> *"maybe their lack of understanding might have been apparent in terms of, I think maybe [peer mentors] didn't have that much work to begin with, so people probably didn't quite know […] why they might get a peer mentor involved?"* (Billie)

"How we all slot together" (Adrian)

If non-peers could identify a need for change, they were more open to exploring how peer mentors could be integrated into the team. The processes involved in this concept include '*finding the objective fit', 'utilising relational qualities'* and *'presence of the peer mentor role'.*

Finding the objective 'fit'

This category depicts the practical and objective ways in which non-peers tried to adapt to, and support, the integration of peer mentors into the existing teams. Interviewees described having to negotiate office space for example, or making space in work schedules to provide supervision to the peer mentors. Non-peers described a need to provide, and/or encourage the peer mentor, to engage in further training to develop their role. This was in consideration for the level of skills required to meet service needs.

Utilising relational qualities

Non-peers described various personal relational attributes which were key to integrate the role. These included being accommodating to different ways of working; being inclusive and relating to the peer mentor like other non-peer colleagues, allowing the peer mentor to be part of clinical work; being open-minded towards the role; normalising lived experience and trusting the role. There was also a need to have patience around settling the peer mentor into the role:

> *"[…] [peer mentor] be quite disruptive […] in the office […] So that was really difficult because I, you don't want to say to somebody, you don't want to dampen somebody down. But it took [peer mentor] a while to settle but [peer mentor]'s settled now […]"* (Charlie)

Being accommodating underpinned non-peers allowing the peer mentor autonomy in their role. Non-peers described peer mentors having autonomy in relation to the work they were involved in, for example, specialist groups, training and direct clinical work. Allowing this autonomy was key to peer mentors demonstrating how their role could fit with services, and how the role's key qualities could support the team and service delivery:

> *"[…] tell me if you want to make changes to this rather than me telling you this is what we're gonna bring in. […] if you think you can do more on that, fine, lets look into how to do more on that. […] It's about getting the peer mentor involved […] They are pretty much a part of the whole, the whole thing in terms of designing what they can do."* (Jordan)

Presence of the peer mentor role

This category is important for non-peers to experience changes described in *'reconnection with values'.* Non-peers described being continuously reminded of the service user through the presence of the peer mentor role, with several describing the peer mentor as 'bringing the human into the room'. Additionally, the peer mentors reminded non-peers of compassionate and nurturing qualities that they could utilise towards each other and themselves. Peer mentors were also positioned as advocates for service users, and this encouraged some non-peers to challenge existing practice around service user care. The peer mentor's presence, therefore, was not only a reminder but a catalyst for change in terms of how non-peers relate to themselves and others, and empowered non-peers to advocate for changes they wanted:

> *"um, then the peer mentor kind of helped kind of me advocate as well. It was like well if they can do it, I can do it as well, they were kind of encouraging for, for me […]"* (Robin)

"Us getting to know [peer mentor], [peer mentor] getting to know us" (Adrian) – Finding commonalities and aligning values

Non-peers described varying positive personal qualities of the people behind the peer mentor roles, with some questioning whether it was 'personality' or the 'peer mentor role' that was creating change. One non-peer described how the peer mentors had similar life situations to other non-peers within the team, demonstrating a connection being made on a personal level. Additionally, getting to know the person behind the peer mentor title fed into relating to the peer mentor in the same way as other colleagues, increasing their equality and importance within the team. This concept was also key for moving those non-peers who experienced a

sense of threat to become more inclusive and comfortable with the role. Witnessing the peer mentor role also supported this move, allowing non-peers to further make sense of the role around the 'person':

> *"some of the team members […] were a little bit unsure of how it was going to work so they might have, been a bit reluctant to sort of, to reach out and support [peer mentor] in the first sort of instance. But it's how [peer mentor] sort of just continued, […] and now [peer mentor]'s quite well accepted within the team and everyone knows who [peer mentor] is and what [peer mentor] does."* (Jamie)

"[Peer mentor] has enhanced the practice" (Drew) - Observed change in service delivery

All interviewees described changes in service delivery and how the existing team worked. These included approaching complexities around service user care in different ways for example, peer mentor involvement allowed one team to continue intensely supporting service users in the community where previously they may have been admitted to a mental health ward. Some teams also described changes to how they supported service users, for example, keeping service users within the service for longer as part of a more recovery informed approach to care. Non-peers also spoke about coming to recognise the value of lived experience, and the power this could have on service user recovery and wellbeing. All these observed changes were considered to complement and 'enhance' the work non-peers do, and were valued amongst non-peers.

"Team were supportive… It's just on another level" (Jamie) – Reconnection with values

This category depicts those changes related to how the non-peers relate to each other and the changes they have noticed in themselves through the integration of peer mentors. These include being more mindful of their behaviour or what they say, demonstrating an increase in compassion and nurturing towards service users. This is strongly linked with the presence of the peer mentor in *'how we all slot together'*, a process demonstrated in the below non-peer quote:

> *"[…] when [peer mentor]'s in the room it feels like, yeah, you're more compassionate in kind of like your handovers and more compassionate in the way you discuss um, certain people."* (Robin)

Robin also described an initial need for there to be changes towards more person-centered and compassionate care. The peer mentor has reconnected this non-peer with the values that they connect with around service user care. This is similarly seen in other interviews. Additionally, when interviewees spoke about non-peer colleagues, they recognised that compassion, kindness and support were already embedded within team cultures. However, this is then enhanced and thus moves teams closer to these values that underpin their work.

"We need to keep [peer mentor] protected" (Adrian)

When participants experience change, both in service delivery and personally, there is a desire to protect the role. There is also a desire to protect the role when non-peers come to know the 'person' behind the peer mentor title. Protecting the role took two forms: protecting due to well-being and protecting due to value. Non-peers recognised that having lived

experience was part of the peer mentor role, and thus described being aware of peer mentor well-being. Non-peers spoke about wanting to protect and ensure peer mentors well-being didn't suffer in the role, and thus were mindful of ways in which they could support this:

> *"I think, you know, […] peer mentors are there because […] they've um, taken a mental health journey and they're at a place where they're much stronger but they're still going to be vulnerable to re-, relapse, or potentially vulnerable. So, I think […] whatever we can do to maintain and nurture their mental health […]"* (Billie)

Closely linked to protecting for wellbeing is protecting due to the value they brought to the team. This led to a desire to prevent the role from being spread too thinly or the role involving work outside of the understood remit of a peer mentor role.

Wider Influences

This category depicts those outside influences that impacted how non-peers integrated peer mentors into the team. It included three spokes: engagement with the PMDT, the COVID-19 pandemic and non-peer staff changes. These wider influences impacted various aspects of the model. As the teams were all involved in the pilot project of introducing peer mentors into existing mental health teams, both non-peers and peer mentors engaged with the PMDT to differing degrees. This included peer mentors and non-peers seeking support from the team if required, and peer mentors having supervision with the PMDT. When *'making sense'* of the role, the PMDT provided information to support the preparation and readiness of teams to integrate the peer mentor role.

The COVID-19 pandemic had positive and negative influences on how non-peers integrated peer mentors. Some teams were unable to prioritise the induction of the peer mentor role due to the pandemic:

> *"[…] [peer mentor] didn't really get a good induction of, of the roles of the people in the team. […] it wasn't good in the beginning really […] they just sat around while we were all flapping basically."* (Charlie)

The pandemic also influenced how some teams were able to connect with each other. This meant it took longer for non-peers to get to know the peer mentor and understand *'how we all slot together'*. It also meant that peer mentors were unable to get to know non-peer roles, thus challenging for both peer mentors and non-peers in terms of finding the 'fit' within the service:

> *"[…] in normal times, you know, our peer mentors would have really got to know, probably got to know people more […] if we'd been able to continue on a more regular basis that culture of stopping for lunch together and just getting to know each other."* (Billie)

A positive impact on teams included being more mindful of each other's wellbeing, and being kinder to each other. This may have supported the compassionate agenda linked with the peer mentor role. However, it also made it difficult for some non-peers to recognise the sole influence of peer mentors on the team. This was also found when non-peers discussed the integration of new non-peer staff into teams who were more flexible in thinking and engaging in models which teams described as more aligned to recovery-based. Having this type of new

non-peer staff challenged existing rigid culture and supported the inclusiveness of peer mentors into teams.

DISCUSSION

To date, no research has specifically explored how non-peer staff modify their practice to support and make use of peer mentor involvement in the delivery of services. This study aimed to understand and describe how this occurs in statutory, established mental health teams. Multiple changes were identified in the current study. This included non-peers engaging in more 'recovery-focused' practice and some describing themselves or colleagues changing their views of peer mentors, particularly with an emphasis on realising the power of lived experience in supporting service users. Non-peers spoke about 'thinking differently', more innovatively, allowing services to provide a richer, holistic intervention to service users. Further, office cultures were described as adapting, embracing more compassionate initiatives. The current study highlights similar findings to previous research, including the impact of existing team cultures and non-peer assumptions (Berry et al., 2011; Gates & Akabas, 2007; Gillard et al., 2015). Both these impacted how open non-peers were to integrating peer mentors into the team. The multiple changes identified in the current study allowed the team to enhance their service delivery involving the peer mentor, whilst holding on to existing models and interventions. This has been found in previous research, where peer mentors complement and enhance rather than replace non-peer practice (Gray et al., 2017; McLean et al., 2009; Moll, 2009; Otte et al., 2020).

The second aim of the current study was to ascertain the processes involved in integration and the influence this has on ways of working for the existing non-peer team. The overall process of peer mentor integration is similar to that found by Ehrlich et al. (2020), where peer

mentors found their legitimate ‘fit’ within the team, they became valued members and enhanced service delivery. However, the current research provides a further understanding from the perspective of non-peers, and the key processes which lead them to value peer mentors and adapt practice to enhance service delivery.

Using constructivist grounded theory methodology allowed for an abstract understanding of non-peer experiences, particularly ‘identifying a need for change’. This concept may not have been discovered through other methodologies such as thematic analysis which would have provided a more descriptive understanding of the data. The processes of ‘identifying a need for change’ and ‘making sense’ both involved self-reflection and evaluation, whereby non-peers drew on their experience and knowledge of working with peer mentors and service users in service delivery; considered how aligned they felt with the current culture of a team; how remote they felt from the needs of service users and how much they knew about the peer mentor role in comparison to their own roles. Drawing on social comparison theory (Festinger, 1954), non-peers engaged in a process of evaluating themselves including their own attitudes and abilities, in comparison to this new role being introduced. This allowed them to either identify aspects they would like to move towards and embrace through a process of upward social comparison, or it reinforced current ways of working and attitudes through downward social comparison. Upward social comparison allowed some non-peers to acknowledge how remote they felt from values such as compassion, which were embedded within the peer mentor role.

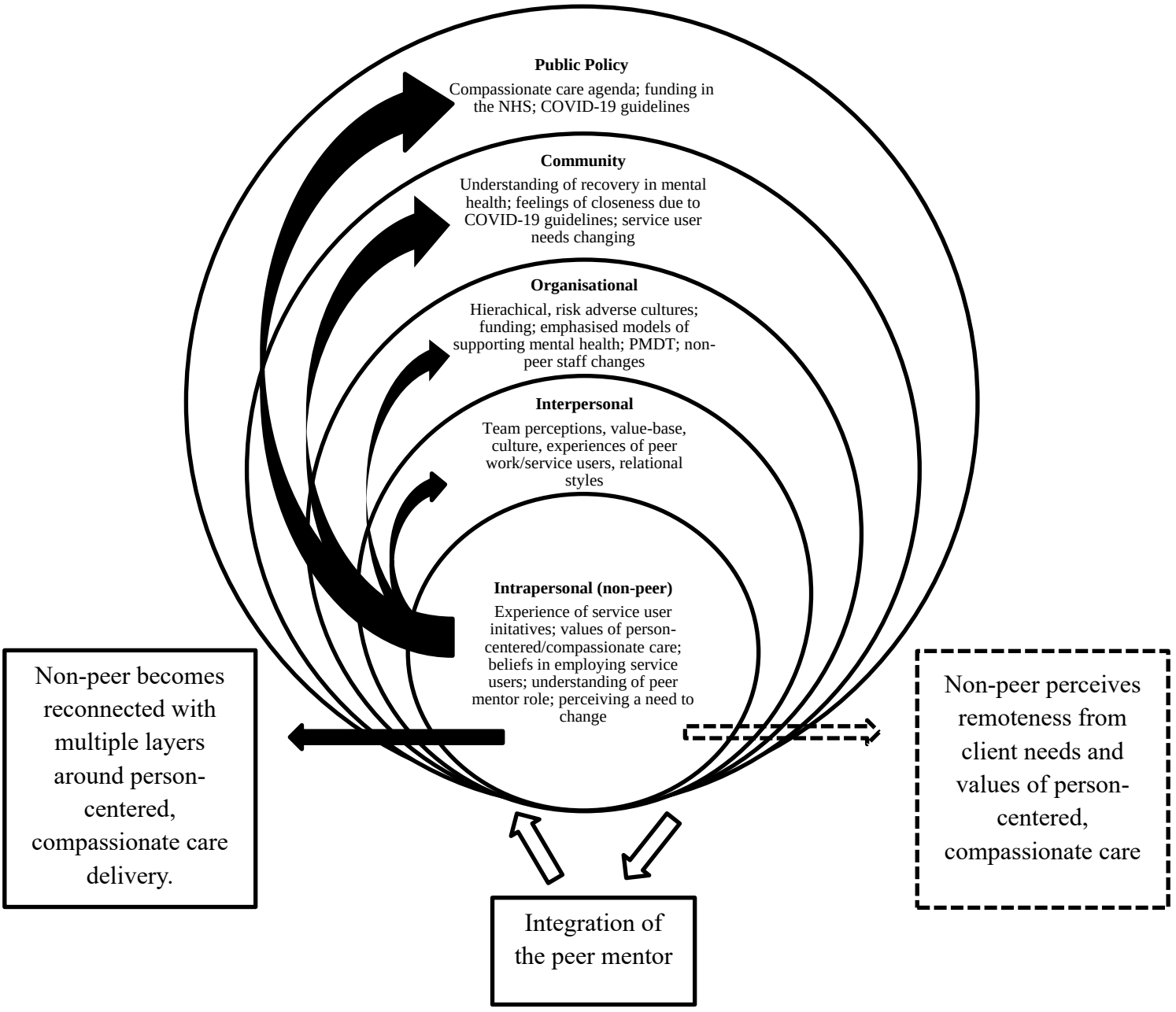
For some non-peers, the need for change and adaptation was identified prior to introducing peer mentors, thus suggesting non-peers were ‘ready for change’. Identifying a need to change was a key process as it overcame challenges in organisational culture and role ambiguity. Even if a non-peer felt uncertain about the peer mentor role, if they identified a need to change, they were less likely to experience a sense of threat. ‘Readiness to change’

has been researched, particularly in relation to the transtheoretical model (TTM) of behaviour change (Prochaska & DiClemente, 1982). The TTM has increasingly been used and adapted when exploring 'readiness to change' for interprofessional collaboration (Clark, 2013; Schirazi et al., 2018). The current study's findings do make sense within an adapted TTM (Schirazi et al., 2018), however the TTM does not consider the wider systemic influences which were identified in the current study's theoretical model.

Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1979) posits that human development occurs through relationships with immediate individual contexts, which are situated within wider communities and society. The current theoretical model suggests there were immediate contexts which influenced how non-peers integrated peer mentors into teams, for example, the team culture including characteristics of the team. However, it also further sheds light on those wider system influences such as service user needs and organisational cultures, which influenced how the team functioned. Organisational culture has been identified as a facilitator and barrier to the integration of peer mentors (Ibrahim et al., 2020). The current study provides further understanding of its influence, specifically how it can impact whether a person identifies a need for change which was an important factor in people becoming open to exploring how the role can fit within a team. McLeroy et al. (1988) social ecological model (SEM) details five levels of systemic influence which relate to this study: intrapersonal, interpersonal, organisational, community and policy. The PMDT as an example of organisational influence supported teams to feel 'ready', which aligns with previous findings suggesting a need for organisational support when introducing peer mentor roles (Gillard et al., 2013; Gates & Akabas, 2007; Mancini, 2018; Moll, 2009). It is beyond the scope of the current study to detail the wider systemic influences within an SEM fully, however see figure 3. for overview.

Figure 3.

Ecological model (based on McLeroy et al., 1988) presenting multiple layers impacting how non-peers integrate peer mentors into existing teams, and upward influence of the integration of peer mentors on non-peer staff reconnection to systemic layers.



Relational processes were also identified as key within this model, for example, getting to know the peer mentor as a 'person'. This supported non-peers to move from threat to openness towards the peer mentor role, and aided the process of finding the 'fit' of the peer mentor, resulting in enhanced service delivery and a reconnection with value based working. When linking with the SEM above, the COVID-19 pandemic guidelines prevented informal staff interactions, which have been considered vital processes alongside formal processes when integrating new employees (Grant & Dziadkowiec, 2012). Although the SEM acknowledges the interpersonal influences, it does not fully account for the relational processes identified.

Research exploring relationships between professionals in organisations provides further understanding, demonstrating that strong relationships within teams contributed to effective service delivery and better rapport with service users (Gittell et al., 2000; Hustoft et al., 2018; Lee et al., 2014; Uijen et al., 2014). Relational Coordination Theory (Gittell, 2012) argues that for teams to effectively co-ordinate, there needs to be shared understanding and goals, and mutual respect in relationships which promote better communication. This is supported by a recent systematic review exploring interprofessional working, which suggested a need for professionals to bridge gaps in professional perspective and communication, and create spaces to support interactions between professionals (Schot et al., 2019). Getting to know the peer mentor, in the current study, suggested an alignment of values and a finding of commonalities between the peer mentor and non-peers. This has been found elsewhere, suggesting that non-peers and peer mentors come to understand and value each other's roles through repeated interactions and thus building relationships (Asad & Chreim, 2016). In the current theoretical model, this alignment of values also included non-peers embracing recovery-focused values. This is important, particularly as research suggests that if values of

the recovery model are not commonly held within teams, peer mentors may not be able to successfully achieve the aims of their role (Woodhouse & Vincent, 2006).

Getting to know the person behind the peer mentor role also included witnessing the role. This was an important mechanism to moving the non-peers from a place of feeling threat emotions and protecting self and team, to being open to exploring the 'fit' of the peer mentor role. Social Learning Theory (Bandura, 1977) provides further understanding of how this occurred within the current theoretical model. Attention, for example, is an important mediating process proposed by Bandura, and for the current study, non-peers were observing and interacting with the peer mentor thus bringing attention to the behaviours and actions of the peer mentor. When considering motivation as another mediating process, actions of the peer mentor such as compassion based team activities were positively reinforced by colleagues. For those who did not identify a need for change, this process of vicarious reinforcement may have influenced their move to be more open and embrace the peer mentor as part of the team, with a change in beliefs and behaviours. Previous research has also explored the use of social learning theory in interpersonal working, demonstrating the influence of social environments around staff members which can then reinforce both individual and collective team values to provide better care for clients (Stanley et al., 2020).

Constructivist grounded theory would argue that non-peers are not passive to wider systemic influences, and would have been actively engaging in behaviours which reinforced the cultures and structures within and around the team (Charmaz, 2014). The important relational processes identified in this theoretical model led to non-peers reconnecting and strengthening alignments with person-centered and value-based working. This demonstrates how employing peer mentors can be a catalyst for change for non-peer beliefs, understandings and behaviours, as well as service delivery. It is important to note, the teams were all described as

compassionate within the current study, thus this demonstrates a desire to 'strengthen' alignments with compassionate care rather than it being a new concept for teams. Relating this to the SEM, the peer mentor as a catalyst influenced how the non-peers interacted with the multiple layers (see figure 3.). Examples of this include expansion to recovery-focused working to support mental health difficulties at the organisational level and reconnection with client-based needs within the community. Combining both systemic and relational understandings allows the current study's theoretical model to fully recognise those factors which influence the changes demonstrated by non-peers to existing practice, and provide further understanding how non-peers integrated peer mentors overall.

Limitations and future research

This study explored the views of non-peers who had experienced the integration of peer mentors into their teams, and asked them to retrospectively reflect on their team prior to the integration. Previous research has found that exposure to peer mentors can positively influence non-peer views (Byrne et al., 2019; Gray et al., 2017; Tse et al., 2017). Thus, participant responses may be biased by this exposure and a desire to demonstrate positive working relationships. Future research should consider interviewing non-peer staff at different time points of integration to understand the process of 'exposure' on non-peer experiences.

Additionally, this may be further exacerbated by selection bias, where those participants who had positive relationships with peer mentors may have been more likely to participate in this study. This may have reduced the identification of, for example, power dynamics which have been found in previous research (Barr et al., 2020; Berry et al., 2011; Gillard et al., 2013).

Future research should consider using alternative methodologies such as discourse analysis, which could further explore ideologies around power and resistance.

The sample of participants were all recruited from statutory services in one NHS Health Board. As previous research has demonstrated differences in challenges and benefits between types of organisations (Gillard et al., 2015), caution should be given to transferring findings to other sectors or other geographical areas. However, the sample was varied including both generic and specialist mental health teams, which is representative of NHS Healthboard mental health service delivery. Theoretical sampling demonstrated the importance of recruiting from different settings, and through recruitment, the authors were able to further validate the theoretical model proposed. Analysing a range of participant perspectives suggests a degree of 'triangulation by perspective' (Patton, 2014), further providing validity to the resulting model.

The COVID-19 pandemic and the surrounding support from a PMDT, place a unique context on this study, suggesting caution should be applied to generalising the findings outside of these contexts. However, they also represent broader influences which impact both positively and negatively on the integration. As the current study showed, for example, changes in clinical team staff also influenced integration, which could be experienced within teams at any time. This study aimed to interview from a team who had integrated peer mentors prior to the pandemic and without the support of a PMDT however, no staff members volunteered to participate. Future research may want to explore integration in the context of no wider PMDT team, or with reduced pandemic restrictions, to compare findings to the current study.

Clinical Implications

There are several clinical implications from this research. Firstly, organisations should consider how ‘ready’ non-peers are for the integration of peer mentors, and provide support accordingly. This can be through creating group or individual spaces for discussion around fears and concerns related to the role, or through identifying needs for change which externalise the reason for introduction such as service user needs changing. This may reduce the potential for non-peers internalising the introduction as something wrong with how services are currently delivered.

Secondly, teams should prioritise the formal and informal ways of connecting with peer mentors. Building relationships is key thus teams should prioritise the induction of peer mentors by for example, formally introducing the individual who will be a peer mentor to the team prior to starting. Recognising wider influences, organisations need to think innovatively around how non-peers can continue to engage in informal interactions, creating spaces which allow non-peers and peer mentors to develop a relationship.

Thirdly, organisations should continue creating a safe environment for lived experience to be discussed in the workplace. Differing understandings and models of mental health such as trauma-focused, biomedical and recovery, may impact how comfortable non-peers feel discussing their own lived experience. However, the sharing of lived experience from non-peers, as well as peer mentors, reinforces the recovery model and challenges prejudicial views around people who have experienced mental health difficulties and their ability to work.

CONCLUSION

As expressed by the theoretical model proposed, integrating peer mentors into existing non-peer teams is complex. The non-peer team goes through multiple service and personal changes, when integrating the peer mentor role, with key relational processes identified. The current study acknowledges the multiple systemic layers which impact how non-peers will integrate peer mentors into teams. However, it also identifies how the peer mentor as a role and as a person reconnects non-peers and existing teams to client needs and value-based working. With the development of peer mentor roles in statutory services increasing, these findings have important clinical implications for organisations considering integrating peer mentors into existing mental health teams.

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APPENDICES

Appendix A: 'Journal of Mental Health' author guidelines

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Instructions for authors

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Journal of Mental Health is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

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- Should be no more than 4000 (excluding abstracts, tables and references) words
- Should contain an unstructured abstract of 200 words.
- Should contain between 3 and 7 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.

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   For single agency grants
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Updated 14th April 2021

Appendix B. PROSPERO entry confirmation (with title amendment confirmation)

CRD-REGISTER <irss505@york.ac.uk>
Mon 07/12/2020 14:24

Dear Mrs Berrett,

Thank you for submitting details of your systematic review "What are non-peer staffâEUR(tm)s perceptions of working with peer mentors? A meta-synthesis of qualitative findings" to the PROSPERO register. We are pleased to confirm that the record will be published on our website within the next hour.

Your registration number is: CRD42020224900

You are free to update the record at any time, all submitted changes will be displayed as the latest version with previous versions available to public view. Please also give brief details of the key changes in the Revision notes facility and remember to update your record when your review is published. You can log in to PROSPERO and access your records at https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.crd.york.ac.uk%2FPROSPERO&data=04%7C01%7Cthomasjl4%40cardiff.ac.uk%7Ca13e7b5c6d004f82e3ac08d89abbbe0f%7Cbdb74b3095684856bdbf06759778fcbc%7C1%7C0%7C637429478420190149%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=5uc652L0DREWT6U4Haju%2Fo8k02RU%2BMQijapyOHCoq%2FU%3D&reserved=0.

Comments and feedback on your experience of registering with PROSPERO are welcome at crd-register@york.ac.uk

Best wishes for the successful completion of your review.

Yours sincerely,

Lesley Indge
PROSPERO Administrator
Centre for Reviews and Dissemination
University of York
York YO10 5DD
t: +44 (0) 1904 321049
e: CRD-register@york.ac.uk
https://eur03.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.york.ac.uk%2Finst%2Fcrd&data=04%7C01%7Cthomasjl4%40cardiff.ac.uk%7Ca13e7b5c6d004f82e3ac08d89abbbe0f%7Cbdb74b3095684856bdbf06759778fcbc%7C1%7C0%7C637429478420190149%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=6RU4pjroU3EP3avaOrljd5zoxkiBbzrDhZmvpoe4o0o%3D&reserved=0

PROSPERO is funded by the National Institute for Health Research and produced by CRD, which is an academic department of the University of York.

CRD-REGISTER <irss505@york.ac.uk>

Thu 18/02/2021 14:45

Dear Mrs Berrett,

Thank you for submitting amendments to your systematic review record CRD42020224900 on the PROSPERO register. We are pleased to confirm that the updated record will be published on our website within the next hour.

You are free to further update the record at any time, all submitted changes will be displayed as the latest version with previous versions available to public view. Please also make brief notes of any key changes in the Revision notes facility. You can log into PROSPERO and access your records at https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.crd.york.ac.uk%2FPROSPERO&data=04%7C01%7Cthomasjl4%40cardiff.ac.uk%7C4be07d09054c438f14ea08d8d41be207%7Cbdb74b3095684856bdbf06759778fcbc%7C1%7C0%7C637492563511276841%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=yfwJjgWdCokY4YIxvx5f%2FEQggrrWDVoOpO3Zxn19Zl4%3D&reserved=0.

Best wishes for the successful completion of your review.

Yours sincerely,

Susan Sutton
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PROSPERO is funded by the National Institute for Health Research and produced by CRD, which is an academic department of the University of York.

Appendix C. Search strategy modifications

PsycInfo

(“peer mentor*” OR “peer adj2 worker*” OR “peer specialist*” OR “consumer consultant*” or “Peer Relations/” OR “Peers/”) AND (“exp Mental Health Services/” OR “exp Mental Health Personnel/” OR “mental health service*” OR “mental health team*” OR “psychiatric service*” OR “psychiatric team*”)

SCOPUS:

((TITLE-ABS-KEY (peer W/2 worker*)) OR (TITLE-ABS-KEY (“peer mentor*”)) OR (TITLE-ABS-KEY (“peer specialist*”)) OR (TITLE-ABS-KEY (“peer consultant*”)) OR (TITLE-ABS-KEY (“consumer consultant*”))) AND ((TITLE-ABS-KEY ("mental health service*")) OR (TITLE-ABS-KEY (“mental health team*”)) OR (TITLE-ABS-KEY ("psychiatric service*")) OR (TITLE-ABS-KEY (psychiatric team*)))

CINAHL:

(“peer mentor*” OR peer N2 worker* OR “peer specialist*” OR “peer consultant*” OR “consumer consultant*”) AND (“mental health service*” OR “mental health team*” OR “psychiatric team*” OR “psychiatric service*”)

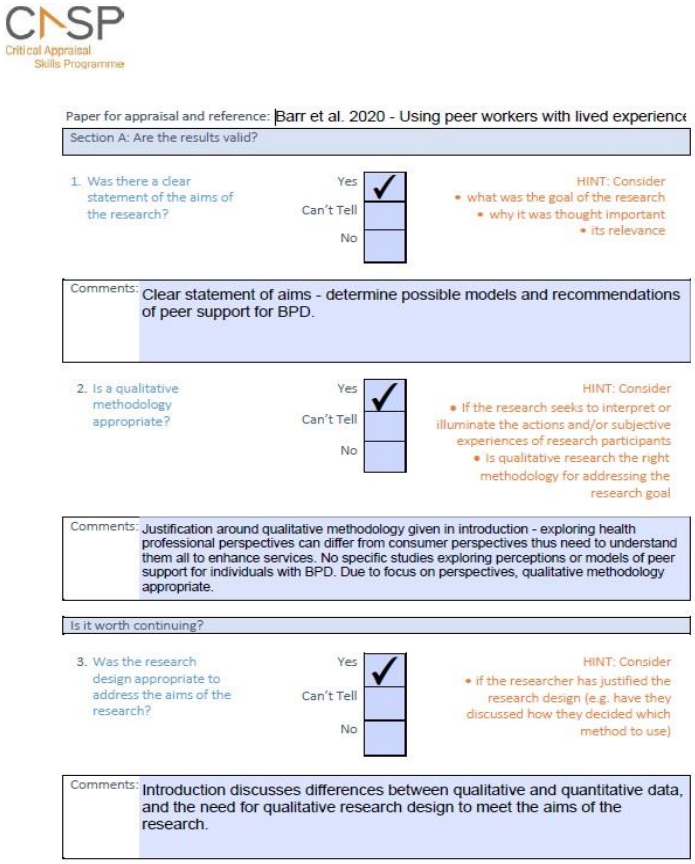
Appendix D. Example of inclusion/exclusion criteria being applied to the 10% of full articles reviewed by second reviewer

