A Meta-Ethnography of Factors Contributing to a Positive Experience for Those Within Mental Health Peer Support Roles, and a Grounded Theory Analysis Exploring the Processes of Readiness for Initial and Sustained Involvement for Service Users Involved in Mental Health Co-Production Activities

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PREFACE

In recent years organisations have recognised the value and importance of embedding co-production within mental health services. Co-production in mental health settings refers to a process in which service users, carers and staff work together as equal partners towards shared goals (Social Care Institute for Excellence, 2015). Relating to the term co-production are various levels of peer involvement, with roles including 'Expert by Experience' and 'Peer Support Worker', as well as initiatives such as 'Service User Networks' and 'Recovery Colleges'. As co-production has become more common practice, there has been an increase in research in the field. Much of the research to date has explored implementation issues and barriers faced as mental health services move towards this new way of working. Whilst this research is valuable, much of the research overlooks the importance of ascertaining the perspectives of the individuals employed in such roles or focuses on identifying the challenges faced within roles. This thesis places its focus on the individuals engaging in co-production activities in two ways; firstly, by exploring through a systematic review of the literature to identify what has contributed to a positive appraisal of involvement for individuals within roles, and secondly by describing an empirical investigation of the processes involved in initial readiness and subsequent sustained involvement in co-production activities.

Paper one presents a qualitative meta-synthesis employing the method of meta-ethnography to synthesise and present the data. The systematic review aimed to provide new insights and a conceptual model related to the factors that contribute to a positive experience for those providing a peer support role in a mental health setting. A systematic literature search resulted in twelve studies meeting the agreed inclusion criteria. Studies were subsequently quality assessed.

Through following the processes of meta-ethnography, three core concepts of 'organisational processes', 'internal processes' and 'relational processes' were identified. Within the core concept of 'organisational practices' were the subordinate concepts of 'clear avenues of support', 'commitment within the system', 'clear role structure and responsibilities' and 'professional development opportunities'. Within the core concept of 'internal processes' were the subordinate concepts of 'feeling trusted to work autonomously', 'personal development and growth' and 'sense of making a difference'. Finally, the concept of 'relational factors' encompassed the subordinate concepts of 'positive interactions with staff', 'integration within the team' and 'connection with those in similar roles'. The findings of the review have implications for clinical practice, with organisations needing to consider how they integrate individuals within the immediate and wider system, as well as considering how they provide sufficient opportunities for personal and professional development.

Paper two presents a grounded theory analysis exploring the processes underlying individual readiness for involvement in co-production roles, as well as considering factors influencing their sustained involvement. Within the current co-production research literature, there has been limited exploration of factors involved in peer readiness for involvement and the processes that may underlie this. The current study aimed to use the insight gained to develop a theory that can be used to inform the development of guidance around supporting individuals to become and remain involved in roles outside of their own care. Ten individuals recently involved in co-production activities completed semi-structured interviews. Analysis of data was conducted using a constructivist grounded theory methodology.

The emerging theoretical model described several key processes that individuals navigate prior to, and subsequently during, their journey into co-production activities. Individuals' initial motivation for considering involvement was found to be an important component of their journey to readiness. Motivating factors were shaped by participants' previous

experiences of mental health services and often involved a sense of desiring change, both within the mental health system and within their own identity. Processes involved in readiness included: 'building awareness of own mental health', 'desire for personal growth' and 'recognition of their own potential'. Perceived readiness for involvement was also deemed to be influenced by a range of external factors, with particular importance being placed on organisations providing opportunities for meeting with others in similar roles, as well as roles that allow for 'graded exposure' to clinical activities. Wider influences on individuals and the process of becoming 'ready' were identified, with normalisation of mental health within organisations emerging as a key concept. With regards to ongoing involvement in activities, participants discussed a variety of positive and negative aspects of experiences that influenced this decision. Recommendations for clinical practice are discussed, specifically the need for organisations to provide individuals with opportunities to meet others in role prior to involvement and to provide clarity within roles. Importantly, the research identifies a need for organisations to demonstrate commitment to providing a work environment that clearly acknowledges the value and importance of learning from and working with individuals throughout their recovery journey.

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PAPER 1

What Factors Contribute to a Positive Experience for Those Employed in Peer Support Roles in Mental Health Settings? A Meta-Ethnography

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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

The involvement of peer specialists in mental health services is increasingly being valued. Research recognises that peers within such roles report varied experiences. This review aimed to provide new insights and a conceptual model of factors that contribute to a positive experience for those providing a peer support/specialist role in a mental health setting. A systematic review of the qualitative literature was conducted, investigating peer support providers' experiences within such roles. Twelve studies met the inclusion criteria and were subsequently quality assessed. The qualitative method of meta-ethnography was adopted to synthesise the data, with three core concepts being identified. The findings of the review indicate that organisations, both at a wider and more immediate team level, make a large contribution to the experiences of peer specialists within their roles. The review identifies a number of relational factors that have an impact on peer specialists' experiences. Importantly, the review highlights a number of areas that facilitate a positive experience within peer support roles. Recommendations for clinical practice identified include the need for organisations to provide structures of support that facilitate both professional and personal development, opportunities for accessing support and guidance from others in peer support roles, and role clarity.

Key words: Qualitative; peer support; mental health; peer specialist; expert by experience; role satisfaction; service user

INTRODUCTION

In the last 30 years, governments both within the UK and internationally, have placed increased emphasis on embedding peer support roles within mental health services as part of embracing a recovery orientated model of mental health care (Davidson, 2016). Solomon (2004) defines peer support services as being ‘‘provided by individuals who identify themselves as having a mental illness and are receiving or have received mental health services for their psychiatric illness and deliver services for the primary purpose of helping others with a mental illness’’ (p. 393).

Peer support can take many forms and exists in many guises, and at various levels. Peer support in mental health settings can range from informal online forums to regular mutual support groups, through to initiatives and roles forming part of formal healthcare services. A briefing from the UK organisation ImRoc in 2013 (Implementing Recovery Through Organizational Change) defines eight core principles of peer support that are applicable across a range of settings: mutual (shared experience of mental illness), reciprocal and non-hierarchical, non-directive, recovery-focused, strengths-based, inclusive, progressive, and emotionally safe.

Whilst in the 1970s and 1980s peer support within mental health settings evolved to be seen as an alternative to the mainstream mental health system as part of the ‘Mental Health Consumer Movement’ (Davison et al., 2006), government funded organisations are now increasingly recognising the value of peer services and investing in the introduction of peer support roles within their mental health services (Moran et al., 2012). This shift towards incorporation of peers within existing services, as opposed to externally operating, is likely to have been influenced by the increased recognition of the potential value of such roles. Indeed, in the UK, the Department of Health (DOH) recognises peer support as an important

facilitator of individual mental health recovery, as well as recognising the link between involvement and positive recovery outcomes for recipients (DOH 2008, 2012). This notion was further supported by a review from The Centre for Mental Health (2013) which commented on the unique position of peer support workers within mental health settings, remarking on their perceived ability to move away from the symptom and dysfunction focus often seen in traditional healthcare settings.

Alongside published reports and guidance, the body of research evidence related to the impact of peer support roles has grown in recent years. Peer support models have demonstrated effectiveness in a variety of settings and with a variety of psychiatric presentations including 'borderline personality disorders' (Barr et al., 2020), and 'severe mental illnesses' (Fan et al., 2019; Fortuna et al., 2020). Recent qualitative literature reviews appear to confirm the potential for peer support services to achieve recovery outcomes in line with those seen in traditional mental health settings (Davidson, 2016; King & Simmons, 2018; Shalaby & Agyapong, 2020).

Many researchers have chosen to focus their efforts on identifying the benefits for those receiving peer support. Research has revealed wide-ranging benefits for peers including areas of functional/tangible improvement e.g., reductions in hospitalisations and use of crisis services, reduction in symptoms, reduction in substance abuse and an improvement in practical and employment skills (Clarke et al., 2000; Davidson et al., 2012; Felton et al., 1995; Lehman et al., 1997; Rowe et al., 2015; Sledge et al., 2011; Solomon & Draine 1995; Van Vugt et al., 2012). An overall increase in satisfaction with services received has also been reported as a benefit (Gates & Akabas, 2007). There have additionally been reported psychological benefits related to recipients' sense of self, with receiving peer services being linked to an increased sense of autonomy, belonging, self-efficacy, self-esteem, and

hopefulness (Davidson et al., 2012; Rowe et al., 2007; Slay & Stephens, 2013, Sledge et al., 2011; Solomon & Draine 1995; Vayshenker et al., 2016).

Whilst the aforementioned studies suggest a benefit from receiving peer services, it is important to acknowledge that research in this area has been critiqued for its lack of high-quality research studies, often relying on service evaluation and low-quality case studies as opposed to Randomised Controlled Trials (Gillard, 2019). A recent meta-analysis by Burke et al., (2019) specifically investigated the impact of mental health peer support interventions on outcomes of self-stigma, empowerment, and self-efficacy in recipients. They reported small but significant improvements in empowerment and self-efficacy for those receiving group-based peer-led interventions but commented on the vast majority of included studies being classed only as 'moderate' or 'weak' quality. They additionally noted the lack of high-quality research regarding the impact of one-to-one peer support.

Whilst there has largely been a focus on the experience of recipients of peer support and the implications and/or barriers to implementation at a service level, in recent years a body of literature has emerged regarding the experiences of the providers of support; the peer specialists themselves (Clossey et al., 2016). Much of the emerging research has concentrated on identifying the barriers and challenges faced by individuals entering such roles. Indeed, researchers Forbes et al., (2021) acknowledge that peer specialists face barriers unlike any other role within the mental health system. Gates & Akabas (2007) have examined the challenges and difficulties faced by peer specialists when employed by mental health services, suggesting five problematic areas: poorly defined jobs; negative attitudes from non-peer workers; role conflict and confusion; lack of clarity around confidentiality; and limited opportunities for networking and support. Building on this investigation, in the UK a consultation commissioned by Together in the United Kingdom highlighted several challenges to the professionalisation of peer support services including: a lack of financial

support; inappropriate content of existing training programs; and misalignment with existing organizational structures (Faulkner & Kalathil, 2012). In recent years, research has highlighted the impact that the aforementioned misalignment can have, suggesting that a lack of organisational understanding of the roles has resulted in negative consequences for individuals in peer specialist roles including a lack of training opportunities, poor pay, and discrimination or prejudice from non-peer workers (Adams, 2020; Jones et al., 2020; Kuek et al., 2021).

Perhaps prompted by the plethora of research emerging regarding the difficulties faced by peer specialists and their associated organisations, consideration is increasingly being given to factors that contribute to a positive experience for peer specialists within organisations. A recent Australian study by Scanlan et al., (2020) surveyed 67 peer workers using measures of job satisfaction, burnout, job demands and opportunities for development, with the survey also exploring the contributing factors to these ratings. Researchers found that resources of social support, job control, feedback, and rewards and recognition were associated with positive workplace experiences. Several other recent studies have identified role clarity, respect from staff, autonomy, and a clear understanding within the organisation of their job role as important factors in peer job satisfaction (Cronise et al., 2016; Kuhn et al., 2015).