Author and Year	Paper Title	Qualitative	Primary empirical research?	Written or translated into English?	Non-peer staff as participants?	Non-peer staff data extractable?	Setting is adult (18+) mental health	Roles formally employed?	Include or exclude?
Aguey-Zins et al. (2018)	Staff Attitudes Towards Consumer Participation and Peer Worker Roles in a Community Mental Health Service	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**INCLUDE**
Dragatsi (2012)	Integration of a peer provider in a mental health clinic: Perspectives from a peer provider and a clinic director	Unsure *Second reviewer: No?*	Reflective piece	Yes	Yes *Second review: Yes, clinical director experience*	Unsure as a reflective piece *Second reviewer: Unsure*	Yes *Second reviewer: Not really a research study*	Yes	*Second reviewer:: Unsure of inclusion – There's no formal analysis of quali experience, more a written description… it's not really a stay at all so I would exclude. Can we discuss?* Confirmed reflective piece and no qualitative methodology. **EXCLUDE**
Gillard et al. (2015)	Developing a change model for peer worker interventions in mental health services: A qualitative research study.	Yes	Yes	Yes	Yes		Yes	Yes	**INCLUDE**
Mancini (2018)	An Exploration of Factors that Effect the Implementation of Peer Support Services in Community Mental Health Settings	Yes	Yes	Yes	Yes *Second reviewer: interviews with non-peer MH workers*		Yes	Yes	**INCLUDE**

Author and Year	Paper Title	Qualitative	Primary empirical research?	Written or translated into English?	Non-peer staff as participants?	Non-peer staff data extractable?	Setting is adult (18+) mental health	Roles formally employed?	Include or exclude?
Otte et al. (2020)	Beneficial effects of peer support in psychiatric hospitals. A critical reflection on the results of a qualitative interview and focus group study	Yes	Yes	Yes	Yes *Second reviewer: Mostly PSW, but MHP data is extractable*	Yes	Yes	Yes	**INCLUDE**
Phillips et al., (2018)	Supervising Peer Staff Roles: Literature Review and Focus Group Results	Yes	Yes	Yes	Yes *Second reviewer: Focus group with non-peer supervisors currently supervising peer workers.*	Unable to extract non-peer raw data *Second reviewer: May depend on if you need the full data?*	Yes	Yes	*Second reviewer: Unsure if this really meets your criteria – can we discuss?* Confirmed no raw data to extract of non-peer experiences which doesn't allow for a full understanding of author interpretations/findings. **EXCLUDE**

Appendix E. CASP scoring examples

Appendix E.1. Lead researcher example 1



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Paper for appraisal and reference: Barr et al. 2020 - Using peer workers with lived experience

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ✓ / Can't Tell / No

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: Clear statement of aims - determine possible models and recommendations of peer support for BPD.

2. Is a qualitative methodology appropriate?

Yes ✓ / Can't Tell / No

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: Justification around qualitative methodology given in introduction - exploring health professional perspectives can differ from consumer perspectives thus need to understand them all to enhance services. No specific studies exploring perceptions or models of peer support for individuals with BPD. Due to focus on perspectives, qualitative methodology appropriate.

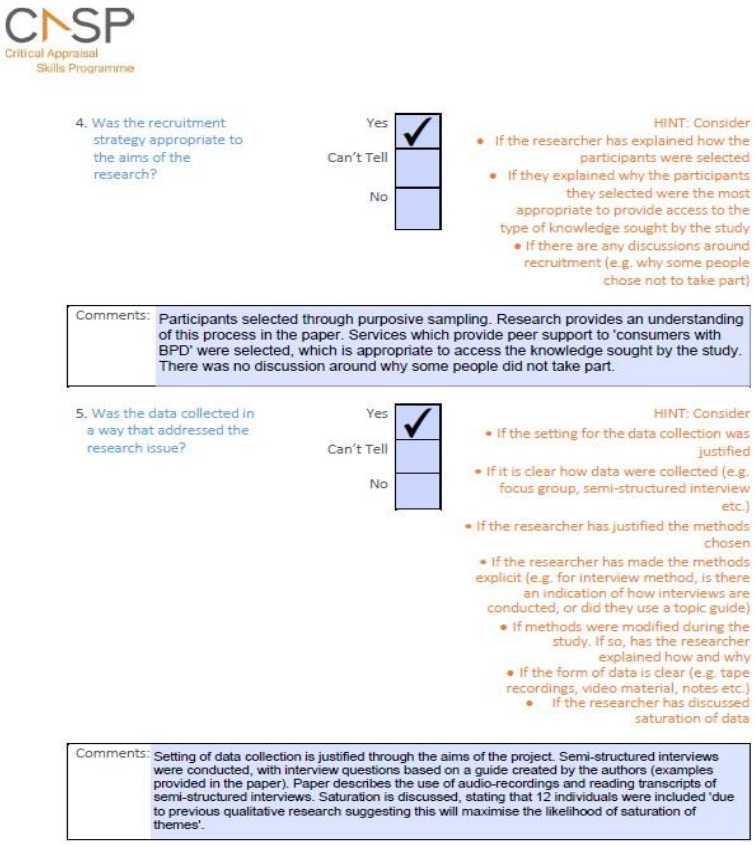
Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ✓ / Can't Tell / No

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: Introduction discusses differences between qualitative and quantitative data, and the need for qualitative research design to meet the aims of the research.



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4. Was the recruitment strategy appropriate to the aims of the research?

Yes ✓ / Can't Tell / No

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments: Participants selected through purposive sampling. Research provides an understanding of this process in the paper. Services which provide peer support to 'consumers with BPD' were selected, which is appropriate to access the knowledge sought by the study. There was no discussion around why some people did not take part.

5. Was the data collected in a way that addressed the research issue?

Yes ✓ / Can't Tell / No

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments: Setting of data collection is justified through the aims of the project. Semi-structured interviews were conducted, with interview questions based on a guide created by the authors (examples provided in the paper). Paper describes the use of audio-recordings and reading transcripts of semi-structured interviews. Saturation is discussed, stating that 12 individuals were included 'due to previous qualitative research suggesting this will maximise the likelihood of saturation of themes'.

6. Has the relationship between researcher and participants been adequately considered?

Yes	
Can't Tell	
No	✓

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: There is no description referring to the critical examination of the researchers role in formulating the research questions or data collection.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: States ethical approval has been sought and informed consent received from all participants.

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8. Was the data analysis sufficiently rigorous?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments: In-depth description of analysis process provided. Interpretive phenomenological methodology was used to ensure preconceptions were 'bracketed', and analysis of data was performed using 'reflective thematic analysis'. Describes how themes were collated. Research team members coded independently, and discussions between researchers were used to ensure themes depicted participant responses. Inter-rater reliability for coding was also provided. Themes were presented to participants to validate themes and ensure accurate meaning was captured. Sufficient data is presented for the different themes found. No description of why data presented was selected from original sample.

9. Is there a clear statement of findings?

Yes	✓
Can't Tell	
No	

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: Findings are made explicit with sufficient data to support themes. Contrasting views were discussed in the paper. More than one analyst and participants involved in analysis, increasing credibility of findings. Findings are discussed in relation to the original research question and aims.

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Section C: Will the results help locally?	
10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used
Comments:	No previous research in the area, specifically exploring peer workers with lived experience supporting people with a diagnosis of borderline personality disorder. Paper outlines the importance and value of the findings particularly for clinical practice. Also provides 'two models' of peer support for BPD, again recommendation for clinical practice. The paper outlines future research particularly in relation to the two models outlined and their evaluation. The paper also broadens the findings to general mental health teams, thinking about how the peer worker role may look (e.g. integrated or complementary).

Appendix E.2. Lead researcher example 2

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Paper for appraisal and reference: Berry, Hayward and Chandler, 2011

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ✓ | Can't Tell | No

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: Clear aim - to use qualitative methodology to further explore the integration of PSWs in to existing MH teams in the UK.

2. Is a qualitative methodology appropriate?

Yes ✓ | Can't Tell | No

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: Exploring experiences of PSWs in MH teams, from both peer and non-peer perspectives. Qualitative methodology appropriate for this.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes | Can't Tell ✓ | No

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: Although the research design could be considered appropriate, there is no justification of why this methodology or way of collecting data was considered.

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4. Was the recruitment strategy appropriate to the aims of the research?

Yes | Can't Tell ✓ | No

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments: Researcher explains how participants were selected, with an understanding of why the participants selected were the most appropriate. Although can assume non-peer participants, no justification of why this hadn't been broadened out or why other non-peer staff took part.

5. Was the data collected in a way that addressed the research issue?

Yes | Can't Tell ✓ | No

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments: Setting of data collection was justified. Semi-structured interviews were conducted however no justification of why these methods were chosen. Seperate schedules created for PSS and PSS managers. No understanding of areas covered in schedules though so unclear if they address aim. Audio recordings used and transcribed. No discussion of data saturation.

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6. Has the relationship between researcher and participants been adequately considered?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: Reflexivity section at the end of the paper which outlines bias.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	
Can't Tell	✓
No	

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: Explanation of participants informed consent process. Participants were shown draft of findings for validity and some material was not used due to compromising confidentiality of participants. Limited demographics were taken due to concerns of visibility of participants. However, no statement suggesting ethical approval which questions ethical processes engaged in.

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8. Was the data analysis sufficiently rigorous?

Yes	
Can't Tell	✓
No	

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments: Data analysed through thematic analysis (Braun and Clarke 2006). Analysis was inductive. No discussion of how categories/themes were derived from data. Explicitly states only first author coded the data with some consultation of analysis of findings with other authors. Researcher does discuss reflexivity and possible influence on the data.

9. Is there a clear statement of findings?

Yes	✓
Can't Tell	
No	

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: Findings are explicit in the paper. Adequate discussion of evidence. Validation through participant involvement in reading draft findings. Findings discussed in relation to original research question.

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Section C: Will the results help locally?	
10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used
Comments:	Produced novel findings to add to the peer mentor literature, particularly superordinate themes including identity in PSS. Researcher embeds research into existing knowledge and understanding, including contradictions. Discusses limitations of generalising to other populations due to setting and small sample size.

Appendix E.3. Second reviewer example

CASP Critical Appraisal Skills Programme

Paper for appraisal and reference: Gordon & Bradstreet 2015

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ✓ / Can't Tell / No

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: Relevant literature outlined in the introduction, which supports the identified aims discussed at the end of this section

2. Is a qualitative methodology appropriate?

Yes ✓ / Can't Tell / No

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: Yes, paper wanted to understand the basis for local decisions regarding the introduction (or not) of peer workers, with an emphasis on what might engender their wider use - therefore seems qualitative methodology is appropriate

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ✓ / Can't Tell / No

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: Discusses how the teams were selected and why, as well as outlined the methods of research. Although the researcher did not justify the method design, it appears appropriate to the aims.

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4. Was the recruitment strategy appropriate to the aims of the research?

Yes ✓ / Can't Tell / No

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments: Explains why participants were selected, although if there were, or any reasons for non-partaking was not discussed

5. Was the data collected in a way that addressed the research issue?

Yes ✓ / Can't Tell / No

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments: Data collection methods were outlined and it is clear how data was collected in order to address the research aims.

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6. Has the relationship between researcher and participants been adequately considered?	Yes		HINT: Consider • If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location • How the researcher responded to events during the study and whether they considered the implications of any changes in the research design
	Can't Tell		
	No	✓	

Comments: This was not addressed by the article

Section B: What are the results?

7. Have ethical issues been taken into consideration?	Yes	✓	HINT: Consider • If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained • If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) • If approval has been sought from the ethics committee
	Can't Tell		
	No		

Comments: Paper reports that ethical principles were practised in line with the guidelines of the Social Research Association and the Respect Guidelines, and elaborates on how this was done

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8. Was the data analysis sufficiently rigorous?	Yes	✓	HINT: Consider • If there is an in-depth description of the analysis process • If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data • Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process • If sufficient data are presented to support the findings • To what extent contradictory data are taken into account • Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation
	Can't Tell		
	No		

Comments: There is a description of the analysis process, with discussion around the approach, such as developing an analytical framework that reflected the research questions and the content of the collected data, and which used descriptive headings under which data were summarised. Sufficient data is reported in the article.

9. Is there a clear statement of findings?	Yes	✓	HINT: Consider whether • If the findings are explicit • If there is adequate discussion of the evidence both for and against the researcher's arguments • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst) • If the findings are discussed in relation to the original research question
	Can't Tell		
	No		

Comments: There is a clear statement of the findings, which are discussed in relation to the original research question. The creditability of findings is discussed via triangulation of findings, eg. here was triangulated evidence across research participants from both of the health boards and from the Scottish Government focus group that in order to increase adoption of peer working, there was a need to build a costed argument

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Section C: Will the results help locally?	
10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used
Comments:	Discussions about contribution the study makes to existing knowledge or understanding, including clinical practice. New areas of research are discussed. The research focused on participants and services within Scotland, with no discussion of how findings could be transferred.

Appendix F: Stage four of meta-ethnography : determining how the studies are related.

Underlined – Core theme in paper; *Italics* – Sub-theme in paper; Summaries underneath.

Aguey-Zins (2018)	Barr et al. (2020)	Berry et al. (2011)
Peer worker Role in the Delivery of Services Involvement in services; benefits of lived experience perspective; educational role of peer Factors Important in developing collaborative relationships between community Mental Health staff and peer workers Culture and approach of services – less power imbalance; Non- peer staff concerns	Consumer peer workers provide shared experiences to consumers that bring hope and connection Reciprocal relationship compared to power imbalances between non-peer and consumers All groups agreed that it is important to allow consumer choice in selecting a peer worker in which to work Importance of a suitable match All groups agreed that it is important to consider offering support for consumers from both mental health professionals and consumer peer workers Maximize benefits for consumers Areas of disagreement Value of peer worker when included or separated from the team; Concerns of inclusion Mental health professionals identified how consumer peer workers and carer peer workers inform and improve mental health care Peers change services to recovery oriented; Educational role of peer Mental health professionals described the value of consumer peer workers and looked for opportunities to strengthen their contribution Stigma; Role clarification; Concerns around boundaries; Supervision and training	PSS worker as 'other' *PSS professional identity* Flexibility in peer role *Non-peer professionals positioning the PSS as "other"* Uniqueness of role; Peers help with change in service users; Team fragility and instability; Non-peer ambivalent attitudes PSS worker as a "change agent" *Expectations of the PSS worker to be a "challenger"* Challenge practice of immediate team and whole service; Change in culture; PSS role models of recovery *The Challenge of being a challenger* Issues of power *Opening up to disclosure* Cultural change Readiness for PSS worker employment *The importance of shared expectations* Essential to 'readiness' *The importance of the employment setting* *The importance of commitment and support* *Readiness of the PSS workers* Alignment between expected and actual role

Byrne et al. (2018)	Byrne et al. (2019)	Cabral et al. (2014)	Coates et al. (2018)
Benefits to service users Unique skills and perspectives of peers not outcome of interaction with traditional roles; Peer to SU relationship perceived more equitable then SU to non-peer; Lived experience provides unique credibility to the roles; Job title reported positive opportunities for building rapport; Success seen through reductions in relapse, case management and rehospitalisation. Benefits for the Organisation and Colleagues in Traditional Roles Utilising peers in formal and informal ways; Bridging role; Challenging prejudicial attitudes; Retention and absenteeism of peers Limitations of peer work Peers pose threat to non-peer roles; Non-peer previous experience of peer work; Tokenism; Lived experience as a strength Practical Strategies and Supports *Recruitment* Adequate planning and recruitment; Assessing peer mentors for range of 'softer skills'; Systems evolve with time *Flexible workplaces/Reasonable adjustments:* Reasonable adjustments; Whole workforce support *Supervision:* Key to management of peers	Exposure Linked with enthusiasm and growth of peer role; Management exposure Management support for Peer work: commitment and action Organisational commitment; Commitment translated into action Champions of peer work Assist the success of the peer workforce Peer Management roles Role model and mentor peer roles; "voice at the table" Organizational culture and acceptance Need for preparation of workplace culturally; Top-down support	Educating others about recovery Lack of expectations and role ambiguity for peer specialists Better definition would reduce ambiguity; unclear how to involve peer specialists Challenges in supervising peer specialists Evaluating performance of peers; More guidance needed	Individual work with consumers and carers Non-peers initially reluctant to refer; Non-peer trust developed in time Peer work training and supervision *For peers:* Training overcomes non-peer concerns Stakeholder feedback Initial non-peer reluctance changed to working collaboratively

Collins et al. (2016)	Doherty et al. (2004)	Ehrlich et al. (2020)	Gates & Akabas (2007)
The place of lived experience in mental health services Peers offer a new type of support to service users; Lived experience as a positive contribution; Non-peer openness of own lived experience The contribution of the peer support worker PSW role in development of services; PSWs could be a cost-effective measure; Services being unable to fully support PSWs; Measuring peer role The impact of work on the PSW Benefits to the PSW; Conflict in relationship change to co-worker; PSW managing lived experience disclosure; PSW managing well-being Role ambiguity Peer support workers and team dynamics MDT to have clarity; Integration Into team - "them and us"; Potential problems based on previous experience	Benefits to the client More time than non-peers; Personal understanding of difficulties of mental illness; HCAS as positive role models; Clients more likely to accept advice Benefits to the team HCAs personal experience; Engage clients whom team have difficulties; Changes in language used Difficulties for clients High incidence of sick leave and related issues; HCAs struggled with issue of role conflict Difficulties for the team Case managers more sensitive and guarded to HCAS; Team more accepting and sensitive of different abilities of all staff, and clients Other issues Supervision	Navigating a legitimate place within an inter professional team *'Fit' with team understanding and beliefs about including PSWs as members of a clinical mental health-care team:* Little clarity of PSW role; Clarity of role occurred over time; Lived experience alone was insufficient to meet complex care role of teams *'Fit' with clinically based hierarchical structures* PSWs and clinical staff perspectives could be challenging *'Fit' with consumer needs:* PSWs suggestions were more easily accepted Legitimacy - becoming a valued team member with diverse roles *The valuable support role of PSWs:* Valuable contributions recognised over time Traversing the clinical care landscape in ways that support consumer care *Bridging relationships with care providers in multiple contexts:* PSWs help move care beyond traditional clinical spaces	Attitudes toward peer providers Stigma; Move services towards recovery; value of peers Role conflict and Confusion Caused breakdown in peer and non-peer communication; Confusion of peer identity; Peers connection with clients considered 'unprofessional' *Policies related to staff/client relationships* Differences for non-peers and peers *Poorly defined jobs* Extensive array of responsibilities; Unreasonable expectations of peers; Confusion when tasks overlapped; Non-peer jobs in jeopardy *Inadequate training and lack of communication* Lack of preparation led to role confusion; Hiring process key point in transition from peer to consumer Lack of Clarity Around Confidentiality *Disclosure of Peer Status* Labelling of peer worker role; Revealing peer status *Peer Access to Client Records:* Consequence of no access was frequent miscommunication Lack of Opportunities for Networking and Support Opportunities for support affected; All staff should be treated the same; Supervision; Part-time status impact

Gillard et al. (2013)	Gillard et al. (2015)	Gordon & Bradstreet (2015)	Gray et al. (2017)	Hamilton et al. (2015)
Who becomes a peer worker, how and why? Peer route to further employment; Prior experience sufficient to work as Peer Worker; Unexpected demands of peer role Building new teams Equality in non-peer and peer relationships; Difficulties implicit in changing relationship; Initial resistance; Non-peers feeling 'threatened' by PW role Being a peer worker: an experience of conflicted identity Peer worker identity as alternative and positive, and complex and conflicted Challenging boundaries Within team and PSW - service users; Need for boundaries stemmed from peer workers mental health; Measures in place to reduce peer exposure to 'professional' and 'social' overlap; Supervision Is a body of peer practice emerging? Engaging service user and role model; PSWs bring insight and additional skills	Common issues across organisational contexts Existence of formal recruitment process; Strategic agendas; Over-formalising role; Maintaining conventional boundaries Peer Workers in the Statutory Sector Tensions from type of culture; shared expectations; Insecurity of non-peer staff; Lived experience as added dimension; Training of PW; lack of managerial support; Stigma Peer Workers in Organisational Partnerships Distinctiveness of peer worker roles highly valued by non-peer staff	What sort of evidence needs were indicated? Lack of information about peers; cost-effective evidence needed; evidence of how to integrate If decision makers had the "right evidence", would we then see universal provision? Government support; Consistent with organisational principles and practices; Healthboard not limited to risk-adverse culture	Knowledge and understanding of peer support Limited exposure; Vague definition of peer support Peer support workers' relationships with clients were seen as unique Peers as friends and support workers; Differing relationships to caseworkers; Peers overcome non-peer relationship obstacles; Peers as gateways to clients Blurring boundaries and managing peer support worker health Concerns of being 'too friendly'; Risk to peer mental health *Compliance and Choice - not included as discusses role of case manager, no reference to peer mentors from non-peer perspective* Lack of organisational recognition of the value of peer support Expressing value for peer mentors; Organisation not recognising value of lived experience Recovery has many different interpretations PSWs role model recovery	*Implementation facilitators* Initial worries changed through preparation; Value over time; CPs have access to information not available to non-peers; Presence and contribution "cut across professional elitism" *Implementation Challenges* Flexible or structured working with CPs; CPs lacked knowledge of standard workplace behaviour; Challenges resolved over time

Holley et al. (2015)	Hurley et al. (2018)	Kilpatrick et al. (2017)	Mancini (2018)
Risk to Peer Workers: Boundaries and Well-being *Boundaries and the Risk to Peer Worker Well-being* Non-peer concerns of PW sharing lived experience *Supporting the Peer Worker* Peer Workers and Risk Management *Peer Working and Possible Risk to Service Users* Lack of clear chain of responsibility; Accountability *Service Users at risk, preparing peer workers* Preparation of peer workers; Training for peers *Risk management, Peer Workers and Disclosure* Disclosing risk information to wider staff team; Friendships and breaking confidentiality *Reservations about peer workers involvement in risk management* Peers taking on same responsibility as non-peers; Risk training triggering for peer; Tokenistic training Alternative peer-led approaches to managing risk and crisis *Changing the focus of risk* Risk dealt with in a more positive way *Enabling Services users to Own their risks* Changed the way risk was talked about with service users; Manage risk in a more positive way *Moving away from a risk-averse culture*	Challenges and opportunity peer workers Role stress impacting peer recovery; Complexities surrounding inclusion of PW; Flexibility of role Lived experience is an inconsistent construct, not confined to Peer Workers, and experienced as insufficient to fulfil the Peer worker role PW as positive role model; Breadth of possibilities with lived experience; Non-peer lived experience blurring boundaries; More than lived experience needed	Tokenistic or genuinely effective? Non-peers questioning rationale of employment of people with lived experience; Tokenism; Financial investment in PWs; Benefits of lived experience; Benefits for PW; Role creating change; Integral role in mental health services Clear boundaries not blurred lines Solutions to overcome tokenism; blurred boundaries; clear boundaries reduces risk; supervision and support; Induction process; Appropriate support mechanisms Reasonable adjustments; Reducing obstacles Individualised; Processes to support PSWs meet demands of role; Lived experience not enough for role Organizational culture PSWs cause challenge existing delivery of services; Move to recovery-orientated services; PW as valuable as paid professional role; Needing more than PSW employment to challenge organisational culture; Training and educating non-peers	Fidelity *Role Clarity* Struggling to understand and utilise peer role; Clear expectations reduce misutilisation; Lack of non-peer preparation *Blurred professional boundaries and expectations* Professional boundaries; difficulties supervision peer role Organisational culture and support *Team work* Key element of effective peer integration; Varying levels of team inclusion; Challenging non-peers; peers positioned as "second-class" professionals Accommodations Peer well-being; lack of guidance Strategic Implementation Top-down support; Poor communication of policies and procedures

McLean et al. (2009)	Moll (2009)	Moore et al. (2020)	Oborn et al. (2019)	Otte et al. (2020)
Recruitment process *Awareness raising* Ongoing process *Defining the role of the peer support worker* Challenging *Supervision and Support* Evolving own approach to supervision; Steering group support National Perspectives How much guidance needed; Attributes needed alongside lived experience; Compromising peer wellbeing; Commitment from all levels Assessing different types of impact Inability to quantify impact on SU; Benefits to service users Introducing new perspectives and strategies for wellness PSW given more credibility by service users; Peer mentors can progress recovery in service user Positive impacts *Increased self-confidence* For PSW Changing the organisational culture Leading change not a reasonable expectation of PSW role	Defining and establishing the roles Peer role supplementary, complementary, alternative Challenges to being a role model Benefits and pressures of being a role model; Managerial support Fitting in/being accepted Supportive and welcoming approach by non-peers; Time taken for non-peers to feel comfortable; Limited hours to interact challenges integration	The little things' Peer worker voice the unvoiced; Elevates validity of discourses Embodied Affect Unique quality of peer relational work; Interaction needs to be witnessed to value it Challenge Tension between biomedical and peer discourse; Impact of challenge was non-verbal; Challenger role as valuable and uncomfortable	Establishing trust and rapport with the supported person PWs access a shared space with service user; PWs cross clinician-patient boundary Understanding and interpreting mental health needs of supported persons Peers apply differential knowledge to therapeutic practice; Lived experience as a strength; Role models; PW validates service user Bringing insight to treatment processes having previously received care Lacking experience of services could be disadvantage of role; Bringing lived experience; Bridging; PW offer unique insights; Different to predominant approach in services	Benefits for patients *More time for one-on-one attendance* Peers have time for tasks non-peers don't *Improve adherence* Different connection Benefits for mental health professionals *A valuable corrective* *A bridge between mental health professionals and patients* *Improved continuity in treatment offers* Continuity in recovery groups

McLean et al. (2009) continued.

Influencing the appropriate use of language
PSW modelling recovery and influencing team
Practice

Bridging the gap between staff and service user
Addressing divide of 'them and us'

Reality check for professionals
PSW remind non-peer of efforts made to recover

Impact on teams
Helping clinical staff to enhance their skills
Bridge between non-peer staff and service users

Establishing appropriate levels of integration to NHS working practices
Confidentiality
Uncertainty of role; Issues resolve over time

Adapting to individual skill sets
Expectations individually appropriate to each peer

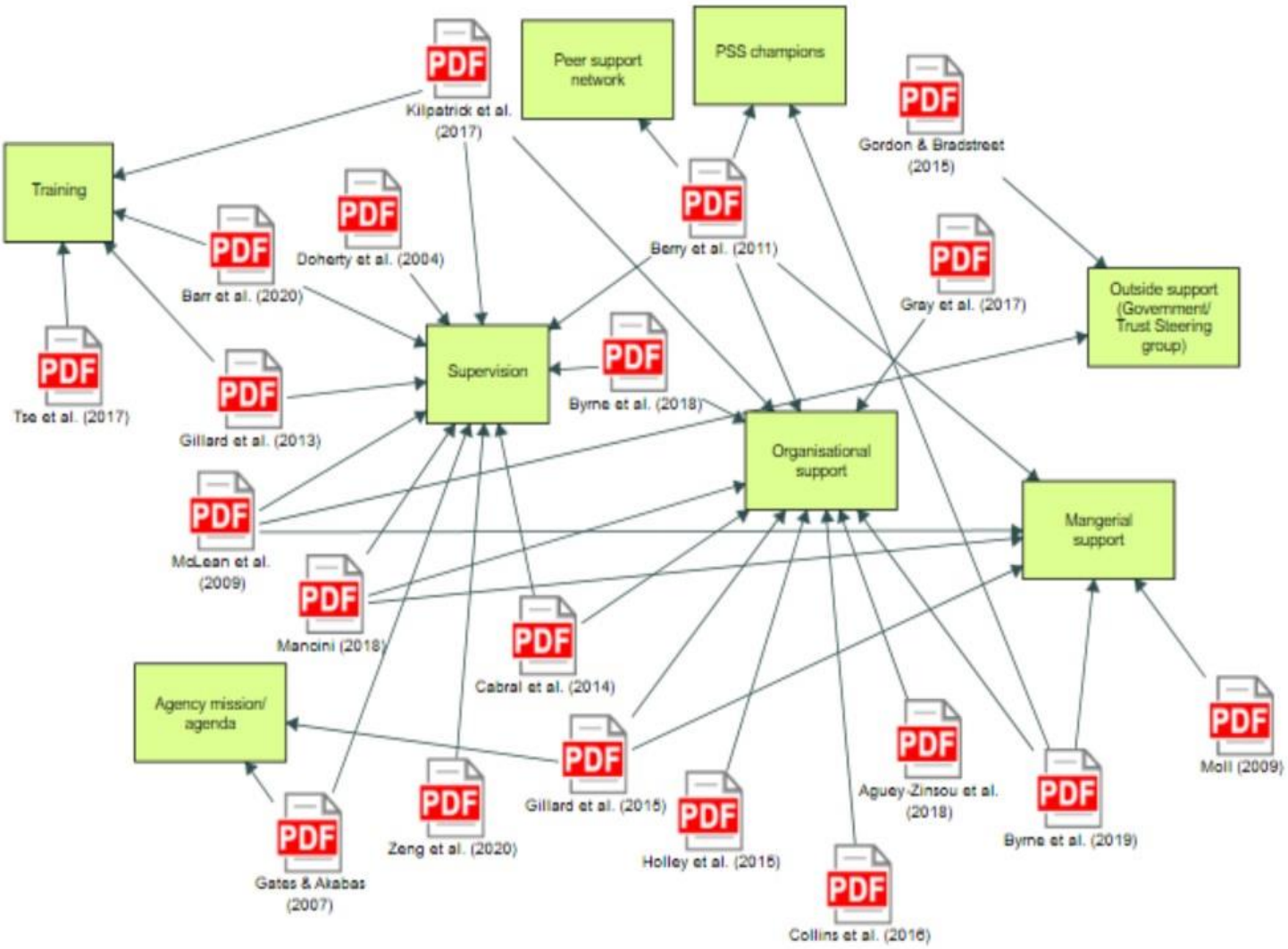
Peer workers using mental health services
Non-peers tempted to use peer workers in other roles outside of 1:1 support