It is important to acknowledge that the aforementioned studies used pre-determined categories and relied on descriptive, quantitative reports via the use of surveys to assess the experiences of peer support workers. There has been recent recognition of the need for rich, qualitative studies that allow for further exploration of the factors and mechanisms that contribute to effective and positive peer support work experiences (Gillard, 2019; King & Simmons, 2018).

Rationale for the current review

Recent systematic reviews in the area of peer support in mental health settings have focused on implementation issues from an organisational perspective (Aakerblom & Ness, 2021; Ibrahim et al., 2020; Mutschler, 2021) as well as 'consumer' views of the benefits of access to peer specialists (Burke, 2019; Miyamoto & Sono, 2012). Within the existing literature, there has been an acknowledgement of the need to further explore and understand the experiences of peer specialists. Despite this, to date, there has been no formal qualitative synthesis of factors that contribute to a positive personal appraisal of involvement for peer specialists. Walker and Bryant (2012) completed a qualitative meta-synthesis of peer support in mental health services which included commentary on the experiences of peer specialists. However, this review did not have a clear focus on the contributing factors to a positive experience for those within roles, choosing to broadly cover the experiences of providers, consumers, and organisations. Additionally, the analysis largely focused on describing and identifying the frequency of challenges and benefits encountered by peer support workers, as opposed to attempting to construct third order concepts based on the reviewer's interpretation of the first and second order concepts alluded to by the original studies (Schutz, 1962). Whilst the qualitative review described above is undoubtedly insightful, there is a need for a qualitative synthesis with an exclusive focus on the experiences of the peer specialists. The aforementioned review by Walker and Bryant included studies dated from 1990-2010 and as such it was felt that the commentary of this review in relation to consumer providers' experiences may be out of date. Therefore, an in-depth and up-to-date exploration of current peer specialists' experiences was indicated as qualitative syntheses can become out of date, as experiences, beliefs and social phenomena change over time (France et al., 2016).

Aims of the current review

This review aimed to provide new insights and a conceptual model related to the factors that contribute to a positive experience for those providing a peer support role in a mental health setting. It was hoped that having a greater understanding of factors that contribute to a positive experience for individuals within such roles, may inform and encourage organisations to consider what may be helpful in their future employment and support of such individuals.

METHOD

The study consisted of three overarching stages: 1. Systematic literature search 2. Critical appraisal of studies and 3. Data synthesis. The stages will be outlined below.

Protocol and registration

The protocol of this systematic review was registered on PROSPERO (International Prospective Register of Systematic Reviews) on 15th July 2021 and subsequently amended (details of method of analysis added) on 5th November 2021 (Registration number: CRD42021256491; see Appendix B).

Systematic literature search

A comprehensive database search was conducted in November 2021 to identify qualitative literature investigating the experiences of individuals employed in a role outside of their own care within a mental health setting. As previously referred to, this encompassed a variety of levels of involvement and roles within mental health services and included individuals working within roles including 'Peer Specialists', 'Peer Support Worker', 'Consumer Provider' and 'Expert by Experience'. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance (Liberati et al., 2009) was followed to

inform the process of identification, selection, and critical appraisal of the identified research papers.

Search terms used were identified through discussion with supervisors, discussion with an information specialist and initial searching of the background literature by the author. Agreed search terms were subsequently combined within each concept with the Boolean operator 'OR 'and across all concepts with 'AND'. An example of the search terminology used can be found in Appendix C.

Searches were undertaken via: PsycINFO (via OVID), MEDLINE (via OVID), Scopus (via Elsevier), CINAHL (EBSCO) and Web of Science. The grey literature, including relevant policy documents and third sector published materials, was identified using Google Scholar, openDOAR, OpenGrey and EThOS. Additional searching was completed via backward searching of reference lists of papers meeting the inclusion criteria and forward searching of studies citing the included papers. All returned papers from the main search and searching of the grey literature were collated via Endnote software and duplicates removed. Titles and abstracts of remaining papers, following further manual duplication removal, were screened independently by the lead reviewer based on the inclusion/exclusion criteria outlined below. A second independent reviewer screened 10% (N=27) of articles at the stage of abstract reviewing, with inter-rater agreement being 100%. Search results at each stage of this process were reported using the aforementioned PRISMA flowchart.

Searches were limited to articles published in English. Following consultation with experts in the area (who commented on the relative infancy of the research area), no limits were placed on the year of the studies included. Copies of the full search strategies used in the review are available from the author. The inclusion and exclusion criteria were agreed with supervisors and are outlined below (Table 1).

Table 1*:* Inclusion and exclusion criteria:

Inclusion	Exclusion
Qualitative studies of various methods including- focus groups, interviews, case studies, open-ended questionnaires.	Exclusively quantitative studies.
Mixed-method studies where the qualitative data is extractable.	Mixed method papers where qualitative data is not extractable or is insufficient.
Studies where roles of peer support or similar are within a mental health setting.	Studies involving peer support in a non-mental health setting.
Research clearly includes perspectives of providers of peer support (can also include reference to recipients and professionals alongside this).	Research solely investigating perspectives of recipients of peer support or professionals involved in peer support initiatives.
Primary empirical research, peer reviewed articles.	Papers which are not primary empirical research (e.g., systematic reviews, books).

Papers that met inclusion criteria based on the title and abstract screen were then collated for full text review. This process was completed independently by the main reviewer based on the above inclusion and exclusion criteria. A second independent reviewer screened 10% (N=5) of full text articles for inclusion at this stage. Inter-rater agreement was initially 80% (4 out of 5 papers) but following further clarification of the inclusion and exclusion criteria, full agreement was quickly reached.

Critical appraisal of studies

The use of a quality appraisal tool, and subsequent strong inter-rater reliability via independent rating of the papers by an external rater, was an integral part of the systematic review process. It is nonetheless important to note that this review did not include or exclude papers based solely on the quality appraisal rating. Atkins et al. (2008), whilst providing in-depth commentary on the process of conducting a qualitative meta-synthesis (specifically using the meta-ethnography method), found that quality appraisal ratings of qualitative research often provide a reflection of the quality of the written report rather than the study

itself, adding that despite this, the process of completing the quality appraisal helps researchers to identify the papers contributing most meaningfully to the overall synthesis. In line with Atkins et al. (2008) throughout the quality appraisal process, the author placed greater emphasis on the richness of papers and the 'thickness' of the data. 'Thick' data was characterized by the use of at least semi-structured interviews and a minimum of a thematic analysis of the data presented (Knowles et al., 2014). This is in contrast to 'thin' or descriptive data which lacked detailed qualitative analysis and provided few quotations in relation to reported experiences.

The Critical Skills Appraisal Programme (CASP) checklist for qualitative studies was used by the reviewer to assess quality of papers chosen for inclusion. The CASP checklist is one of the instruments recommended by the Cochrane Collaboration (Noyes et al., 2008). The checklist incorporates the principles and assumptions underpinning qualitative research, with consideration being given to the following: clear statement of purpose; appropriateness of methodology; design and recruitment strategy; data collection procedure; recognition of the relationship between the researcher and participant; ethical consideration given; rigor of data analysis; clarity of findings; and value of the research. Whilst there is no designated scoring system for the CASP checklist, in line with previous systematic reviews in the area of peer support (Charles et al., 2020; Ibrahim et al., 2020) a basic scoring system was introduced. 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 meta-ethnography research commentary and comprehensive guidance from Toye et al. (2014), half a point was allocated to questions where the allocated rating was 'can't tell' or 'partially met'. A maximum score of nine was possible for each study, as question 10 was not formally rated. This decision was made as question 10 was deemed to be highly subjective, measuring predicted impact and value as opposed to measuring methodological quality. In line with other meta-syntheses (Fox et al.,

2015; Graham et al., 2020), studies were graded from A to C to indicate their methodological quality based on their CASP score. Table 2 below describes the scoring system utilised:

Table 2: CASP scoring system

Grade	Likelihood of methodological flaws	Score on CASP
A	Low	8.5 or higher- no confirmed significant methodological flaws
B	Moderate	5 to 8
C	High	Less than 5

A proportion of included papers (N=4, >25%) were inter-rated, again using the CASP tool, by a Trainee Clinical Psychologist with no affiliation to this project. Inter-rater agreement was 97.2% and any disagreements were discussed; comparing the relevant paper to the CASP item until 100% agreement was reached between both reviewers.

Data Synthesis: Development of meta-ethnography

The overarching method of synthesis followed by the author was that of meta-ethnography proposed by Noblit and Hare (1988). As a form of qualitative synthesis, meta-ethnography aims to go beyond the description of existing data, using an inductive approach with the aim of new conceptual development through the reinterpretation of published findings (Britten et al., 2002). Meta-ethnography has established itself as the leading method of qualitative synthesis across diverse areas of healthcare (Campbell et al., 2011, Ring et al.,2011) and was deemed to be the most appropriate and comprehensive method of qualitative synthesis for the chosen subject area.

Noblit and Hare (1988) outlined a seven-stage approach to completion of a meta-ethnography, this is outlined below (Table 3) alongside commentary of how this guidance

was adhered to by the current reviewer. It is important to note that the stages contained within the approach are not entirely linear and at times stages of the process overlapped, as would be expected when utilizing a constant comparison method (Charmaz, 2014).

Guidance throughout the synthesis was additionally taken from the worked example of meta-ethnography by Britten et al. (2002) and research methodology commentary/worked example of meta-ethnography by Atkins et al. (2008). Detailed tables for each of the included papers were developed through stages four to five of the process to assist with the collating of information, reviewing, and comparison of the studies. Throughout the process of translation and synthesis of the multiple studies, these tables were considered alongside the original texts and, following the guidance of Noblit and Hare (1988), the reviewer considered how 'one case is like enough, except that…' (p.33). Concepts across papers were compared and contrasted, with concepts being matched with others (reciprocal translation). The papers were additionally reviewed for any instances where the data was in opposition (refutational translation). As no instances of disagreement were identified, reciprocal translations were employed across the data set. A grid format was utilised alongside the aforementioned tables to aid the clear communication of endorsed concepts within each of the studies. A line of argument was developed by the reviewer through a process of re- interpretation of the existing interpretations (third order constructs) and comparison of these interpretations, ultimately leading to the integration of findings within a new interpretation and associated theoretical model.