Unique and distinct features of peer support
Using lived experience as a strength e.g. overcoming power dynamic between staff-patient relationship, model recovery and hope

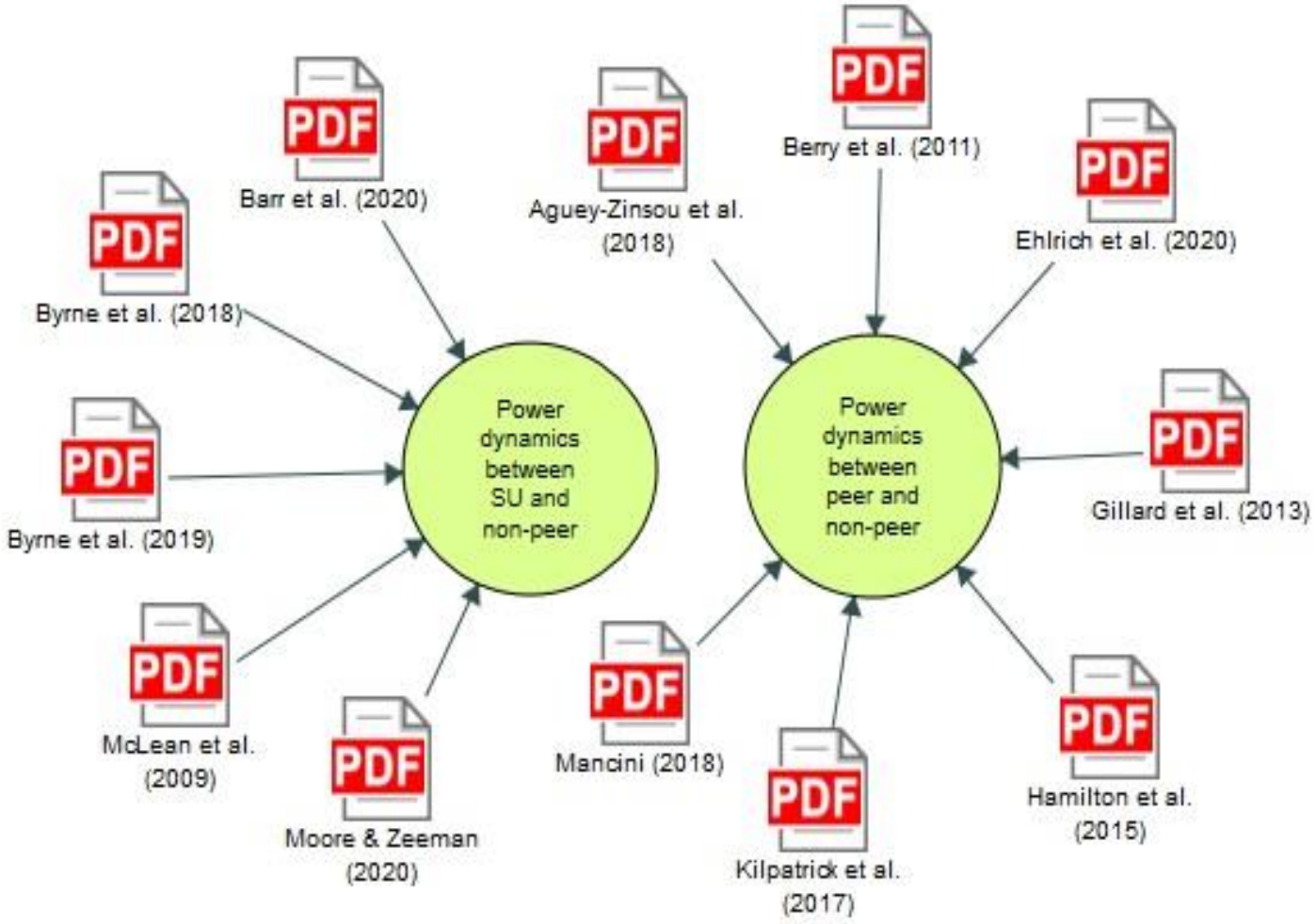
Tse et al. (2017)	Weir et al. (2019)	Zeng et al. (2020)
Perceptions over time about PSWs *Essential ingredient of PSWs: turning mental illness-related experiences into assets* Lived experience a special asset *Initial uncertainty and confusion* Role not clearly defined; Improvements and positive contributions noticed over time; Non-peer changing views *PSWs growing resilience and confidence over time* Non-peer concerns of peer relapse; Running mutual support groups Services users' changes over time: the challenges and promise of peer support services *Improved connections with others* PSWs enhance SU connections with others	Positive first impression Shared experience/identity facilitated easy conversation; Shared experience engaged veterans in service; Mental Health stigma Understanding professional friend Peer friendship important for service user engagement; PSW as a role model; PSWs need various skills and competencies Helpful and supportive connector Valued PSW role as positive for veterans; PSW engage veterans with service and treatment Open door PSW enhanced veteran engagement through non-judgemental open door	Task environment: generating public value for PP *Collegial relationships* Resistance due to lack of organisational value of PP; Organisational adoption of recovery in culture *Informational support* From organisations for PPs Instrumental support: the pivotal role of the supervisory relationship Supervision; Reasonable accommodations Mental health management Managerial concern for PP mental health; Formal vs. individualised approach to support; Well-being plans adopted service-wide

Appendix G: Concept map examples

Appendix G.1. 'Wider system support'



Appendix G.2. 'Power imbalances'



Appendix H: Example of stage five of meta-ethnography: translating the studies into one another

Common concepts identified in stage 4	Aguey-Zinsou et al. (2018) – 1st and 2nd order interpretations	Barr et al. (2020) - 1st and 2nd order interpretations	Berry et al. (2011) - 1st and 2nd order interpretations	Byrne et al. (2018) - 1st and 2nd order interpretations	Byrne et al. (2019) – 1st and 2nd order interpretations
Preparation	Did not endorse this concept.	Did not endorse this concept.	Did not endorse this concept.	<u>Recruitment</u> Adequate planning and recruitment was viewed as critical to organisational preparedness and key to ensuring an effective peer workforce. Poor planning was seen to contribute to situations where peer workforce development appeared rushed and where the foundations for understanding and communication were not well established. "I think it was very much 'we're getting this money to do this, it's gonna be great to have this fresh idea' . . . rushed like a bull out a gate—just get people in positions and not actually think about whether they're right for that position"	<u>Organizational culture and acceptance</u> Participants raised the need to prepare the workplace culturally for the employment of peer workers. When peers were seen to be ' 'imposed' upon management or the team, it adversely affected the acceptance of peers within the workplace. Adequate preparation, including change management and cultural readiness, was considered important across all levels of the organization when introducing peer roles. Different techniques were described to achieve positive organizational culture including planning, preparation and transparency and actively encouraging peer workers to provide ongoing and honest opinions and ideas.

Common concepts identified in stage 4	Cabral et al. (2014) – 1st and 2nd order interpretations	Coates et al. (2018) – 1st and 2nd order interpretations	Collins et al. (2016) – 1st and 2nd order interpretations	Doherty et al. (2004) – 1st and 2nd order interpretations	Ehrlich et al. (2020) – 1st and 2nd order interpretations
Preparation	Did not endorse this concept.	<u>Peer work training and supervision</u> *For peer workers* While the intensity of the Certificate IV was at times overwhelming, it played a role in overcoming staff concerns. Clinicians commented that knowing the peer workers were receiving professional training which helped to increase their confidence in the peer workers.	Did not endorse this concept.	Did not endorse this concept.	Did not endorse this concept.

Common concepts identified in stage 4	Gates & Akabas (2007) – 1st and 2nd order interpretations	Gillard et al. (2013) – 1st and 2nd order interpretations	Gillard et al. (2015) – 1st and 2nd order interpretations	Gordon & Bradstreet (2015) – 1st and 2nd order interpretations
Preparation	Role Conflict and Confusion *Inadequate Training and Lack of Communication* Role confusion and conflict appeared to occur when agencies did not prepare nonpeer staff for the inclusion of a peer colleague. They were not provided with training on issues around working with someone with a mental health condition or the expectations for the peer at the agency. When asked about what types of training were provided to staff and management, few mentioned training around the Americans with Disabilities Act, accommodation, or mental health issues. Some voiced the opinion that training was not needed. "They are clinicians and they should know how to and be able to relate to the peer.'' Others, however, recognized the need. ''I think the staff needs more training around working with peers, regarding stigma and working with someone who has a mental health condition. The peers don't feel as connected to the staff.'' Finally, the peers themselves were not provided training on workplace policies and practices and how they applied to their position. Lack of Clarity around confidentiality *Disclosure of Peer Status* Co-workers, for example, were rarely provided a formal introduction to the peer role and peers were not given the opportunity to determine to whom to disclose, when to disclose and what information to share. As a result, staff had a misunderstanding of the peer role and the ability of the peer to join the staff as a productive worker.	Did not endorse this concept.	Peer Workers in the Statutory Sector As such peer workers were required to undertake the same mandatory training as other staff, with additional training in how to relate their lived experience as part of the role: "They may use their lived experience in an inappropriate way. They may not understand the importance of things like hope and experience and understanding and compassion and mutuality. All those things you get taught in a course. (STA2SM01)"	What sorts of evidence needs were indicated? In addition to unmet evidence needs regarding costed "arguments", the need for evidence on (successful) implementation also emerged. This need arose from identified challenges in establishing and/or delivering peer support services. Particular challenges were raised about how to ensure workers' compliance with professional requirements (such as patient confidentiality, information sharing with the wider multi-disciplinary team), maintenance of workers' wellbeing and risks to service continuity in the event of workers becoming unwell. In fact, there was a view that the significant challenges involved in establishing a service of this sort could lead to a "why bother?" attitude. As a consequence, there were calls for information/ evidence on how to go about employing peer workers and then how to ensure their ongoing and productive role within the multi-disciplinary team. ""There's not a lack of evidence around about its appropriateness and effectiveness… there is a lack about then "how do we go about making it happen?" (M.I4)" …partnering evidence on implementation with resources (such as job descriptions, employment contracts, supervision protocols, etc.) in order to make the establishment of a peer support service a less daunting prospect.

Common concepts identified in stage 4	Gray et al. (2017) – 1st and 2nd order interpretations	Hamilton et al. (2015) – 1st and 2nd order interpretations	Holley et al. (2015) – 1st and 2nd order interpretations	Hurley et al. (2018) – 1st and 2nd order interpretations
Preparation	Did not endorse this concept.	<u>Implementation Challenges</u> An unexpected challenge was that some CPs did not have sufficient knowledge of standard workplace behavior, or what one MHICM staff member called "basic work professionalism," such as notifying the team when sick, arriving on time, responding in a timely period to messages, prioritizing tasks, and working proficiently with computers. Furthermore, CPs required more training than anticipated on documenting interactions with clients, particularly refraining from making clinical judgments based on their observations, an activity VHA had reserved solely for clinicians. Working with the VHA's computerized medical record also posed a notable challenge. One staff member said, "I think the biggest problem was with [a CP who] didn't have a clue to CPRS [Computerized Patient Record System]."	<u>Peer Workers and Risk Management</u> *Service Users at Risk, Preparing Peer Workers* The need for peer workers to be fully prepared to support service users who may be at risk to themselves or others was widely acknowledged: "I think the peer support worker should be able to know what to do when someone is in crisis. I think it's all about risk management as well as they are there as a peer support, I think it would be good because obviously mental health there's a lot of risk assessing. If someone comes to you they're suicidal and they've got a plan that, you know, I'd like to think that the peer support would know how to support that person and what to do and who to call, you know, so that the risks are managed safely….(STA3ST02)". Some services actively involved peer workers in mandatory risk training alongside other members of staff in order to prepare them for difficult situations: "… you know the peers had a great sense that they weren't clinicians so it was just about what the warning bells were for them and what was their route, what was their process? It was a really useful exercise because from that we were able to look at processes, you know, what do you do if this happens? (STA1SM01)"	Did not endorse this concept.

Common concepts identified in stage 4	Kilpatrick et al. (2017) – 1st and 2nd order interpretations	Mancini (2018) – 1st and 2nd order interpretations	McLean et al. (2009) – 1st and 2nd order interpretations	Moll (2009)
Preparation	<u>Clear boundaries and not blurred lines</u> The induction process and training for PSWs was emphasized as integral to reinforce and educate around the issue of appropriate work professional conduct boundaries. "I think there would have to be training for them in advance about what is appropriate and about what is not appropriate, what information you should be revealing, what personal details you should be revealing and what is the best form or best behaviour in that respect" <u>Reasonable adjustments; reducing obstacles</u> In addition to reasonable adjustments, participants identified processes to ensure that PSWs were able to meet the demands of the role effectively. These were identified as structured induction, training and education, structured and regular supervision and the importance of engaging with other team members from the outset. "To ensure the peer support work fits in, it would be a proper induction, proper training, ensuring they have the skills and knowledge to carry out the job" <u>Organizational culture</u> Supportive training and education for colleagues were highlighted by participants as important to the successful implementation of this role to build capacity, understanding of the role and its value and how it can be best utilized. "Supervision, training, it's more training for their colleagues I think is key. I don't think they have any problems meeting organisational demands it's the constraints they are coming up against of other colleagues"	<u>Fidelity</u> *Role Clarity* All non-peer mental health workers noted the impor-tance of communication and guidelines for peer roles and expectations. Most noted that they were told that they had to hire a peer specialists and were given no information about what a peer was supposed to do on their team, nor did they receive any training or consultation about how best to implement peers.	<u>Recruitment Process</u> *Awareness Raising* All sites put extensive effort into awareness raising, and the key learning was clear; that it is an ongoing process which should not be underestimated and has to be maintained. "I think perhaps we need more chipping, more hammering, more because I don't think, I think their intentions are absolutely really, really good and they really definitely believe in it. I mean we've had nothing but good stuff but they're busy people and they forget. (Supervisor)" <u>National Perspectives</u> On balance there may have been too much emphasis on local sites being autonomous, as at the pilot outset site teams did not feel sufficiently knowledgeable about what the peer support worker role would entail and wished for more guidance on some key aspects of implementation. There was a cautionary note raised in that the potential consequence of a lack of guidance could be the development of peer support worker services that were not ideal.	Did not endorse this concept.