Table 3: Reviewer's demonstration of the seven stages of meta-ethnography outlined by Noblit and Hare (1998):

Phase	Description	Current study methods
1	Getting started	Identifying areas of interest- this included consultation with supervisors as well as checking existing reviews in order to avoid duplication.
2	Deciding what is relevant to the initial interest	Once a specific area of interest had been identified, clear inclusion and exclusion criteria were defined. Development of a search strategy and Boolean operators following consultation with an information specialist. Registration of the review with PROSPERO (see Appendix B).
3	Reading the studies	Repeated reading of the studies to familiarize self with key concepts. Quality rating of the studies and discussion of ratings with secondary rater.
4	Determining how the studies are related	Identification and description of metaphors/concepts within the studies. Second order concepts from included studies presented in a table for further comparison of concepts (Table 4). Concept maps were used at this stage to support the development of relationships (Appendix D).
5	Translating the studies into one another	Constant comparison between identified concepts. Grid created to aid clear comparison of concepts endorsed across studies. Identification of similarities and differences- there were no refutational translations identified, thus reciprocal translations were used (see Appendix E for translation example). Concepts organised into further abstracted conceptual categories.
6	Synthesising translations	Development of line of argument through integration of the translations into a conceptual model. Creating a visual structure of developed conceptual categories.
7	Expressing the synthesis	Expression of synthesis in written form complimented by visual representation of conceptual categories.

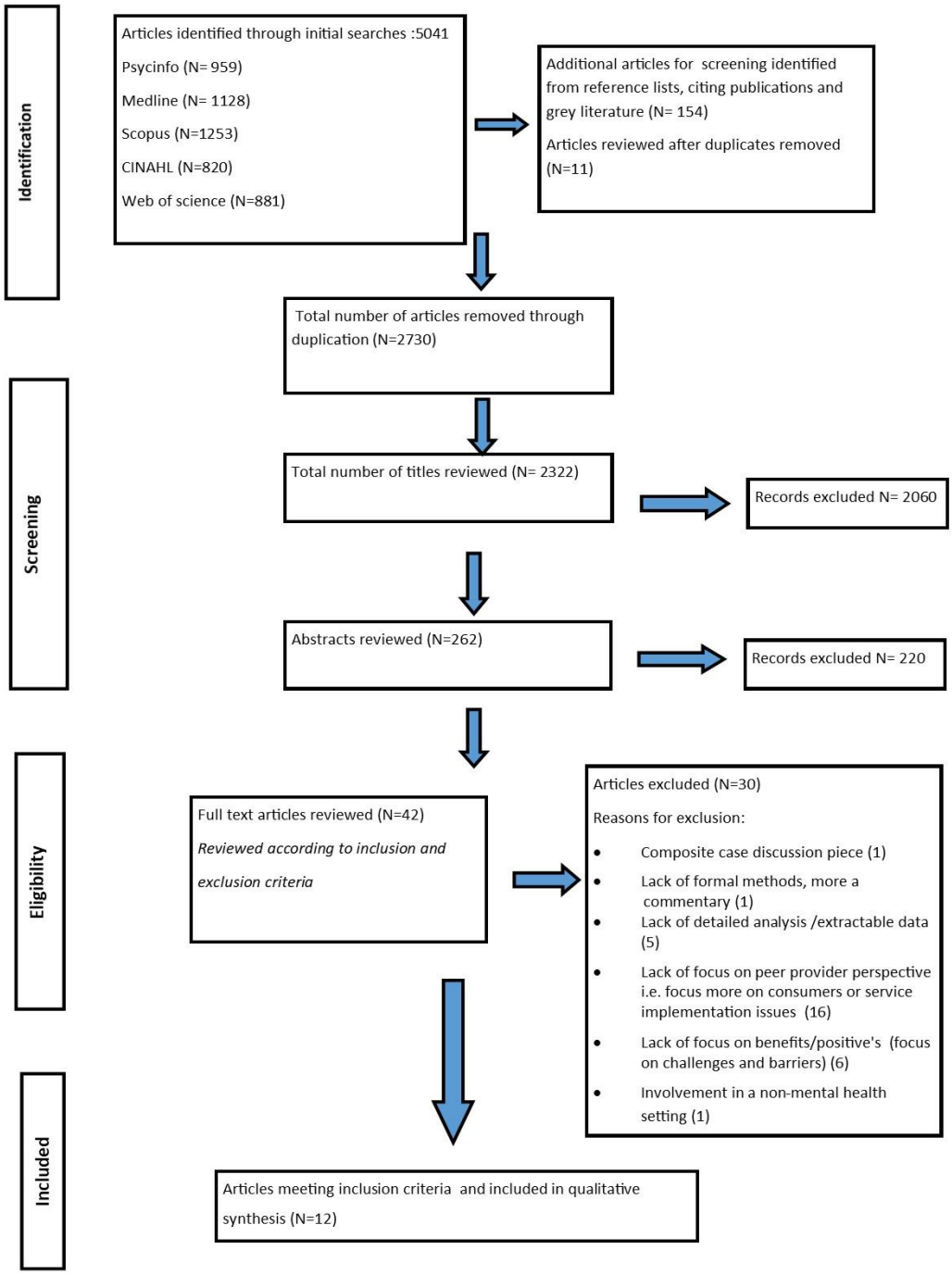
During the synthesis stage of the process, the reviewer made use of Schutz's (1962) notion of first order constructs (original quotes representing the participants' interpretation of their own experiences), second order constructs (researchers' interpretation of participants' personal interpretations of experience) and third order constructs/synthesised themes (current

reviewer's interpretation of first and second order constructs- synthesised to facilitate the construction of a novel theoretical understanding of the data). Throughout this process, the reviewer took guidance from Britten et al. (2002), constructing tables to assist with the process of comparison across the studies and discovery of recurring concepts. A reflexive journal was used by the reviewer throughout this process as well as regular discussions with supervisors to share emerging ideas. The synthesis concluded by considering, utilising the line of argument approach, the current reviewer's interpretation of the key interactions between concepts and between the identified theoretical understandings (Britten et al., 2002).

RESULTS

Figure 1 demonstrates the stages of the study selection process, utilising the PRISMA model. An initial 5041 articles were identified, with an additional 11 being added from the review of article reference lists, citing publications and grey literature. Following removal of duplicate records, 2322 records were initially reviewed, with 262 abstracts subsequently being reviewed. A total of 42 full articles were reviewed, with application of the inclusion and exclusion criteria leading to 12 articles being included in this review. None of the 12 included studies were sourced from the grey literature.

Figure 1: PRISMA flow diagram of the systematic search strategy



Study Characteristics

A total of 171 peer specialist participants were included across the twelve studies that constitute this review. Participant sample sizes within studies ranged from four to thirty-one (Hurley et al., 2018 and Moran et al., 2012 respectively). There was variation across studies in the level of detail provided regarding the demographics of participants i.e., age, educational level, and years of experience, though all but two (Hurley et al., 2018; Kido & Kayama, 2017) reported on the gender of participants. Gender of participants was reasonably equal with 83 Female and 74 Males respondents reported (14 participants' gender demographics were not reported). Terminology used to describe roles of participants varied dependent upon the setting and country, with all appearing to share similarities regarding key characteristics and role responsibilities. All but two of the included studies (Kido & Kayama, 2017; Kuek et al., 2021) were based in a Western culture. Table 4 provides further information on the characteristics of the included studies, including the terminology used by authors and/or different roles held by participants.

Recruitment of participants within studies varied and included liaison with statutory services, government funded mental health teams and third sector charities. All included studies focused on samples within general mental health teams as opposed to diagnosis specific services, though one study explored the experiences of individuals working within a service supporting those with a dual mental health and substance abuse disorder (Salzer & Shear, 2002). All but one study explored experiences of peer specialists within adult mental health settings, with one looking at experiences within a youth mental health setting (Mayer & McKenzie, 2017).

Several of the studies incorporated exploration of experiences of non-peer colleagues alongside the primary focus on peer specialists' experiences. For example, the study by

Mancini (2017) used a sample of both peer providers within a mental health setting and non-peer mental health workers. Hurley et al. (2018) recruited a sample of peer workers alongside 'support facilitators' who worked at a systems level to improve coordination and integration of a wider 'peers in recovery' programme. Within both of the aforementioned studies, the researchers were deemed to have placed sufficient focus on the experience of peer specialists to warrant inclusion in this review. For the purpose of the current review, elements of the studies with a focus on other stakeholders have not been included and are not included within the analysis of the studies' second order constructs.

All of the included studies reported exclusively qualitative findings. Hurley et al.'s 2018 research formed part of a larger mixed methods study of efficacy of a 'peers in recovery programme', but this publication did not report on any of the quantitative elements of this. Similarly, the study by Moran et al. (2012) formed part of a larger mixed methods study, with quantitative exploration not being discussed within the review.

Data collection methods varied across the included studies, with semi-structured interviews being the most frequently used format. Focus groups were used in conjunction with individual semi-structured interviews within the research by Clossey et al. (2016).

Methods of data analysis varied, with approaches informed by grounded theory and thematic analysis being the most common methods adopted. One study (Kuek et al., 2021) was longitudinal in nature and, as such, an adapted form of analysis was utilized; primarily employing grounded theory principles and methods. Depth of explanation of the methods used varied greatly within studies, and this contributed to some of the studies' lower CASP ratings. This will be discussed in greater detail below.