Common concepts identified in stage 4	**Moore & Zeeman (2020) – 1st and 2nd order interpretations**	**Oborn et al. (2019) – 1st and 2nd order interpretations**	**Otte et al. (2020) – 1st and 2nd order interpretations**	**Tse et al. (2017) – 1st and 2nd order interpretations**	**Weir et al. (2019) – 1st and 2nd order interpretations**	**Zeng et al. (2020) – 1st and 2nd order interpretations**
Preparation	Did not endorse this concept.	Did not endorse this concept.	Did not endorse this concept.	Did not endorse this concept.	Did not endorse this concept.	Did not endorse this concept.

Appendix I: Example of stage six of meta-ethnography: Synthesising translations

Concepts identified in stage 4	2nd order interpretations	3rd order interpretations (Concept for synthesising)
Existing organisational culture	a) Peer workers were mistreated and undervalued by services b) Organisations undervaluing peer contribution led to resistance from staff c) Perceived tokenism of employment may prevent full integration in team d) Organisational culture can cause fragility and instability in the team e) Perceptions and acceptance of peers within organizations was thought to impact on experience of peers f) Peers align with organisational mission to promote recovery g) Highly structured and well-developed cultures cause tension in expectations of peer role h) Organisations need to make a shift from risk-adverse cultures to embed peer workers i) Peer mentors disrupt and challenge existing delivery of mental health services – movement from historical medical model to recovery-orientated services.	THE EXISTING TEAM: The organisational culture, previous exposure to peer work and non-peer attitudes overlap, and all influence the initial experience of non-peers when peer mentors integrate into the team. They seem to set the foundations for how open and accepting, or resistant and defensive non-peers will be to peer mentors integrating into the team. Previous exposure to peer work can shift both organisational culture and non-peer attitudes towards recovery-focused practice, as well as provide some clarity on how the role can be embedded into teams. Organisational culture can influence non-peer attitudes, increasing the perceived value or tokenism of the role.
Previous exposure to peer work	a) Those non-peers with significant experience employing peers saw some concerns e.g. absenteeism as 'myths' or negative assumptions b) Lack of exposure may prevent employment of peers c) Exposure increased enthusiasm and growth for peer roles d) Management exposure is important as determined whether employment of peers was meaningfully supported and actioned. e) "Theoretical benefits" of peer work could be enough to consider employment of peers j) Limited exposure led to little understanding of range of possibility of the role, or definition of the role.	
Non-peer attitudes	a) Ambivalent attitudes due to concerns regarding e.g. role blurring, wellbeing stability, boundaries and client lack of acceptance. b) Fears that peer workers "threaten" non-peer roles c) Non-peers lacking confidence in the role and reluctant to utilise d) Persistence of stigma from non-peers in relation to the capacity of people with mental health being able to work e) Non-peers suggested peer workers are "cheap labour" f) Positive attitudes linked to organisational promotion of recovery and role clarity	

Appendix J: Email advertisement sent to teams

Understanding how mental health teams integrate peer mentors: A grounded theory study

I am a final year Trainee Clinical Psychologist looking to recruit non-peer staff members to participate in a research study. This study aims to understand the processes involved in existing non-peer staff adapting practice to integrate peer mentors into the team. Participants will have:

- Worked for the mental health team before peer mentors were employed
- Currently work alongside peer mentors, in the same team, for at least 6 months
- Be 18 years old or over

The study will involve a one-off, one-hour interview with the researcher, Jennifer Berrett, which will be conducted via virtual platform. Times will be flexible to fit around any clinical duties you have.

Your participation in the study is voluntary. If you would like further information or have any questions about the study, please email Jennifer Berrett at:

thomasjl4@cardiff.ac.uk

We look forward to hearing from you,

Best Wishes,

Jennifer Berrett
(Trainee Clinical Psychologist)

Appendix K: Participant Information Sheet

NHS WALES GIG CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

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Prifysgol Caerdydd
Adeilad y Tŵr
Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

PARTICIPANT INFORMATION SHEET (VERSION 6.0)

Title of Project: Understanding how mental health teams integrate peer mentors: A grounded theory study.

Name of Researcher: Mrs. Jennifer Berrett

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. **Please take time to read through the following information carefully**. If you would like more information or if there is anything that you do not understand, please do not hesitate to contact us (contact details at the bottom of this information sheet). It is important to note, you do not have to accept this invitation and should only agree to take part if you want to.

What is the purpose of the study?

Research has demonstrated several benefits, and challenges, for both peer mentors and non-peer staff when peer mentors are employed into mental health teams. Non-peer staff have been identified as playing a key role in the success of integration, however to date, research has relied on small sample sizes of non-peer staff, and predominantly focused on benefits and challenges following the integration of peer mentors into teams. To our knowledge, there has been no exploration of how non-peer staff modify or develop existing practices to adapt to

peer mentors being integrated into a team. With an increase in positions for employed peer mentors within mental health teams, it is vital we understand what may influence the relationship between peer mentors and non-peer staff, to support future integration.

Why have I been invited to take part?

We are looking for non-peer staff members from mental health teams who employ peer mentors, who have worked in the service for at least 6 months, who worked in the service before a peer mentor was employed into the team, and are over the age of 18. If you meet this criterion, then you will be eligible to take part. However, you are under no obligation to take part in this study; it is completely your choice. If you do decide to take part you will be able to retain this information sheet and a copy of the consent form. Please note, if you decide to take part, you are free to withdraw at any time and without giving a reason (please see data protection section below for more details).

What will happen if I take part?

If you choose to participate and provide written consent, you will be invited to take part in a one-off individual 1-hour interview with the researcher, Mrs. Jennifer Berrett. You will be asked for your thoughts about the integration of peer mentors within mental health teams. You may refer to general job roles including Mental Health Practitioner, Occupational Therapist and Peer Mentor; however, you will not be required to disclose any individuals you specifically think about during the interview.

The individual interview will be completed via a virtual platform, around any clinical duties you have to perform as part of your job. Additionally, it will be audio recorded, which will ensure that any findings from the data can be confirmed by another researcher involved in the study if required. However, through transcription by the field researcher, Jennifer Berrett, data will be anonymised. This will include removing job titles and team names. Following transcription, the audio-recording will then be deleted on the audio-recording device by Jennifer Berrett. Please note, you can withdraw from the study following data collection without giving a reason (please see data protection section below for more details).

Are there any risks in taking part, or benefits from participation?

There are no anticipated risks to you from taking part in this study. We are aware that you will complete interviews within your clinical time, thus we will be flexible and negotiate this time with you well in advance.

Additionally, as the data will be related to team members you work with, we will ensure all standard research procedures apply including confidentiality, anonymization and right to

withdraw. Peer Mentors have also been made aware of the research to ensure they are comfortable with this being conducted within their workplace, even though they are not directly participating. We will also contact each participant following data collection and analysis, to ask you to review and consent to the quotations being used in the final write-up of the research.

If you have any concerns about risk, please do not hesitate to contact any of the researchers (details at the bottom of this information sheet).

Direct benefits from taking part in this study are related to the opportunity and space for you to reflect on your working life and practice, which you may not have the chance to do very often. Additionally, indirect benefits are related to your ongoing support of employing Peer Mentors in services.

Will my participation be kept confidential (Data Protection)?

All the information collected about you during the research is strictly confidential. All participants will be identified by a random number only instead of their name, and any identifiable information collected such as professional job role or gender will be coded to ensure anonymity. As stated, participation is entirely voluntary, and you may withdraw at any time without having to give a reason. If you withdraw after the study has begun, under new Data Protection guidance, we will keep the information already obtained. Please see statement from Cardiff University and the NHS regarding data protection guidance:

"Cardiff University is the Sponsor for this study based in the United Kingdom. We will be using information from you to undertake this study and will act as the Data Controller for this study. This means that we are responsible for looking after your information and using it properly. If collected, Cardiff University will keep identifiable information about you for 15 years after the study has finished. The legal basis we will rely upon to collect and store your information is public task. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible. You can find out more about how we us e your information at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection. The University's Data Protection Offer can be contacted at: inforequest@cardiff.ac.uk ."

Additionally, NHS Health Research Authority also provide further information regarding Data protect within the NHS. Please see statement below which relate to the use of data in this study:

"NHS, specifically Aneurin Bevan University Health Board (ABUHB), will collect information from you for this research study in accordance with our instructions. The NHS will use your name and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Individuals from Cardiff University (the sponsor organisation) and regulatory organisations may look at your research records to check the accuracy of the research study. ABUHB will pass these details to Cardiff University along with the information collected from you. The only people in Cardiff University who will have access to information that identifies you will be people who need to contact you about the research or audit the data collection process. ABUHB will keep personal identifiable information about you from this study for 6-12 months after the study has finished."

What will happen to the results of the study?

Data will be used for a thesis for the South Wales Doctoral Programme of Clinical Psychology. Results may be published in an academic journal and presented at scientific conferences and to relevant authorities (e.g. NHS Trust).

Payment

There is no payment for participants.

Who do I contact if I have a problem?

We do not anticipate any problems, however if you feel you need to speak to someone about the research, please do not hesitate to contact any member of the research team and we will try to help. If you have any concerns about the study and wish to speak to someone independent, you can contact:

Dr. John Fox
02920 870582
foxj10@cardiff.ac.uk

Who is monitoring this study?

This study has been reviewed by the Cardiff University School of Psychology Research Ethics Committee and approved by Aneurin Bevan NHS Health board. This process is to protect your rights, safety, and dignity. It is also being regularly monitored by my supervisors. Contact details for the Cardiff University School of Psychology Research Ethics Committee are as follows:

Cardiff University School of Psychology Research Ethics Committee
Cardiff University
Tower Building, 70 Park Place, Cardiff
CF10 3AT
Tel: +44(0)29 208 70360
Email: psychethics@cardiff.ac.uk

Who has provided sponsorship and insurance for this study?

Cardiff University has agreed in principle to act as Sponsor for this project, as required by the UK Policy Framework for Health and Social Care Research. Cardiff University is a member of U.M. Association Limited, who will provide both employer's liability insurance and public and products liability insurance for this research study.

Who can I contact if I have further questions?

If you have any further questions, please do not hesitate to contact any member of the research team and we will try to help.

Lead Researcher

Mrs. Jennifer Berrett thomasjl4@cardiff.ac.uk

Principal Investigator

Dr. Jessica Woolley Jessica.Woolley@wales.nhs.uk

Chief Investigator

Dr. Heledd Lewis LewisH31@cardiff.ac.uk

Co-Supervisor

Dr. Andrew Thompson Thompsona18@cardiff.ac.uk

Thank you for taking the time to read this participant information

This study has been reviewed and approved by the Cardiff University School of Psychology Research Ethics Committee, and further permission to conduct the research with an NHS setting has been granted by Health Care Research Wales (HCRW), and Aneurin Bevan University Health Board.

Cardiff University School of Psychology Research Ethics Committee
Cardiff University, Tower Building, 70 Park Place, Cardiff, CF10 3AT
Tel: +44(0)29 208 70360
Email: psychethics@cardiff.ac.uk v6.0, 25/10/2020, IRAS: *259989*

Appendix L: Participant consent form

NHS WALES GIG CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

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Prifysgol Caerdydd
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Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

PARTICIPANT CONSENT FORM

Title of Project: Understanding how mental health teams integrate peer mentors: A grounded theory study.

Name of Researcher: Mrs. Jennifer Berrett

Please initial all boxes you agree with:

	Please Initial
1. I confirm that I have read and understood the participant information sheet (Version 6.0) for the above-named study.	
2. I have been given the opportunity to ask any questions, and have had any questions answered to my satisfaction.	
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
4. I understand that relevant sections of the data collected during the study may be looked at by members of a Cardiff University research team, from regulatory authorities or from NHS Health Boards, where it is relevant to my taking part in	

this research.	
5. I agree to take part in a one-off interview, approximately lasting one hour.	
6. I understand that participation will involve the one-off interview being audio-recorded, and this audio-recording will be destroyed once the information has been transcribed.	
7. I understand that information I give may be published as part of the research, however, this will be fully anonymised and non-identifiable.	
8. I give consent for anonymous quotations of mine to be published in the study write-up if required.	
9. I understand that my information will be stored securely in lockable storage.	
10. I agree to take part in the above study.	

Name of Participant (PLEASE PRINT)	Date	Signature
Name of Person Taking Consent (PLEASE PRINT)	Date	Signature

This study has been reviewed and approved by the Cardiff University School of Psychology Research Ethics Committee, and further permission to conduct the research with an NHS setting has been granted by Health Care Research Wales (HCRW), and Aneurin Bevan University Health Board.

Cardiff University School of Psychology Research Ethics Committee
Cardiff University, Tower Building, 70 Park Place, Cardiff, CF10 3AT
Tel: +44(0)29 208 70360
Email: psychethics@cardiff.ac.uk

Appendix M: Debrief Form

NHS WALES GIG CYMRU
School of Psychology
Ysgol Seicoleg
South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

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Prifysgol Caerdydd
Adeilad y Tŵr
Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

PARTICIPANT DEBRIEF FORM

Understanding how mental health teams integrate peer mentors: A grounded theory study.

Thank you very much for participating in the research.

We hope you found it interesting.

Overall, the research aimed to explore the processes involved in how non-peer staff modify or adapt existing practice when peer mentors are integrated into a team. It is hoped that this research will have implications for the integration of peer mentors into staff teams, for example, it may provide a further understanding of the complex challenges of integration. The implications of this are particularly important as Peer Mentors are considered a vital component to the recovery approach increasingly adopted by services and teams (Watts, Downes, and Higgins, 2014).

If you have any further questions in relation to this study, please do not hesitate to contact any member of the research team and we will try to help.

Lead Researcher

Mrs. Jennifer Berrett thomasjl4@cardiff.ac.uk

Principal Investigator

Dr. Jessica Woolley Jessica.Woolley@wales.nhs.uk

Chief Investigator

Dr. Heledd Lewis LewisH31@cardiff.ac.uk

Co-Supervisor

Dr. Andrew Thompson Thompsona18@cardiff.ac.uk

Alternatively, if you have any concerns about the study and wish to speak to someone independent, you can contact:

Dr. John Fox 02920 870582 foxj10@cardiff.ac.uk

Thank you again for taking the time to participate.

This study has been reviewed and approved by the Cardiff University School of Psychology Research Ethics Committee, and further permission to conduct the research with an NHS setting has been granted by Health Care Research Wales (HCRW), and Aneurin Bevan University Health Board.

Appendix N: Final interview schedule (alterations highlighted)

Interview Schedule

Initial open-ended questions:

What, if anything, did you know about peer mentors before they joined the team?

- [Follow-on]:… and as a team, how much do you think the team knew about peer mentors and their roles within mental health services?

How was the idea of peer mentors introduced?

- [Follow-on]: How did the team prepare, if at all, for peer mentors to start within the team?
- [Prompts]: Can you describe any written information or meetings or informal discussions that you recall about peer mentors starting in the team?

Could you describe your view of peer mentors before they joined the team?