Table 4: Study characteristics, results and CASP ratings

Study Number	Authors and country of research	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
1	Clossey et al (2016) USA	The experience of certified peer specialists in mental health	"The goal of this research was to explore the CPS experience from the perspective of the workers. This work sought to describe the experiences of the workers, and what they perceived to be the barriers and facilitators of effective CPS practice"	13 employed Certified Peer Specialists (CPS) Sample consisted of 7 males and 6 females Individuals were all employed part time within 'consumer led services' in mental health organisations. Role responsibilities were not specified	Respondents from 8 different mental health organisations including consumer run organisations, Psychiatric rehabilitation programmes and 'traditional' mental health settings	Semi-structured interviews (N=3) and focus groups (N=3)	Grounded Theory utilising coding guidance from Miles and Huberman (1994)	• Feeling supported by organisations and through appropriate supervision as important contributors to positive experience • Good training and adequately funded roles as important • Feeling well integrated in the organisation as a whole • Experience of unclear boundaries and job roles as unhelpful • Job stressors including workload and negative reception from the 'system' as contributing to a negative experience	7 (B)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
2	Forbes et al (2021) USA	Experiences of Peer Support Specialists Supervised by Nonpeer Supervisors	"What is helping and what may be hindering PSS practice of building relationships based on common experiences, hope, trust, choice, and being person-driven (International Association of Peer Supporters [iNAPS], 2013) due to direction given to the PSS during supervision?	20 Peer Support Specialists. Sample consisted of 13 females, 6 males and 1 'Other' No details provided r.e role duties	Peer Support Specialists working within adult community mental health settings	Semi-structured interviews employing Critical Incident technique	Thematic Analysis (Braun and Clarke, 2006)	• Supervisor attitudes to peer work • Integrated roles within system • Recognition of the need form trauma informed supervision • Supportive working environment • Support from other peers and opportunities for networking	7 (B)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
3	Kido and Kayama et al (2017) Japan	Consumer providers' experiences of recovery and concerns as members of a psychiatric multidisciplinary outreach team: A qualitative descriptive study from the Japan Outreach Model Project 2011-2014	"The objective of this study was to clarify consumer providers (CPs) subjective experiences as members of a psychiatric multidisciplinary outreach team that provided services to individuals with a mental illness living in the community"	9 Consumer providers-does not provide details of gender of participants although states 'most were male' Role involves promoting engagement with services-visiting individuals in the community to encourage continued or reengagement with the rest of the MDT	Consumer providers within psychiatric multidisciplinary outreach teams in Japan	Semi-structured interviews	Qualitative descriptive methods	• Earning trust and building relationships with consumers through shared experience • Receiving positive feedback • Using own experience within MDT • Gaining self-confidence and managing own mental health through involvement	6.5 (B)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
4	Mancini (2017) USA	An Exploration of Factors that effect the Implementation of Peer Support Services in Community Mental Health Settings	To explore the question: "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?"	23 Peer workers consisting of 12 females and 11 males Varied role responsibilities ranging from running groups to direct work with individuals to 'mediation' between individuals and services	Peer specialists working with community based mental health services. Services included supported housing, psychiatric rehabilitation, employment, case management, and outpatient psychiatric and substance abuse treatment.	Semi-structured interview	Thematic analysis (Boyatzis, 1998)	• Level of autonomy • Clear roles and responsibilities • Inclusion, acceptance, and respect from colleagues • Opportunities for professional development	7.5 (B)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
5	Mayer and McKenzie (2017) UK	'It shows that there's no limits': the psychological impact of co-production for experts by experience working in youth mental health	To explore the what, why and how of co-production through the research question: what is the psychological impact of co-production on young people who are experts by experience?	5 Males aged 21-28 No details provided r.e role responsbilities	Recruited from mental health charity where all participants had been employed by an expert by experience	Semi-structured interviews	Interpretative phenomenological analysis (Smith et al. 2009)	• Autonomy, agency, and respect. • Feeling valued • Sense of professional identity • Transition in identity through role, for self and the way viewed by others	8 (B)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
6	Moran et al (2012) USA	Benefits and Mechanisms of Recovery Among Peer Providers with Psychiatric Illnesses	"The purpose of the present study was to identify the benefits resulting from being a peer provider".	31 Peer providers consisting of 17 Females and 14 Males "Participants provided a variety of services, including personal support (one-on-one relationships), group facilitation (e.g., leading recovery groups), and program-level initiatives (e.g., curriculum development, advocacy)"	Participants worked as peer providers in different mental health agencies in a large north-eastern American city. The majority (84%, n = 26) worked in conventional human services agencies and the remaining 16% (n = 5) worked in peer-run agencies where the majority of staff were also persons in recovery from mental illness.	Semi-structured interviews	Grounded Theory	Foundational wellness through increased understanding of own condition, increase in self-care. Emotional wellness through: Experience of positive emotions through role, increase in self-esteem and improved sense of identity, empowerment Growth and spiritual wellness through change in perspectives, personal growth Social wellness through improved relationships and social network, sense of connection Occupational benefits: Developing skills, career development, meaningful identity	7 (B)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
7	Mowbray et al (1998)	Consumers as Mental Health Providers: First-Person Accounts of Benefits and Limitations	"This article examines the benefits and limitations identified by a group of consumers who served as peer support specialists (PSSs) in an integrated case management/vocational services demonstration project"	11 participants consisting of 6 males and 5 females Individuals acted as 'case manager extenders'and role models for assigned clients. Other activities included running job support groups, helping clients to prepare resumes, set up bank accounts, acquire clothing for interviews or work, or learn the bus system.	Peer support specialists employed as part of a 3-year project aimed at improving vocational opportunities in MH	Semi-structured interviews	Qualitative descriptive methods	• Practical benefits from involvement-pay and development of routine and skills. • Experiencing a safe and positive work environment • Retaining contact with MH system and peers as a positive • Receiving positive feedback from staff and recipients • personal growth through role	5.5 (B)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
8	Kuek et al (2021) Singapore	A Longitudinal Qualitative Analysis of the Way Peer Support Specialist Roles Change Over Time in a Psychiatric Hospital Setting in Asia	"Our primary goal was to explore the changes and evolutions to the peer support role, if any presented themselves, within a tertiary psychiatric hospital setting in Singapore"	10 peer support specialists consisting of 6 females and 4 males "The job descriptions of the PSS vary between departments, but universally include service seeker/user supportive roles based on the principle that lived experience of illness and recovery should be used to help current service users achieve their goals. All PSS operate as part of a wider clinical team, instead of independently	Peer support specialists within inpatient setting	Repeated semi structured interviews at 3 points in involvement (baseline, 4 months, and 8 months)	Constant comparison method- utilising principles of Grounded Theory	• Development of role clarity • Having an established role with clear support • Role narrowing- having clear responsibilities and meaningful opportunities • Role maturation- career development	9 (A)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
9	Debyser et al (2019) Belgium	The transition from patient to mental health peer worker: A grounded theory approach	"To investigate how peer workers experience their transition, and which processes facilitate it. This insight will allow peer workers to be more adequately prepared for their transition and supported within the healthcare organization during the development of their new role"	17 peer support workers consisting of 10 females and 7 males Roles included: telling their recovery stories, performing policy-supporting work, offering individual recovery support to patients, participating in network consultative bodies, setting specific consultation structures, and guiding recovery working group	Mental health peer workers from various settings	Semi structured interviews	Grounded Theory-symbolic interactionism used as a framework	• Role as contributing to personal recovery • Continued growth as a peer worker and implications for personal development • Opportunities to develop confidence through feeling heard and recognised	9 (A)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
10	Vandewalle et al (2018) Belgium	Constructing a positive identity: A qualitative study of the driving forces of peer workers in mental health-care systems	"The aim of the present study was to develop a conceptual framework representing the driving forces of peer workers to fulfil their position in mental health-care systems."	14 peer support workers consisting of 8 females and 6 males Roles involved: Facilitating support groups, designing and leading group activities, sharing recovery stories, supporting peers in their recovery, performing administrative tasks, and participating in mdt meetings at the team and policy level	Peer Support workers within various community and inpatient settings	Semi structured interviews	Grounded Theory (Glaser and Strauss 1967)	• Using past experience as an asset • Moving out of restrictive role of 'service user' • Recognition and respect from other professionals • Experiencing supportive working conditions • Developing and employing self-care strategies	9 (A)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
11	Salzer and Shear (2002) USA	Identifying consumer-provider benefits in evaluations of consumer-delivered services	"This paper attempts to identify benefits within this framework using data from an in-depth qualitative study of the benefits expressed by consumer providers about their positions"	14 Peer support specialists consisting of 8 males and 6 females Roles include serving as a role model, spending time in the community with individuals helping them to develop cognitive and behavioural strategies to manage their difficulties	Peer support specialists employed in community-based roles supporting individuals with dual mental health and substance abuse disorders	Semi structured interviews	Thematic analysis	• Benefits of being able to facilitate others recovery • Own recovery benefitting from involvement • Social approval • Professional growth • Job related benefits • Job related recovery • Mutual support	8 (B)

Study Number	Authors and country	Title	Aims of study	Sample and details of role (where available)	Study setting	Data collection method	Method of data analysis	Results and key concepts (second order constructs) related to a positive experience within role	CASP quality rating
12	Hurley et al (2018) Australia	Qualitative study of peer workers within the 'Partners in Recovery' programme in regional Australia	"Given that the PW role is based upon the lived experience of mental health challenges, one imperative is to ensure role expectations are based around supporting worker well-being, as well as promoting the well-being of others. Given there are few identified Australian studies into the experiences of PW's and the PW workforce is being rolled out into an underprepared mental health system (Byrne et al. 2013), there is need for critical examination of the PW role"	4 Peer Support workers- no demographic information supplied Role involves working at system level to improve coordination and integration in support of consumer recovery.	Peers In Recovery programme, national mental health programme	Semi structured interviews	Thematic analysis	• Role variance/role clarity • Opportunities through work • Role as shaping identity and language • Trust and building relationships with consumers	8 (B)

Findings of quality appraisal

Studies included in this review were all rated as low to moderate with regards to the likelihood of methodological flaws, with scores ranging from 5.5 to 9 on the CASP (2018) tool. Studies predominantly scored no or partial points due to lack of reflexivity; insufficient rationale for methods used; insufficient explanation of process of analysis; and lack of information regarding ethical considerations (see Appendix F for examples of CASP scoring by lead author and second reviewer). A relative strength of all studies was that aims of the research studies were clearly detailed, and all included clear summaries of their findings. Additionally, all of the included studies employed qualitative methodology, and from review of research aims, this was appropriate methodology in each case.

Although question ten of the CASP has not been formally scored, prompts to consider are provided and consideration is given within the current review as to whether the included studies met these prompts. Table 5 outlines the scoring for each of the included studies using the CASP tool.

Table 5: CASP scoring of all included studies

Quality appraisal CASP question	***Paper no 1:**	**2:**	**3:**	**4:**	**5:**	**6:**	**7:**	**8:**	**9:**	**10:**	**11:**	**12:**
1: Was there a clear statement of the aims of the research?	1	1	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	1	1
3: Was the research design appropriate to address the aims of the research?	1	1	0.5	1	1	1	0.5	1	1	1	1	1
4: Was the recruitment strategy appropriate to the aims of the research?	1	1	1	1	0.5	1	1	1	1	1	1	1

5: Was the data collected in a way that address the research issue?	1	1	0.5	1	1	1	1	1	1	1	1	1
6: Has the relationship between researcher and participants been adequately considered?	0	0	0	0	0	0	0	1	1	1	0	0
7: Have ethical issues been taken into consideration?	0	0	1	0.5	1	0	0	1	1	1	1	1
8: Was the data analysis sufficiently rigorous?	1	1	0.5	1	1	1	0	1	1	1	1	1
9: Is there a clear statement of findings?	1	1	1	1	1	1	1	1	1	1	1	1
10 A: Do the researchers discuss the contribution the study makes to existing knowledge or understanding?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10 B: Do the researchers identify new areas where research is necessary?	Yes	No	No	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes
10 C: Do the researchers discuss whether or how the findings can be transferred to other populations or considered other ways the research may be used?	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
TOTAL CASP SCORE (out of 9)	7	7	6.5	7.5	7.5	7	5.5	9	9	9	8	8

**Paper 1 : Clossey et al. Paper 2: Forbes et al. Paper 3: Kido & Kayama. Paper 4: Mancini. Paper 5: Mayer & McKenzie. Paper 6: Moran. Paper 7: Mowbray et al. Paper 8: Kuek et al. Paper 9: Debyser et al. Paper 10: Vandwelle et al. Paper 11: Salzer & Shear. Paper 12: Hurley et al.*

The two papers with the lowest ratings, Mowbray (5.5) and Kido and Kayama (6.5), shared similar limitations. Both papers lacked a clear or replicable description of the process of data analysis and the reviewer was left unclear as to how the authors had approached the process of conceptualising the arising themes. In particular, Mowbray's paper was primarily

descriptive in nature and relied heavily on presenting participants' first order accounts of their experiences, without fully producing second order conceptualisations of the data.

Findings of data synthesis

Following the stages outlined by Noblit and Hare (1988), the meta-ethnography identified three superordinate conceptual categories encompassing ten subordinate third order constructs. Following the seminal worked examples of Britten et al. (2002) and Campbell et al. (2003), the constructs were collated within a grid format to allow for comparison and to demonstrate where each third order construct was translated from pre-existing translations within the included studies. Please refer to Appendix E for an example of the translation process. The reviewer aimed to label third order constructs in such a way as to remain sufficiently true to the original data, whilst considering the question posed by the current systematic review. Some of the titles of concepts within the original articles were utilized as the labels for the developed concepts, but for some, new labels were created. Throughout this process, consideration was given to the quality ratings and limitations of the included studies, with poorer scoring studies i.e., Mowbray (1998) and Kido and Kayama (2017) making a smaller contribution to the overarching conceptualisation process. Indeed, it was notable that the two lowest scoring studies also endorsed the fewest concepts identified within the construct grid (Table 6).

As previously discussed within this paper, meta-ethnographies often utilise Schutz's notion of first, second and third order constructs. Whilst first order constructs were considered and examined by the reviewer, the existing second order constructs are of primary concern for this review and viewed as the 'building blocks' of the meta-ethnographic approach (Britten et al., 2002). It has been argued by Toye et al. (2014) that first order constructs need to be used with caution by meta-ethnographers, as these are pre-selected quotations chosen by a

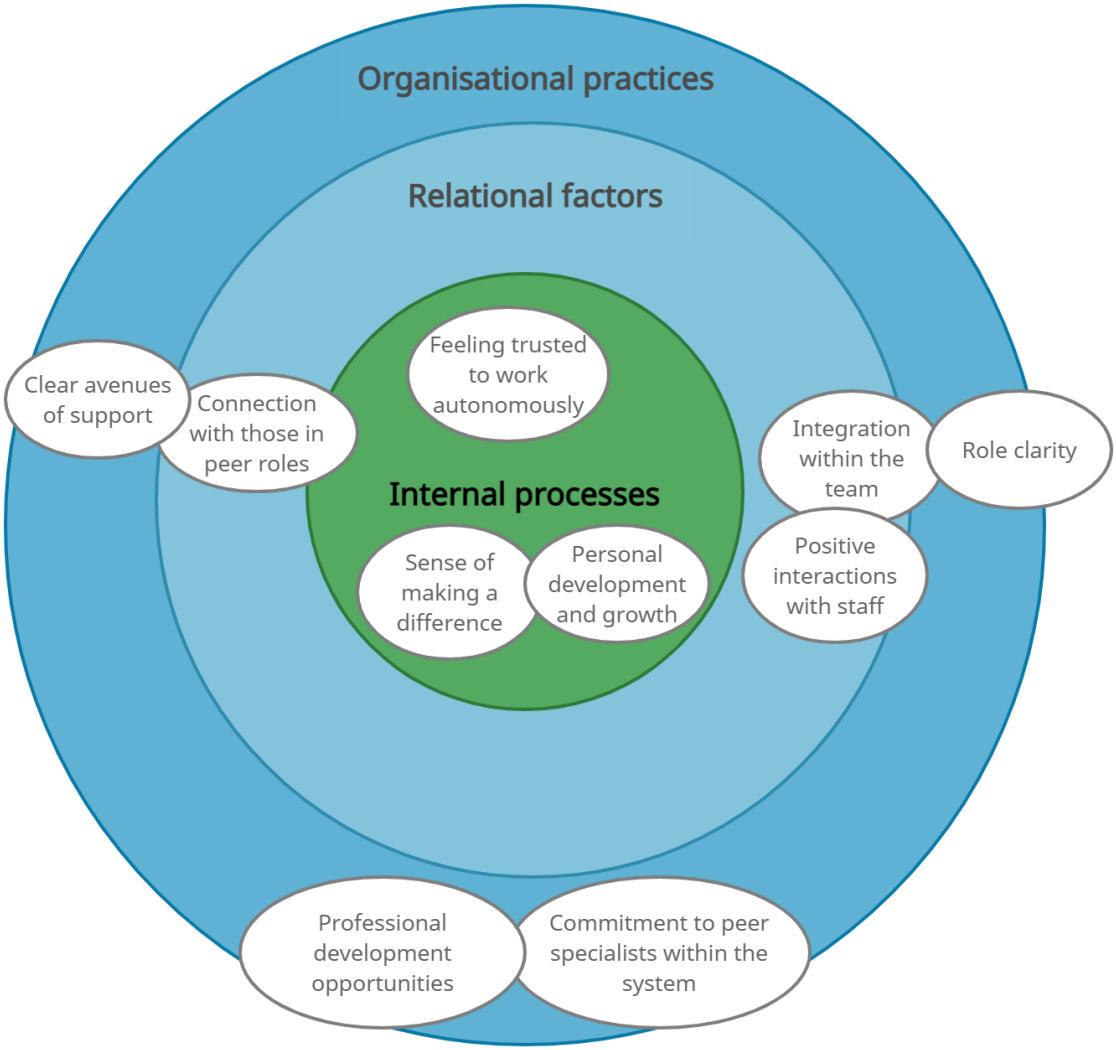
researcher to represent a larger data set, and therefore may, in some ways, be considered as second order interpretations in and of themselves. Using first order constructs within a meta-ethnography therefore risks re-interpretation and misattribution of new meanings from the current reviewer. As researchers have deemed it vital to "preserve meaning from original texts as far as possible within qualitative synthesis" (Walsh & Downe, 2006), a decision was made to focus on second order constructs within this review.

Table 6: Meta-ethnography of reviewed articles- Grid format. * *Paper 1: Clossey et al. Paper 2: Forbes et al. Paper 3: Kido & Kayama. Paper 4: Mancini. Paper 5: Mayer & McKenzie. Paper 6: Moran. Paper 7: Mowbray et al. Paper 8: Kuek et al. Paper 9: Debyser et al. Paper 10: Vandwelle et al. Paper 11: Salzer & Shear. Paper 12: Hurley et al.*

		Third order constructs									
		Organisational practices				Internal processes				Relational factors	
***Study Number**	Quality rating	*Clear avenues of support*	*Commitment within the system*	*Role clarity*	*Professional development opportunities*	*Feeling trusted to work autonomously*	*Personal development and growth*	*Sense of 'making a difference'*	*Positive interactions with staff*	*Integration within 'the team'*	*Connection with those in peer roles*
1:	7 (B)	x	x		x	x		x		x	x
2:	7 (B)	x	x	x		x	x			x	x
3:	6.5 (B)	x						x	x		
4:	7.5 (B)			x	x	x	x		x	x	x
5:	7.5 (B)		x		x	x			x	x	
6:	7 (B)		x			x	x	x	x	x	x
7:	5.5 (B)				x		x		x		x
8:	9 (A)			x	x					x	x
9:	9 (A)		x			x	x	x	x	x	
10:	9 (A)				x		x	x	x		
11:	8 (B)				x	x	x	x			x
12:	8 (B)	x	x	x	x						x

Figure 2 provides a diagrammatic representation of the identified third order constructs, supported by a written narrative below. The written narrative will follow the journey of the experience, discussing core concepts and sub-concepts.

Figure 2: Diagrammatic representation of identified third order constructs:



Conceptual model narrative

The developed model provides new insights and highlights a number of factors that contribute to a positive experience within role for peer specialists in mental health services. Specifically, a combination of inter-connected wider organisational practices, relational factors, and internal processes (of the peer specialist) contribute to the overall evaluation of

involvement as being positive. Perceived commitment to peer specialists within the organisation was deemed to be demonstrated by organisations that provided opportunities for professional development through training and career development opportunities. Perceived organisational commitment to peer specialists additionally appears to have been closely linked with relational experiences within role for individuals. Connection and a sense of integration within the team, complimented by positive interactions with co-workers and a sense of mutual respect, was commonly discussed as contributing to a positive overall experience. Individuals valued having avenues of support within a supervision setting alongside opportunities for networking with other peer specialists. Indeed, there was an overlap in studies that endorsed networking with others in similar roles and those that talked about personal development and growth. It is hypothesised that having access to those in similar roles may have improved peer specialists' confidence within role and/or sense of belonging through sharing of knowledge and experience, ultimately facilitating their sense of personal growth and clear identity. Occurring alongside, and seemingly influenced by the concepts of organisational processes and relational factors, are the internal processes of the peer specialists. Organisations and teams that facilitate positive relational experiences and demonstrate a commitment to co-production at a wider organisational level through their practices, appear to foster a sense of trusted autonomous working within peers, that in turn contributes to their sense of personal development and growth alongside an internal sense of 'making a difference' through their work.

Organisational practices

Clear avenues of support. This construct was discussed in four of the studies, which referred to this with second order constructs designated as 'building supports by creating a

facilitative/supportive environment' (Forbes et al., 2016) and 'good support system' (Clossey et al., 2016). Hurley et al. (2018) highlighted the notable improvement in experiences when clear avenues of support were in place as a peer recovery programme developed:

'As the PIR [partners in recovery] programme matured and gained clarity in its direction there were increasing opportunities for PWs [peer workers] to receive support, which increased opportunities for success and hence reduced the risks to their own recovery. While initially the PWs lacked the support through supervision they felt they needed, when it was in place its impact on the PWs was pivotal' (Hurley et al. 2018, pg. 190)

Forbes et al. (2016) focused on exploring the unique position of supervisors in providing clear and consistent support; providing additional commentary on the need for supervisors to be trauma informed in their approach due to the experiences of the peer specialists that they were supporting.

Commitment within the system. Ten studies made reference to the role that organisation-wide commitment to peer specialists has on the overall experience of individuals in such roles. Studies referred to individuals positively perceiving organisations to be invested in 'systems change' (Hurley et al., 2018) and 'the co-production approach' (Mayer & McKenzie, 2017). Clossey et al. (2016) labelled this second order construct as 'organisational integration', with participants discussing the difference in overall job satisfaction and experience when a sense of connection was felt with the employing organisation. This construct was linked to the 'professional development opportunities' construct, with perceived commitment to peer specialists being linked to clear investment in roles including training and opportunities for skills development within roles.