- [Follow-on]: What, if any, preconceptions did you have about the type of person the peer mentor may have been before they came into the team?
- [Follow-on]: How, if at all, has this changed?
- [If speak of change]: What do you think most contributed to this change?
- [Follow-on]: In what ways, if any, did these preconceptions impact how the peer mentor integrated into the team?

Intermediate questions:

How would you describe your team before peer mentors joined the team?

- [Follow-on]: How, if at all, has this description changed since peer mentors joined the team?

- [If speak of change]: What do you think most contributed to this change?
- [Follow-on]: And in what ways does this description of your team impact, if at all, how the peer mentor has integrated into the team?

After peer mentors were employed, could you describe what it was like for you and your practice?

- [Follow-on]: What did you observe in others and their practice?
- [Follow-on]: How, if at all, was any of this different to before peer mentors joined the team?
- [if difference identified]: What do you think most contributed to this difference?

How has communication between the existing team, so non-peer staff to non-peer staff, been since peer mentors joined the team?

- [Follow-on]: How, if at all, has this changed since before peer mentors were employed into the team?
- [Follow-on]: What about between non-peer staff and peer mentors? How has communication between non-peer staff and peer mentors been since peer mentors joined the team?
- [If changes discussed]: What do you think most contributed to those changes?
- [Follow-on]: Could you describe in what ways, if any, does communication between non-peer staff and non-peer staff, differ, to non-peer staff and peer mentor?

Thinking about the different mental health professionals within the multi-disciplinary team, how would you describe how these professions have adapted to peer mentors joining the team?

- [Follow-on]: What professions, if any, do you think have had to adapt more?
- [Follow-on]: How, if at all, does communication between different professional groups and peer mentors differ?

In what ways, if any, is integrating peer mentors similar to integrating another non-peer role?

- [Follow-on]: In what ways, if any, is integrating peer mentors different to integrating a non-peer role?
- [Follow-on if identified]: What do you think most contributes to the similarities [and/or] differences you've described?
- [Follow-on if identified]: In what ways do these [similarities and/or differences] impact, if at all, how peer mentors have integrated into the team?

[Follow-up if difficulties/sensitivities identified in questions above]:

It seems that you might be alluding to challenges or sensitivities about this, could you tell me a little more?

[Follow-up]: Could you describe, if and how, difficulties are communicated in the workplace, and then if and how they are then managed in your workplace?

[if difficulties discussed]: How, if at all, has any of this communication of difficulties changed since peer mentors have joined the team?

End questions:

Could you describe any other adaptations, if any, that the team made to integrate peer mentors that we haven't already discussed today?

Looking back and reflecting on what we have just been speaking about, what might have been helpful to support the integration of peer mentors into the team?

- [if suggest any]: What do you think it was that meant those adaptations were not initially considered?

What do you think have been the most important changes since peer mentors have been employed, if any, in the team and how the team functions?

Is there something else you think I should know to understand how the team has adapted to integrate peer mentors into your team?

Is there anything you would like to ask me?

Appendix O: Confirmation of ethical approval

Ethics Feedback - EC.20.12.08.6176R

P

psychethics
Tue 12/01/2021 10:42
To: Jennifer Thomas
Cc: Heledd Lewis

Dear Jennifer,

The Ethics Committee has considered your revised PG project proposal: *Understanding how mental health teams integrate peer mentors: A grounded theory study (EC.20.12.08.6176R).*

The project has been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,
Sarah on behalf of Adam Hammond

School of Psychology Research Ethics Committee

Cardiff University	Prifysgol Caerdydd
Tower Building	Adeilad y Tŵr
70 Park Place	70 Plas y Parc
Cardiff	Caerdydd

Appendix P: HRA and HCRW approval

Fri 29/01/2021 09:00

Dear Dr. Lewis,

IRAS Project ID:	259989
Short Study Title:	Understanding how mental health teams integrate peer mentors: A grounded theory study
Amendment No./Sponsor Ref:	NSA01
Amendment Date:	13 January 2021
Amendment Type:	Non Substantial Non-CTIMP

I am pleased to confirm HRA and HCRW Approval for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the guidance in the amendment tool.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.
Please contact amendments@hra.nhs.uk for any queries relating to the assessment of this amendment.
Kind regards

Dr Ashley Totenhofer

Workflow Monitoring Manager

Health Research Authority

Ground Floor | Skipton House | 80 London Road | London | SE1 6LH

E.amendments@hra.nhs.uk

W. www.hra.nhs.uk

Appendix Q: Healthboard approval

FW: IRAS Project ID 259989. HRA and HCRW Approval for the Amendment

Good Afternoon,

[redacted]Health Board Research & Development department has received notification of the above named study amendment. There is no local objection based on capacity to implement the amendment at site. Therefore, please accept this email as confirmation of 'No objection' to the amendment being implemented at [redacted]Health Board.
Please note, following the 'UK process for handling UK study amendments' the Sponsor/CI remains responsible for providing details of the amendment, including copies of revised documents, to all participating Investigators and study teams.
It is also responsibility of the Sponsor/Chief Investigator to ensure that all conditions laid out below are met:

- All necessary regulatory approvals are in place for this amendment before implementation.
- If regulatory approvals are currently outstanding for this amendment it is the Sponsors responsibility to ensure that the PI and study team at [redacted] Health Board are kept informed of the progress of this and informed when regulatory approvals are in place. *If any changes are made at the request of the regulators then it is the Sponsors responsibility to inform the PI and study team at [redacted] Health Board of the nature of these changes, so to ensure correct documentation is used at site.*

Kind Regards

[redacted]
Trial Administrator
Research and Development Delivery Team

Appendix R: Coding process examples

Raw Interview extract	Initial coding	Focused coding	Category	Theoretical concept
(ADRIAN)				
People acknowledge completely the role that [peer mentor] does within the team and its- [peer mentor]'s really well thought of and, and people know that [peer mentor]'s good at what [peer mentor] does as well so um, people will quite often ask [them] for [their] opinion and for advice. Um, quite often people will, quite often people suggest [peer mentor] um, you know, "maybe [peer mentor] should see this person, [they]'d be good with them"	Acknowledging the role Working as a team Liking peer mentor Recognising peer mentor competency Approaching peer mentor for support/Involving in clinical care decisions Considering peer mentor in clinical care Matching service user and peer mentor/Recognising 'fit' of peer mentor	Witnessing the role Getting to know the peer mentor Witnessing the role Identifying another layer of service delivery Matching service user and peer mentor	Finding commonalities and aligning values Observed change in service delivery	
(DREW)				
-and I think we're quite a supportive service anyway but when I say more mindful of that, [peer mentor] mental health, that was really about just ensuring that uh, the nightmare that recruitment is and (laughter), and that trac can be, um, that I would hopefully just try and take some of the stress out of that for [peer mentor]. So I guess there was more of a sense of we just need to ease [peer mentor] in a little bit. We made sure that [peer mentor], or I made sure, that [peer mentor] didn't have a massive case load, [peer mentor] came from a huge case load spreading [themselves] rather thinly and being quite stressed, to quite a small caseload and just wanting [peer mentor] to take a breath and settle in.	Describing team characteristics Being more mindful/Clarifying meaning Criticising job recruitment Feeling responsible/Reducing stress for PM Being aware as a team Wanting to 'ease' peer mentor into role Taking responsibility Controlling caseload Contrasting caseloads Highlighting previous challenges to PM wellbeing/Reducing caseload/Allowing peer mentor time to settle	Describing team characteristics Being aware of peer mentor wellbeing Protecting the peer mentor wellbeing Being aware of peer mentor wellbeing Protecting the peer mentor wellbeing Settling peer mentor	Team culture Protecting the peer mentor Utilising relational qualities	'How we all slot together'

Raw Interview extract	Initial coding	Focused coding	Category	Theoretical concept
(JAMIE)				
Um, I'd probably say [peer mentor], the ways [they] sort of does yeah, the way [they've] taken on the role and how [they] is with the patients and- like I said there was, you know, especially with some of the team members they were a little bit unsure of how it was going to work so they might have, been a bit reluctant to sort of, to reach out and support [peer mentor] in the first sort of instance. But it's how [peer mentor]'s sort of just continued, yeah, [peer mentor]'s continued the way [peer mentor] was and now [peer mentor]'s quite well accepted within the team and everyone knows who [peer mentor] is and what [peer mentor] does. Yeah, [peer mentor]'s very good at bringing us together.	Giving opinion Witnessing the role of the peer mentor Recalling team feeling apprehensive Lacking understanding of 'fit' Team feeling reluctant Avoiding peer mentor/Not wanting to support Peer mentor being consistent Accepting PM as part of team/Acknowledging PM/Understanding peer mentor role Feeling united through peer mentor	Witnessing the role Feeling threat emotions Excluding peer mentor Getting to know the peer mentor Trying to find the 'fit' Increasing nurturing response	Finding commonalities and aligning values Experiencing threat emotions Protecting self and team Finding commonalities and aligning values Finding the objective 'fit' Reconnection with values	Experiencing a sense of threat 'How we all slot together'
(JORDAN)				
Um we kind of knew [them] in person as well because at the time even though when [they] was working in a different organisation [they] still came to us for supervision anyway. So for that there is a lot less of a, a, a need to gel or, or get used to this person before [they] started. And also because of that then we kind of have some kind of expectations of what we want from a peer mentor before [they] joined.	Knowing PM previously Recalling previous working relationship Working alongside PM Supporting the role Identifying positives/ Feeling comfortable/ Being familiar Having expectations Identifying 'fit' in team	Knowing the peer mentor as a 'person'/Having previous experience of peer mentors Having expectations	Making sense of the role	Understanding Integration

Appendix S: Example of memo writing

Appendix S1. Interview memo – Charlie, March 2021

This was the first interview where I had tried new questions in the interview schedule, specifically around communicating difficulties. Again, like past three interviews, 'adaptation' and 'difference' are seen as me checking for 'negatives'/ 'Challenges'. I checked with research supervisors to ensure the questions didn't seem leading this way, and I guess it's the nature of the area maybe? That actually, there are expectancies of challenges and thus participants maybe think I am looking for these to be highlighted. I did do a blurb before this interview stating that all new models have both positives and challenges, and we wanted to hear about the whole experience. This was with the hope of participants knowing that positives are also something we want to explore – not just negatives/challenges. I wonder if this actually reinforced looking for negatives as well as put the interviewee at ease to talk of difficulties or differences?

From the interview, I felt like this was the first time the interviewee felt comfortable to talk about some of the difficulties that they had experienced, which the new questions did seem to open up. The blurb at the beginning may have also supported this. It would be interesting to see what future interviews are like – from speaking with research team, I don't think I am leading from the questions or responses I give. Initial coding is suggesting some level of protection around the peer mentor role. Is there something about being protective of the role and thus not wanting to say about challenges? Maybe this is part of the model? Protecting the peer mentor – need to ensure I listen out for this in the future interviews. Focused coding may provide me with some further understanding.

Another thing I'm noticing from the interviews is the 'type of team'. Interviewers one, two and three all spoke about being 'supportive' prior, and two spoke about specific characteristics such as 'small' – linking these to how they managed integration. This interview spoke about nurturing qualities. These examples were often given in contrast to teams which didn't seem supportive or felt different. It would be helpful to interview people from general teams rather than specialist, where the team 'make up' feels different. So far, the interviews have all been specialist teams, thus comparing these differences would be helpful.

I guess this openness to change is demonstrated through the interviews. Is the process of adaption much different to that of another team member coming into the team? What are the differences and similarities, and how do these impact adaption, if at all?

The pandemic has come up again in this interview. This is similar to interviewer 2 – what does this tell me about adaption? I'm hearing a lack of prioritisation around the PM role. It's almost like teams were trying to get their heads around changes due to the pandemic, that they weren't even able to consider this role. Is there something about this making it easier for peer mentors as teams don't have time to be apprehensive (as identified so far but ensure this is really embedded in data as aware SR also states this threat response). Or does it make it more difficult?

I really enjoyed this interview as it seemed similarly to others, that PMs are settling well into teams over time. However, I need to be aware of my looking for ‘positives’, particularly ensuring my responses aren’t leading.

Appendix S2. Memo following interview transcription (Adrian)

Transcribing this interview really made me aware of the 'protective role'. I had reflected on this following interview, and this has just been reinforced. As identified in an earlier interview, I wondered about something to do with 'protection' and maybe that is why there seems to be some possible hesitancy. This interviewee even stated 'I'm not sure if I should be saying something else…' suggesting I may be looking for something different to what they were saying to me. This protection of the role – how does this work with peer mentors? Why are they wanting to protect the role to such an extent? Is it because of well-being maybe? I've already begun to pick up 'being more mindful around wellbeing', however it feels like there is a move from apprehension or uncertainty to protecting the role. How do you move from being apprehensive about wellbeing "are they well enough?" to protect them due to their wellbeing. Need to explore further.

This interviewee spoke about comparing the role to other roles in the team to provide understanding. It seemed identifying a team of professions which support 'recovery focused' working can really help peer mentor work. Does this fit with the type of team? If you aren't diverse already including "recovery-focused-like" professions – does it make it difficult for a non-peer to picture what the role might be? And actually having this group of people then helps support this?

I felt like I may have led one or two responses in this interview. I really need to ensure I don't slip into *clinician* mode. However, I did feel the answers sat with their previous responses thus didn't seem to impact what they said. Need to keep an eye.

Appendix S3. Conceptual category development memo – Observed change in service delivery

Definition

This category has emerged after making constant comparisons between all the aspects of the data including codes, memos, reflective journal and categories etc. What emerged is the change that teams experience following the integration of the peer mentor in relation to how they deliver services. It was important that this category stayed grounded in the data, as there may have been some assumption that there would be change and I guess the hope was that the change would be positive. However, using the reflective journal and memos for coding and interviews, there were descriptions of how the non-peers experienced change to service delivery through the integration of the peer mentors. These were reinforced by the focused codes created focusing on: 'Changing approach to client care' ‘Valuing the role’ ‘Identifying another layer of service’ ‘Recognising the power of lived experience’ ‘Enhancing team delivery’ ‘Connecting with clients’ ‘Needing additional support with clients’ – These were all describing the changes that were experienced as a result of the integration of peer mentors.

The concept is described below by Jordan:
"One is now, we, we can have some clients can access to some intervention much earlier than they would, because at the moment our waiting list is fairly long, and some clients we, if we think they need, their needs are greater then we can get peer mentor intervention earlier so they don’t feel being left out or left in the cold you know whilst on the waiting list. And the others, for example I have a client now ask me went along doing different type of things in sessions, peer mentor can come in and help him understand what we talked about and actually put some experiments, you know behaviour experiments as part of planning for them. So yeah all these, all these, you see a lot of change in terms of what we can do. Far more flexible I would say."

How does it arise?