Clear role structure and responsibilities. Four studies endorsed this concept, with participants discussing the benefits of clear roles and responsibilities within their

organisation. Mancini (2017), within their labelled second order construct of ‘clear roles and responsibilities’ noted the following:

‘All peers identified the need for clarity in roles and responsibilities as the most important factor influencing the effective integration of peer services into mental health treatment teams and organizations’ (Mancini, 2017, pg. 130)

Linking this construct with the construct of ‘clear avenues for support’, Forbes et al. (2021) highlighted the role of supervisors in providing peer workers with the role clarity that was desired:

‘In the experiences of PSS [peer support specialists], steps toward role integration were achieved by NPS [non-peer supervisors] helping to construct role clarity, supporting role adaptation, and negotiating jointly the challenges of maintaining practice boundaries’ (Forbes et al., 2021, pg. 3)

The role of the supervisor in initially facilitating peer specialist communication with other members of the staff team around role responsibilities was also remarked on by Kuek et al. (2021):

‘Participants felt that effective communication and being proactive with their supervisor and the team were essential in clarifying their roles within the group.’ (Kuek et al, 2021, pg. 5)

Professional development opportunities. A large number of studies (eight out of twelve) reported the importance of professional and skills development opportunities when facilitating a positive experience in role for peer specialists. Studies varied in their labelling of this second order construct, with ‘ongoing professional development’ (Mancini, 2017), ‘developing skills and competencies’ (Moran et al., 2012), ‘gaining specific skills’ (Mowbray, 1998) and ‘professional growth’ (Salzer and Shear, 2002) all being used as descriptive labels.

Linking back to the construct of 'commitment within the system', several papers commented on the relationship between integration of roles within the wider system and investment in professional development, this was directly recognised by participants as well as researchers:

'Peers clearly stated that they required ongoing professional development opportunities as a means to enhance their integration into mental health agencies.' (Mancini, 2017, pg. 131)

Internal processes

Feeling trusted to work autonomously. Several of the papers included participant commentary on the importance of a sense of being respected in a professional capacity and, as such, being allowed to work with a degree of autonomy:

'Peers identified autonomy as an important factor in job satisfaction. Autonomy included having the freedom to provide genuine peer services without micro-management, intimidation or interference by supervisors and non-peer staff' (Mancini, 2017, pg. 130)

Referred to by Mayer and McKenzie (2017) as 'enabling agency', participants appeared to link role autonomy with a sense of personal accountability:

'Participants had a strong sense of personal accountability and responsibility, of their ability to get things done rather than be passively drawn along' (Mayer and McKenzie 2017, pg.1183)

In some instances, a sense of perceived autonomy was linked to the construct of 'sense of making a difference', in that participants reported a sense of pride and achievement from their role in supporting service users in their recovery journey.

Personal development and growth. Seven of the twelve included studies emphasised opportunities for personal development and growth as integral to an overall positive appraisal of roles for peer specialists. Moran et al. (2012) labelled this second order

construct as ‘foundational wellness’ and discussed experiences within roles providing peer workers with an increased understanding and awareness of mental health conditions, including their own mental health. Debsyer et al. (2019) referred to personal development in the form of the discovery of personal strengths and a move away from ‘trapped dynamics’ as a mental health service user. Moran et al. (2012) offered the following description of their labelled construct of ‘personal growth and practicing virtues’:

‘Participants noted that they became more “compassionate” toward themselves and others, “being less judgmental,” having “gratitude” and “appreciating life,” being “much more open,” “generous,” and “helpful”’ (Moran et al., 2012, pg. 309)

Sense of ‘making a difference’. Six studies within the review identified that roles that provided the opportunity for peer specialists to feel that they were making a difference were influential on the overall level of satisfaction reported within their roles. Debyser et al. (2019) and Salzer and Shear (2002) discussed that the opportunity for peer specialists to use their own experiences to offer hope and encouragement to others on their recovery journey was particularly valued. Similarly, Kido and Kayama (2017) remarked on the sense of achievement for peer specialists when witnessing clients’ recovery:

‘The CPs [consumer providers] were able to feel a sense of achievement and the feeling that their actions were worthwhile by seeing the gradual recovery of clients for whom they provided support’ (Kido and Kayama, 2017, pg. 6)

Job satisfaction and a sense of having a rewarding occupation was explored by Moran et al. (2012) in the construct labelled as ‘experiencing positive emotions’:

‘Participants noted feeling joy, happiness, and fun that they had “not experienced in a long time.” They also described feeling “satisfied” and “rewarded” in the face of success and accomplishments at work.’ (Moran et al., 2012, pg. 308)

Relational factors

Positive interactions with staff. As well as organisation wide commitment to peer specialists, many studies discussed the importance of positive experience within the immediate team environment and the impact of forming positive working relationships with colleagues:

'They connected with colleagues as equals, appreciating simply knowing everyone's surname and talking about 'what they had for dinner last night'. They described feeling valued and cared for talking of the help, support, encouragement, respect and understanding they had experienced, of feeling 'comfortable', 'happy', 'relaxed'' (Mayer and McKenzie 2017, pg. 1184)

Moran et al. (2012) described the importance of the working relationship as well as the social network that was provided by being part of a staff team. Mancini (2017) noted the importance of 'peer respect' in interactions between staff, this links back to the internal process construct of 'feeling trusted to work autonomously'.

Integration within 'the team'. Building on the 'positive interactions with staff' construct and linked to the 'clear avenues of support' construct, seven studies looked at the importance of a sense of integration within the team, with some studies commenting on the role of supervisors in enabling this inclusion:

'While role integration is a critical PSS issue, NPS support for the role sends an important signal to other team members about its value and uniqueness' (Forbes et al, 2016, pg. 5)

Mancini et al. (2017) provided an example of how inclusion within the team can be defined:

'Inclusion refers to how well peers 'fit in' with the team and how much they are included in team activities, events and conversations' (Mancini, 2017, pg. 130)

Connection with those in peer roles. Eight of the included studies recognised and discussed the value of having opportunities to meet with or have support from individuals in similar roles (e.g., fellow peer specialists or peer supervisors), with this being termed as 'mutual support' by Salzer and Shear (2002). Moran et al. (2012) labelled this construct as 'peer networking', offering the following summary:

'Having the opportunity to connect with other peer providers was valuable for participants' recovery processes in various ways' (Moran et al., 2012, pg. 313).

Forbes et al. (2021) elaborated on the format that connection may take:

'Many participants suggested that in the absence of a peer supervisor, networking with other PSS was very important. Providing access to conferences and trainings or supporting self-initiated opportunities for PSS to meet with other PSS' (Forbes et al., 2021, pg. 4).

DISCUSSION

This meta-ethnography aimed to build on previous qualitative systematic reviews (Miyamoto & Sono, 2012; Walker & Bryant, 2013) to provide new insights and a conceptual model of factors that contribute to a positive experience for those providing a peer specialist role in a mental health setting. Whilst there was an awareness from consultation of the existing research that involvement in peer specialist roles can result in many benefits for those in role, this review has focused on the mechanisms underlying these benefits, seeking to elicit the enablers and facilitators of a positive experience in role.

The findings of this review highlight that a combination of interlinked organisational, relational, and internal processes influence the experiences of individuals within peer specialist roles. The findings echo those of the aforementioned previous reviews in the area,

in that, peer specialists report a number of benefits from their involvement including; increased self-confidence; a sense of a new positive identity; and valued peer networking opportunities. Within the current review, the importance of roles eliciting a sense of satisfaction and of making a difference to others was found to be an important element contributing to a wider sense of personal and professional development. Opportunities for rewarding work activities were derived from organisations providing opportunities for autonomous working, alongside a clear and well-integrated role within the team.

The importance of integration both within the immediate team and wider organisation was a clear theme throughout the current review and such integration provides a more positive work experience for peers. This is consistent with the existing literature, which as well as recognising the value of authentic and meaningful peer integration within teams (Rebeiro Gruhl et al., 2015), has recognised the need for staff teams to receive support to prepare appropriately for what are often new ways of working for them (Repper et al., 2014). Insufficiently planned peer working arrangements and the impact of these has recently been discussed in the context of introducing peer workers in an Early Intervention service in England (Procter et al., 2019). Similar to the current review's findings, Procter et al. discussed the need for appropriate day-to-day support for individuals, specifically noting the benefit of developing a standard operating procedure (SOP) which outlines plans for recruitment, supervision, referral procedures and likely role duties.

Whilst there is a growing understanding of some of the key ingredients of successful peer integration within teams, there are undoubtedly still challenges to implementing these features. Issues of 'power' and 'change' were identified by Bennetts et al. (2011) as two primary barriers to change, with participants commenting on the continued prominence of the medical model and 'institutionalised thinking' within some mental health settings. A recent systematic review by Ibrahim et al. (2021) identified that organisational culture and staff

attitudes continue to have a powerful influence on the implementation of peer specialists. A further recent piece of qualitative research by Ehlrich et al. (2019) focused on exploring the implementation of peer support workers within a clinical team. As with the current review, a key finding was that role clarity or 'legitimacy' was an important element of overall integration within the team. Whilst the current review has a focus on exploring factors facilitating a positive experience, it seems pertinent to acknowledge and hypothesise that continued implementation issues would have an impact on the personal experience and satisfaction of peers within such roles.

The current synthesis has highlighted several key areas within a role that contribute to a positive experience for peer specialists. Several of the factors identified (positive interactions with staff; role clarity; integration within the team; and connection with those in peer roles) appear to foster opportunities for trusted autonomous working, from which individuals can achieve a sense of making a difference to the lives of others. From this sense of making a difference, peers experience a sense of achievement and personal growth. Peers being able to successfully navigate these internal processes appears to be dependent on their relational experiences within the immediate team, and the suitability of the wider organisational environment in which they are employed. This synthesis highlights the key role of organisations displaying commitment to integration of peer specialists. Consistent with previous literature, the current synthesis and associated theoretical construct and model would suggest that commitment to integration of peer specialists requires substantial initial planning. Organisations additionally need to have robust and clear ongoing structures in place to facilitate meaningful and successful long-term roles for individuals with lived experience.

Finally, it is important to note that the inclusion of studies utilising differing qualitative methodologies within the systematic review can be seen as both challenging and valuable. Different methodologies may have served to elicit different perspectives and information

from participants through the use of differing interview procedures and subsequent analysis. For example, it is likely that a study employing thematic analysis would elicit different responses to a study using grounded theory principles due to the differences in level of structure and opportunities for modification. It is also likely that included studies quality ratings were influenced by the method of analysis chosen, as some lacked sufficient procedural detail. Despite the differing methodologies, as the current review focused on interpreting second order themes presented by the authors, the methodology used to elicit this information was ultimately deemed to be inconsequential. It was not felt by the current author that the inclusion of varied qualitative methods had any detrimental impact on the quality of the synthesis.

Limitations and areas for further research

In line with the eMERGe reporting guidance for meta-ethnography (France et al., 2019), it is important to consider the conduct of the synthesis itself and the limitations within the synthesis process. One methodological weakness within the process was that the author primarily acted as a lone reviewer, with only a small subset of studies being examined by a second reviewer with no affiliation with the project. Additionally, greater consideration could have been given by the author regarding the order in which the studies were synthesised. Although there is no requirement within the guidance from Noblit and Hare (1998) regarding the order in which to synthesise papers, on reflection it may have been useful to synthesise the papers in chronological order, as this may have afforded clearer insight into any changes in experience and contributing factors for service users over time.

All included studies, with the exception of Kido and Kayama et al. (2017) and Kuek et al. (2021), were based within western cultures and caution should therefore be given to a potential cultural bias. Terms used within studies to describe peer roles differed, and it may

be that non-western cultures use terminology which would be unfamiliar to the author and thus not recognised within this review. It would be interesting for future research to consider the different peer roles that may exist across cultures and to explore individuals' experiences within non-western peer mental health settings.

Many of the studies included in this review failed to adequately consider the unique position of the researcher and how this may have influenced their interpretation of the data and identification of themes. As such, further future research would benefit from an increased demonstration of reflexivity from researchers as part of the wider process of quality assurance. Equally, several studies did not include sufficient detail regarding their rationale for using their chosen method of analysis.

Only one study explored the experiences of those working in youth mental health services, and this may be an area for further exploration. Additionally, the review included participants from a variety of settings including third sector organisations, with roles also varying from voluntary positions to full-time paid members of staff. It would be interesting for future research to explore the differences in experience that may exist within specific populations of peer specialists (i.e., are the experiences of individuals in NHS or equivalent settings different from those within third sector organisations?).

Finally, further research may wish to build upon the current review by 'testing out' the theoretical model produced. Whilst the reviewer deems the model presented to have face validity, it would need to be empirically tested in real-world contexts. One option would be to commission a quantitative study exploring the influence of particular variables i.e.: access to peer supervision, structured job plans, training opportunities etc. on occupational satisfaction. If subsequent research confirmed the validity of the current model, this could pave the way

for services being better able to meaningfully appraise whether they are sufficiently supporting the development of peer roles in their services.

Clinical Implications

The findings of this review suggest that mental health organisations recruiting peer specialists need to give careful consideration to the ways in which they demonstrate a wider, as well as a filtered down, 'on the ground' commitment to the integration of individuals within services. Table 7 outlines several key implications; these are elaborated on below.

Table 7: Clinical implications

Level of implication	Details of implication
At an organisational level	• Consideration should be given to the integration of individuals within services with clear induction programmes in place. • Provision of avenues of support through appropriate supervision and networking opportunities. • Clear role structure laid out that allows integration in a team. • Reasonable adjustments should be considered, such as flexible working hours, working from home and more regular breaks. • Principles of compassionate leadership to be embedded across organisation.
On an operational level	• Provision of appropriate supervisors and/or group supervision opportunities with other peer workers. • Provision of an organisational line manager to deal with administrative and clerical elements.
On a personal level	• Peer workers should be supported to feel autonomous in their work to allow a sense of personal growth and role satisfaction.

Specific consideration needs to be given to providing avenues of support via regular and appropriate supervision, alongside informal opportunities for networking with others in similar roles. On a practical level, organisations may wish to consider providing individuals

with a clinical supervisor with lived/peer experience and/or group peer supervision opportunities, alongside an organisational line manager to oversee the more administrative and clerical aspects of the role.

There is a need for services to carefully negotiate and find a balance between providing peer specialists with clear role structure that aids integration within teams, and allowing a level of autonomy within working that facilitates a sense of personal growth and role satisfaction. Furthermore, as services seek to integrate individuals with lived experience into the workplace, consideration should be given to any reasonable adjustments that may need to be made such as offering flexible working hours, opportunities for home working and more regular breaks.

On a wider organisational level, consideration should be given to how services implement the principles of compassionate leadership. There is notable overlap in the guiding principles of compassionate leadership and co-production, with both aiming to build connection across existing boundaries within organisations and foster the sharing of knowledge and skills across the workforce (de Zueleta P.C, 2015; Social Care Institute for Excellence, 2015). Within the current review, it was highlighted that organisational practices and within-team relational factors have a large influence on the experiences of those within peer roles. Integration of peer specialists within teams and wider organisations through providing opportunities for development and meaningful, collaborative working, would be in keeping with the connection building that is key to compassionate leadership.

Through organisations focusing on relationships within teams, listening to each other, empathising, and supporting individuals to feel valued within their role, higher levels of well-being across staff teams have been found, as well as improved levels of high-quality care (Bailey & West, 2022). It is hypothesised, based on the current review's findings, that having

compassionate ways of working embedded through all levels of an employing organisation would be of benefit to those employed within peer specialist roles, as well as their non-peer colleagues.

CONCLUSION

This is the first systematic review of factors contributing to a positive experience for those in peer support roles in mental health settings. Following the process of meta-ethnography, a theoretical model of influential factors has been generated. Twelve studies were deemed eligible for inclusion and contributed to the development of the model. The review and associated theoretical model provide new insights and a greater understanding of the mechanisms that underlie a positive experience within role, with a combination of wider organisational practices, relational factors, and internal processes being identified. The review has led to clinical implications including clear recommendations for organisations to ensure that they are able to provide secure and rewarding roles, through being informed as to the elements that commonly contribute to this. Particular consideration needs to be given to ensuring peer roles exist that balance providing a level of suitable support, role clarity and workplace integration, while also allowing a level of autonomy within the work that fosters a sense of personal development and achievement.

Declaration of interest statement

The author declared no potential conflicts of interest with respect to the research.

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PAPER 2

An Exploration of Service User Readiness for Initial and Sustained Involvement in Co-Production Roles in Mental Health Settings: 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 UK there has been growing recognition of the value of involving service users in the design and delivery of mental health services, which is often referred to as ‘co-production’. To date, there has been limited exploration of factors involved in service user readiness for involvement and the processes that may underlie this. The current study aimed to explore the processes that underlie an individual’s sense of readiness for initial involvement in a role of co-production in mental health settings. The study additionally explored what influences and facilitates ongoing involvement in such roles. Ten individuals recently involved in co-production activities completed semi-structured interviews. Analysis of data was conducted using a constructivist grounded theory methodology. The emerging theoretical model described several key processes that individuals go through prior to and during their journey into co-production activities. Recommendations for clinical practice are discussed which include the need for organisations to provide individuals with opportunities to meet others in-role prior to involvement, and to provide clarity within roles. Importantly, there is an identified need for organisations to demonstrate commitment to providing a work environment that acknowledges the value and importance of learning from and working with individuals throughout their recovery journey.

Keywords: qualitative; service user; co-production; mental health; experts by experience; readiness for change; lived experience

INTRODUCTION

Co-production in mental health settings has its roots in 1970s civil rights and social action movements in the US (Realpe &Wallace, 2010), and refers to a process in which service users, carers and staff work together as equal partners towards shared goals (Social Care Institute for Excellence, 2015). Co-production activities vary from 'Expert by Experience' and 'Peer Support Worker' roles to more broad initiatives such as 'Service User Networks' and 'Recovery Colleges'. Recovery colleges are a relatively new initiative, with the first recovery college emerging in the US in the 1990s (Whitley et al., 2019). Recovery colleges promote a community based, co-produced, education-focused approach to recovery (Perkins et al., 2012). They are now well established in the UK as well as across the US, Australia, and Canada (Thériault et al., 2020), with an international community of practice now established (McGregor et al., 2016).

In recent years, organisations including the Department of Health (2009,2011), NHS England (2016) and the Welsh Assembly Government (2008, 2012, 2020) have become increasingly aware of the importance of co-production within organisations. Following this recognition of the need for increased levels of involvement, The National Collaborating Centre for Mental Health (2019) recently published a resource outlining the evidence base for involvement, as well as exploring the tools enabling co-production in mental health commissioning. This recognition of the need for not only increased levels of co-production, but also high quality, evidence-based co-production activities, has taken place as organisations have moved away from pathologizing mental health conditions, and towards the principles encompassed by the 'recovery model'. (Davidson et al. 2005; Jacob, 2015).

The Department of Health (2016) describes a range of levels of involvement that may occur in services, commonly defined using the 'ladder of participation' (Arnstein, 1969). The ladder

of participation describes eight levels of service user participation, ranging from a distinct lack of participation to 'tokenism', through to 'citizen power' in which service users are seen as being in charge of the organization and its decision making. The New Economics Foundation (2013) offer the following definition of a working model of co-production that services may subscribe to, particularly when aiming for a relationship of 'doing with' as opposed to 'doing to':

"A relationship where professionals and citizens share power to plan and deliver support together, recognizing that both partners have vital contributions to make in order to improve quality of life for people and communities" (pp3 NEF 2013).

As co-production has become more common practice in the recent years (Omeni et al., 2014), there has been a steady increase in research in the field. Much of the research to date has explored the perceived benefits of co-production activities, both for the individuals involved and the wider services (Slay & Stephens, 2013; Vandewalle et al., 2018). Repper and Carter (2011), in a review of the literature on peer support in mental health services, noted all included studies reported benefits from involvement for the peer support workers themselves. One included study (Bracke et al., 2008) employing a survey sample from a Belgian rehabilitation centre, found that providing peer support is more beneficial than receiving it in relation to reported improvements in self-esteem and sense of empowerment, a finding echoed by Ratzlaff et al. (2006). Repper and Carter (2011), building on commentary from Hutchinson et al. (2006), hypothesised that many of the reported benefits experienced by peer support workers may stem from the sense of valued identity within society that employment provides. With regards to the specific related benefits of involvement, Mowbray et al. (1998) interviewed 11 Peer Support Workers, who identified payment as the primary benefit of the role, followed by the structure provided by the role, the supervision provided and the safety of a job in which they could disclose their prior difficulties. Relatedly, Salzer and Shear

(2002) conducted a qualitative study of 14 peer providers in a mental health support programme, and similarly found that participants noted an improvement in self-esteem through involvement, as well as perceived professional growth through skill and knowledge development. It should be noted that whilst the aforementioned research is promising, it is likely that a bias exists; in that participants consisted of those who had seemingly successfully navigated the challenges of involvement. It is likely that such studies also failed to capture the views of individuals who chose to discontinue involvement.

Several studies have explored the challenging aspects of introducing co-production within mental health services, including service users facing negative staff attitudes to co-production (Berry et al., 2011, Doherty et al.,2004; Gates & Akabus 2007; Kortteisto, 2017). Studies have also identified organisational difficulties in ensuring clear and consistent role structure for service users, alongside appropriate levels of support (Ehrlich, 2020; Gates & Akabus, 2007; Mancini, 2018).

Despite the increase in research within the field, it is notable that there is a lack of exploration of the processes and factors involved in an individuals' initial decision to become involved in co-production activities. One study by Berry et al. (2011) aimed to explore service user experiences of integration within a UK mental health trust. Within the interviews, service users spoke about their initial decisions to become involved, as well as their experiences within role. Through analysis of the data, the authors identified 'service user readiness' as a contributing factor to subsequent successful integration within the team. Whilst this study provided a much-needed initial exploration of psychological processes involved in initial involvement in such settings, it did not fully explore any of the potential factors that were identified and was limited by its small sample size (two participants). A recent grounded theory study by Debyser et al. (2019) explored the 'transition process' from service user to mental health peer worker, with a focus on exploring the personal growth of the 17

participants through this journey. The researchers identified several motivators for initial involvement, focusing on the opportunity provided to form a positive identity and to make a valued contribution to society through involvement. Whilst this research provided valuable insight into the motivations for initial involvement, it lacked exploration of the internal processes involved in moving from motivation to actual involvement in roles.