Jordan's extract refers to not only meeting client needs due to their waiting list being fairly long (thus identifying a service), Jordan is also being supported by the peer mentor in the work that they do, meaning the service users become more connected with the service, the service is being enhanced. Jordan describes it as being more 'flexible', which fits closely with a recovery-focused model of working and person-centered approach where clients aren't placed into rigid boxes (as they spoke about in their interview: *LINK: RECONNECTION WITH VALUES).*

As you can see, Jordan's extract is able to describe on the surface how the change comes about: employing the peer mentor. However, through constant comparison, there is also a need to go through *'How we all slot together'* concept – finding the ‘fit’ so in Jordan’s extract, that would be supporting the sessions by e.g. getting involved in behaviour experiments.

An example is found in the interview with Charlie, who talks about how working collaboratively allows a '_FC Change approach to client care' thus linking *‘how we slot together’* to *‘observed change in service delivery’*.

"Yeah. Because we do tend to get them involved with the ladies who need more than one visit a week. We tend, what we’ve found [...] So we’ve been able to intensely nurse them at home where they might have 3 or 4 people in the team involved? And one of those people will be the peer mentor."

How does the concept be maintained or changed?

Factors which influence whether this concept is maintained (continue to experience positive change) or changed (experience negative change) include both relational and situational factors. Relational was suggested by only one participant, who referred directly to the experience of their relationship with the peer mentor.

Adrian:
"[…] [Peer mentor] could have come along and been completely different and being somebody that clashed, we clashed personalities wise and, and the experience that I had may well have not been so positive. But that wouldn't have be anything to do with [them] being a peer mentor, that could be any member of staff couldn't it? that could happen, because you're not going to get on with everybody all of the time."

This really demonstrates the relational processes coming through in the model. It's not just about recognising gaps in service delivery, or objectively measuring e.g. 'waiting list is long' thus needing a peer mentor due to this. It is also about relationships that are built with the peer mentor so the person 'behind the role' *(LINK: Finding commonalities and aligning values]*. Adrian's comment really shines light on this. If the *person* didn't fit, then this category of positive change may also be changed. Same as it is maintained by personalities which don't clash, and work collaboratively together.

Additionally, allowing the peer mentor autonomy provides the peer mentor with space to 'enhance' the service. This has been seen through the additional services being provided due to the specialist interest of the peer mentors. Again, this is in *'how we slot together'* - and is vital to experiencing positive change. Charlie's interview really demonstrated this when they discussed how they were providing care to new clients (also reinforced by other interviews who were keeping clients for longer). This was a special interest of the peer mentor (based on their lived experience), and Charlie describes how they allowed autonomy to see how this would work, and spoke about the change in a positive light.

What are the consequences?
All participants spoke in some respect to wanting to protect the peer mentor role. This is linked to both the need to protect their 'wellbeing' but also due to witnessing the value of the role and it's positive impact within the teams *[LINKING: 'PROTECTING THE PEER MENTOR]*. Teams wanted to learn from the role for future integration, and wanted to ensure the role didn't become over-loaded to ensure the peer mentor was able to continue in the role. This want to nurture the role was a change for some participants who may have experienced an initial threat response and thus actually excluded the role.

Adrian: "It doesn't matter [...] whether there's a peer mentor in the team, or whether there's a peer mentor coming into the team, even without peer mentors, I think that stigma, um, being able to get rid of that stigma, what might help is, is people having an understanding of peer mentor's role and what peer mentors do, rather than people just assuming or being left, left to assume I guess, because if nobody knows, you do then make those assumptions don't you, and you, you start to make your own judgements and opinions on something you don't actually know. But um, I think if some of that stigma could be stamped out if people had a better understanding, regardless of whether a peer mentor was coming to work with them or not, just a better understanding in general."

This extract brings the model full circle, by linking in how those initial assumptions through how you make sense of the role might lead to stigma for the peer mentor role. This interviewee wanted this peer mentor role to be successful and the peer mentor to feel settled in the role. They also spoke about wanting to protect the role which was very important to them. They described in their interview how people came to value the role and thus the role becomes ‘overstretched’. Therefore, their learning was to think about the initial set-up and how this could be changed, protecting the role from future stigmatisation within services and thus allowing it to be successful as a result of the 'positive change' the interviewee has experienced/witnessed.

Appendix T: Theoretical sampling examples

Commonalities and gaps identified	How commonality and gap identified	Potential missing gaps in future data collection	Methods in line with theoretical sampling	Outcome
Participants assume questions are asking about 'negative adaptations', and identify when what they say is not a negative. Is there a bias in the questions or a concern of voicing difficulties?	Initial codes of first three interviews. Research diary. Memo following early interviews.	Participants potentially voice what they think researcher may want to hear, or find it too difficult to spontaneously voice difficulties in detail.	Discussion with research team to ensure no bias in interview schedule (enhancing quality control). Changed interview schedule following first three interviews to include prompts around how difficulties are communicated and managed in team.	Identified how difficulties are communicated and managed in team. Demonstrated common themes emerging around team culture, communicating within teams and 'personal qualities'
First four interviews from specialist teams voicing differences between specialist and generic mental health teams.	Initial codes of first four interviews Research diary. Memo following early interviews.	Potentially data is specific to certain types of teams, and unable to use constant comparison methods across teams to see similar or different occurring processes.	Asked for email advert to be re-distributed, with emphasis on recruitment from a variety of services.	This identified the impact of the 'type of team' on how teams adapted to peer mentors, including team qualities. Questions added to interview schedule following interview 6 to confirm this.
First six interviews describe characteristics of participants linking to how they've come to 'fit' in teams.	Initial codes and focused codes of first five interviews. Research diary. Memo writing. Development of categories.	Need to strengthen this concept development, and the process being identified. Unsure if non-peers have preconceptions of peer mentors, and this is an identified change and/or whether this process of getting to know the peer mentor is key in making changes?	Added questions into interview schedule following sixth interview exploring preconceptions of peer mentors, including how these may have changed if at all, and how the this contributed to integration if at all.	Participants spoke more in-depth about relationship with peer mentor, and how getting to know the characteristics of the peer mentor allowed them to have view changes and reduce uncertainty/ previous assumptions

Appendix U: Two interview extracts

Interview with Jamie:

Interviewer: Yeah. And how was the idea of peer mentors introduced to the team?

Jamie: Um I think it was brought up in a team meeting I think? With our manager. And [manager] sort of, when they were in discussion about it, yeah they sort of said what the plan was because it wasn't just our team, there were a few teams within mental health services that were going to have, or trial the peer mentors. And we were one of the ones chosen. And it was yeah, it was put forward as, as what was going to happen and yeah it wasn't sort of- yeah, it was met a bit with some concerns at first. People weren't really sure how it was going to work in that you know, with our team and, yeah. I think that's how it was introduced. I think it was probably a good few months before [peer mentor name] started before that they first mentioned to the, in the you know, to the team as a whole.

Interviewer: Yeah. Yeah. And how did the team then prepare, if at all, for the peer mentor, or [peer mentor name] joining the team?

Jamie: Um I'm not- I don't think they prepared as such because it was awkward as I'm sure [peer mentor name] started in the April and I think it was sort of- [peer mentor] started just after COVID had hit. So I think we were, we were aware of [peer mentor] coming before COVID but then I think that, that sort of threw a spanner in the works. I think we would have had a bit more preparation done if it had not been COVID. But um, yeah I said you know, there were, there were sort of discussions in the office prior to [peer mentor] starting, there were concerns about um, yeah, just cos the, the sort of team sometimes feel like their office is like a safe space to discuss patients and it was that, you know, would that be appropriate to discuss them in front -you know, with a peer mentor present.

Interviewer: Mmm, yeah. And can you describe um any written information, or any informal discussions, or any formal meetings that the team kind of had before the peer mentor started, if any?

Jamie: As far as I know it was all informal, it was like our team meetings and, and just sort of discussions in the office with our, our manager. I don't think there was any- I'm not aware of any formal um meeting as such.

Interviewer: Okay.

Jamie: Um, no the first time I met [peer mentor name] was when [peer mentor]- I think I saw [peer mentor] on [their]- I might have possibly seen [peer mentor] on [their] interview, on [their] interview day. But I don't think we met [peer mentor] properly until [they] started in the April.

Interviewer: And-

Jamie: No, sorry. [Peer mentor] did come in. I'm sure [peer mentor] did come in for- to meet the team prior to [their] start date. Yeah, we had like a little meet and greet with [peer

mentor]. It was very awkward with COVID, it was very awkward for [peer mentor] to pop in and see everyone. It was, yeah, it was quite difficult, but yeah, we did get to see [peer mentor] before [they] started officially.

Interviewer: Yeah. And could you describe what your view of peer mentors were before um, peer mentor joined the team?

Jamie: As I said I was, yeah, I didn't know anything about the service, about the role to be honest. So I, I didn't sort of see when the clinic- clinicians were discussing their sort of issues and concerns, I didn't really understand where they were coming from at first because I couldn't see, couldn't see it from their point of view. But you know, listening to their concerns I could sort of understand where they were coming from.

Interviewer: Mhmm

Jamie: But um, yeah I didn't know, no I didn't know anything about the role before [peer mentor] started.

Interviewer: And did you have any view then of, of what the peer mentor role might be or?

Jamie: No well only from what we were told by management, only from what [manager name] saying was how [peer mentor] was going to help support patients when, when, while they were with us, while the patients were under the team. But I suppose it's one of those things they were, they have an outline of what the role would be but as, as with a lot of things it changes once its actually in place, it does change. But that was our understanding was that [peer mentor] would be helping to support patients that were in our care.

Interviewer: Okay. And how, if at all, has your view changed now?

Jamie: Oh massively. Like seeing, seeing what [peer mentor] does with the patients and how [peer mentor] is and, with the team as well, [peer mentor]'s very good at sort of bringing us sort of together to do things as a team. And it's, yeah its lovely.

Interviewer: And what do you think has most contributed to that view change?

Jamie: Um, I'd probably say [peer mentor name], the ways [peer mentor] sort of does yeah, the way [peer mentor]'s taken on the role and how [peer mentor] is with the patients and- like I said there was, you know, especially with some of the team members they were a little bit unsure of how it was going to work so they might have, been a bit reluctant to sort of, to reach out and support [peer mentor] in the first sort of instance. But it's how [peer mentor]'s sort of just continued, yeah, [peer mentor]'s continued the way [peer mentor] was and now [peer mentor]'s quite well accepted within the team and everyone knows who [peer mentor] is and what [peer mentor] does. Yeah, [peer mentor]'s very good at bringing us together.

Interview with Robin:

Interviewer: […] And how if at all was any of this different to before the peer mentor joined the team? You know, so you know kind of the differences you've noted in working and others' practice, how was any of it different?

Robin: Um (pause 6 secs) I don't- I wanna say it feels like [peer mentor] brings the human in the room if that makes any sense at all, [peer mentor] brings the human in the room. Um, yeah I think it's kind of, I think it takes the power away from [profession]. That kind of power of "I'm a [profession], I'm going to treat you", and it's kind of taken that kind of power away, which I'm all for. Um, yeah I would say possibly [peer mentor] brings the person in the room so you're kind of more thoughtful about what you say in handovers and how you kind of approach um- cos, cos obviously handovers is where you obviously vent all your feelings and if, you know, for some reason you don't have a good relationship with a certain person, that's where you kind of like vent it. Um, and [peer mentor] brings the hu- human in the room so, and, and to be fair to [them] [peer mentor] obviously doesn't create a, a mat- like strong relationship with everyone [peer mentor] meets because we're human. Um, yeah.

Interviewer: Okay. So is that what you mean by [peer mentor] brings the human in the room? [Peer mentor]'s kind of um, I guess challenging as you mentioned there-

Robin: Yeah, yeah.

Interviewer: -some of the-

Robin: Yeah. It's like when [peer mentor]'s in the room it feels like, yeah, you're more compassionate in kind of like your handovers and more compassionate in the way you discuss um, certain people yeah.

Interviewer: And what do you think most contributes to that difference? So that kind of becoming more compassionate for example, what do you think it is that contributes to that the most?

Robin: Being a human. Being a human being and just remembering that we're all human beings and we do not know how we're going to respond in any circ- any set of circumstances. Yeah.

Interviewer: Okay. And just thinking a bit about communication now [name of participant]. So how has communication been between the existing team, so that's the non-peer staff to non-peer staff, um, how has that been since the peer mentors joined the team? So thinking of your old team.

Robin: Could you reword the question? I don't quite get it.

Interviewer: Yeah so its how's the communication between the existing team, so before the peer mentors joined the existing team, how has that been since the peer mentors joined the team?

Robin: It improved, slowly but it improved. It did, thankfully. Um, because I think even as clinicians there are times where you go "oh no, why did you say that". Um, because it's alright to say "I'm annoyed" and that's okay but I think there is a very fine line um, of when you actually overstep the mark and you're actually saying something at somebody's expense. Um, yeah. I think it has improved.

Interviewer: So it sounds like there has been a little bit of change there.

Robin: Yeah.

Interviewer: And what about between non-peer staff and peer mentors, so how has communication between non-peer staff and peer mentors been since um peer mentors joined the team?

Robin: It's improved, obviously [peer mentor]'s kind of gone from people ignoring [them], love [them], the worst thing (sigh). I'd say "Shall we go for a walk love, come on" . Yeah and obviously people then embracing [them] and being like "Oh no [peer mentor] can do this, oh no I think that actually that would be really, really good for [them] to do that" Um, so more communication. Because [peer mentor] wasn't even having any of those informal chats that you have with people like "oh how's your day? The weathers nice". Um, it's pretty much- as I'm saying it, it sounds like passive bullying doesn't it, it is. Um, but yeah.

Interviewer: Mmm. And what do you think most contributed to um those changes in communication?

Robin: [Peer mentor] being amazing. Just being absolutely amazing, and I think the changes in communication, I think, because the staff group changed, the whole dynamic changed and I think that was a huge, huge, huge aspect of it. And I think having more people on the scale of, kind of, old fashioned, let's be a bit more flexible, swaying towards being more flexible, helps the communication because then that kind of became the minority um of nega- like old fashioned kind of thinking. Um, yeah.

Interviewer: And can you describe in what ways, if any, um does communication between non-peer staff and non-peer staff, differ, to non-peer staff and peer mentors?

Robin: Say it again sorry.

Interviewer: That's okay. So could you describe in what ways, if any, does communication between non-peer staff and non-peer staff, differ, to non-peer staff and peer mentors?

Robin: I think- and even now they do do it, they do, they try to fluff it up a bit. Um so even though it's a lot more balanced now, there is still some of that fluffing up and there is still some of, um, you know in handovers it might get a bit negative. Um, but much, much less so, so much less so now there's a peer mentor in the team. Um, and kind of when [peer mentor]'s in the room, the communication is so much nicer, it is so much nicer.

Interviewer: Yeah, okay When you say fluff it up a bit-

Robin: *Laughter*

*Interviewer: *Laughter* Can you elaborate a little bit more on that?*

Robin: Um, so, okay. How do I mean by fluff it up? So, probably be more articulate about the way that they express themselves- see I'm not good with it. Um, so being more compassionate in the way they describe things, so instead of just being like "oh [service user]'s bloody self-harmed again" it's like "oh no [service user] felt the need to- you know, [service user] felt like [they] needed to do that".