As numerous researchers have highlighted the often complex and non-linear nature of service users' journeys into roles of co-production (Freeman et al., 2016) there is a need for further research that explores the processes involved in precipitating initial readiness for involvement, as well as consideration of factors that maintain or limit continuing involvement. Such research will be informative to mental health services who wish to have an informed approach to recruitment of service users into roles. Research has established that some service users may find unsuccessful involvement in co-production to be an extremely disappointing and damaging process (Gates & Akabas, 2007). Despite this, much of the existing research has neglected to include the views of those individuals who have not benefitted from or who have chosen to discontinue involvement. It is hoped that having a greater formulation/understanding of how individuals view their journey to readiness will support services to intervene by recruiting and supporting individuals appropriately and successfully. It is imperative that services are well informed by individuals with direct experience of these processes to ensure that they develop practices in a co-produced manner, particularly with regards to how and when to involve individuals and how best to support individuals through the ongoing processes associated with involvement.

The primary aim of this research is to investigate the psychological factors involved in a service user's journey into co-production roles, using grounded theory methodology. The secondary aim of the research is that the theory developed can be used to inform the

development of guidance around supporting individuals to become involved and remain involved in roles outside of their own care.

METHOD

Design

Individual interviews employing a semi-structured interview schedule were used to collect data. Interview data was analysed using the principles of grounded theory (Glaser & Strauss, 1967). For the current study, a constructivist grounded theory approach (Charmaz, 2014) was used.

Service User Involvement

A service user with extensive experience of being involved in co-production activities within mental health services and clinical psychology training was an integral part of the supervisory team. As such, this individual provided input at all stages, including in the design of the study and the interpretation of the findings.

Recruitment

Recruitment of participants was initially purposive, via existing links with third sector organisations across South Wales, as well as individuals who have been involved with the South Wales Clinical Psychology Doctorate programme. Organisations who were contacted included: Hafal, Sefyll, 4winds and Interlink. Organisations who agreed to promote the research advertised the study via email and in online meetings; sharing the study information sheet (Appendix G). Several eventual participants contacted the author after being informed about the study by previous participants. Participants subsequently recruited via this form of 'snowball sampling' included individuals currently involved in co-production activities within third sector or NHS settings, although participants were not directly recruited from

NHS settings at any point of the study. The inclusion and exclusion criteria are described in Table 1.

Table 1: Participant inclusion and exclusion criteria:

Inclusion Criteria	Exclusion Criteria
- All participants must be >18 years of age. - Currently involved in co-production of some variety in mental health services or related services. - Able to participate in a verbal interview of up to 90 minutes. - Sufficiently fluent in English to read and understand the information sheets and to participate in the interviews.	- Participants <18 years of age - No service user involvement/co-production activities in mental health services in the last 12 months - Currently undergoing a relapse in their mental health condition, sectioned under the mental health act in the last three months or currently under the care of a crisis team.

Participant demographics

The sample of ten participants consisted of four males and six females. Two participants were aged between 31-40, three were aged between 41-50, another three were aged 51-60 and two were aged over 60. Participants' number of years of experience in co-production roles varied from 1 year to over 20 years, with a mean of 7.5 years' experience across participants. All participants were currently based within roles in South Wales. Further demographic information in relation to participants' current settings will not be included in order to protect their anonymity, given the relatively small field from which participants were recruited.

Data collection and procedure

Data was collected via semi-structured interviews. This allowed a balance of exploring participant constructions of the area of interest, along with exploration of emerging issues of interest (Bluff, 2005). Interviews were conducted virtually due to COVID-19 pandemic guidelines and took place via Zoom. Individuals who expressed an interest in participating in

the research were provided with a participant information sheet (Appendix G). Informed consent via a written consent form (Appendix H) was received from all participants prior to participation in an interview. All interviews were audio recorded, lasting between 34 and 76 minutes, and transcribed verbatim. Debrief forms were sent to all participants following participation (Appendix I).

Interview schedule

The initial interview schedule was developed through discussion with the supervisory team and consultation of the literature in the field. The initial interview was piloted with the service user consultant within the supervisory team. Following this pilot interview, elements of the schedule were altered in order to improve clarity. The semi-structured interview schedule comprised of open-ended questions with corresponding prompts (see Figure 1). In line with constructivist grounded theory; lines of additional questioning to follow were based on the information given by the participant within the interviews. Following initial analysis and coding of interviews, the interview schedule was altered on two occasions (following interviews three and six) to aid the further exploration of emerging codes (see Appendix J for amended interview schedules).

Figure 1: Initial interview schedule

Initial draft semi-structured interview schedule

Thank you for agreeing to be interviewed today and taking the time out of your day to share your experiences. Today I will be asking you some questions about your experiences of being involved in services in a co-production role.

Definition of co-production: Co-production in mental health settings refers to a process in which service users, carers and staff work together as equal partners towards shared goals (Social Care Institute for Excellence 2015). Relating to the term "co-production" are various levels of user involvement with services including roles such as 'Expert by Experience' and 'Peer Support Worker', as well as initiatives such as 'Service User Networks' and 'Recovery Colleges'.

To start with it would be useful if you could tell me the nature of your involvement to date, ie.one role or several, how long have you been involved and briefly what your role involves?

- ***Can you tell me about how you came to be involved in your current role?***

  Can you tell me what it is like starting out in an 'expert by experience' role in co-production?
- ***Before you had experience of being in the role, were you aware of these types of roles and what were your thoughts on this type of involvement?***

- ***What was going on in your life prior to becoming involved in co-production?***
  -How would you describe the person you were then?
  -What drew you to the role at this time?

- ***If you can recall, were there any experiences you had that shaped or influenced your readiness for this type of role?*** -
  -Were there any specific steps you took in preparation for beginning your role?
  - What happened next… was anyone else important/involved in getting started?
  -Who if anyone influenced your decision to become involved?
  - Can you tell me a little about what influence they had on you?

- ***As you look back on your experiences in the role, how has the reality of involvement in co-production compared to what you thought it might be like?***
- *Are there any specific events/instances that stand out in your mind?*
- *What do you enjoy most about your role?*
- *Were there any particularly difficult aspects of taking on your role?*

- ***Were there any times that you reconsidered your involvement/your role in co-production?***
  -What helped you to continue your journey at these points?
  -Are there any particular things/people that have been helpful at these times?
  -What keeps you going on a bad day at work?
- -

- ***From your experiences, when might be a good time in someone's recovery journey to talk to them about co-production?***

- ***How, if at all, has being involved in your co-production role changed you?***
- *Personally, emotionally, mental health, relationships, confidence?*

- ***Looking back on your experiences now, what advice would you give to someone about to start within a co-production role?***

- ***What advice would you give to someone (perhaps a professional) looking to support or encourage someone to take on this type of role?***

- ***Is there anything else you think I should know to understand your experiences better?***

Ethical considerations

Ethical approval was received from Cardiff University School of Psychology ethics board reference EC.21.01.12.6221 (Appendix K).

Care has been taken to present demographics such as age, gender and years of service in such a way as to prevent readers linking categories together and potentially identifying participants.

Consent was sought and confirmed with participants on several occasions throughout their involvement in the research. Participants initially provided written consent after being provided with an information sheet detailing the purpose of the study. Verbal consent was then sought prior to beginning the interview, alongside a reminder that they could withdraw from the study in the month following the completed interview. Participants were also reassured that they could choose not to answer or elaborate on questions at any point during the interview.

Data analysis

Data collection and data analysis took place in parallel, with emerging concepts being used to inform the direction of future data collection. Analysis involved the coding and categorisation of data alongside memo writing, which together were used to inform the eventual formation of a theoretical model of understanding. These processes are described in greater detail below.

Coding

In line with the principles of grounded theory, data collection and analysis occurred simultaneously and therefore, at times, elements of the process overlapped. The process will be presented here in a linear way to facilitate understanding.

Initial coding of data was completed independently by the author in line with guidance from Charmaz (2014), with each verbatim transcript initially being coded line-by-line for action, meaning and processes (see Appendix L for example transcript excerpt and Appendix M for example of coding within Microsoft Word). Following initial coding, 'focused coding' was completed which aimed to highlight the most significant or frequent initial codes that made most analytical sense (Flick, 2014). A method of constant comparison was employed, with the author comparing participants' data regularly and seeking out areas of similarity and difference in their accounts. Tentative conceptual categories were created and tested through ongoing comparison across participants' data. The author met regularly with the supervisory team during this period to discuss emerging conceptual categories and to consider additional areas of exploration through theoretical sampling. Table 2 provides an example of the process of data coding (please see Appendix N for a further example).

Memo writing

Memo writing was used throughout the research process, both immediately post-interview and throughout the coding process. The author used memos to document the thoughts and questions that emerged as they engaged in the process of constant data analysis and comparison. Memos were subsequently referred to during the process of raising focused codes to tentative conceptual categories and in the creation of the subsequent theoretical concepts and model (please see Appendices O and P).

Table 2: Example of coding process

Raw interview extract	Initial coding	Focused coding	Category	Theoretical concept
"No, it was very informal, but they were large groups. And I think I certainly got a very strong sense of imposter syndrome because I looked around the room at the other people and, regardless of what they said about themselves, I still felt that they were in a much more sorted place than I was. So, I kind of felt that I wasn't worthy in some respect to be there because I felt I was still quite vulnerable and that the input that I had would perhaps be coloured but the fact that my mental health, early on, still wasn't great."	Describing first experiences as being within large groups but still informal Looking around the room at first involvements with a sense of 'imposter syndrome' Reflecting on initially feeling not worthy to be there Feeling quite vulnerable and as though early input may have been coloured by own mental health	Reflecting on Initial experiences Comparing self to other professionals Feeling unworthy Recognizing own vulnerability	Importance of early experiences Confidence in ability within role Sense of belonging/not belonging Own MH and 'stability'	Professional identity Normalisation of MH in workplace- 'its ok to have wonky days'

Theoretical sampling

Following the process of constant comparison and thus paralleling interviewing participants and coding existing data; commonalities and gaps in the data were identified. Recruitment was paused following interview three and again following interview six to allow for changes to be made to the interview schedule (please see Table 3). By interview ten it was felt that 'theoretical sufficiency' had been reached (Dey, 1999).

Table 3: Demonstration of theoretical sampling methods

Gap or commonality identified	Process of identification	Potential gaps in data collection identified	Actions taken to address
Participants speaking about the nature of their roles, some ad hoc work whilst others offered full time involvement	Initial coding of first three interviews Review of post-interview memos and research diary Discussion with supervisory team	Need to address whether the nature of the involvement with regards to stability (perhaps practically- payment as well as occupationally) impacts initial involvement	Amendment to interview schedule to add question regarding whether ad-hoc or consistent work was valued and whether this impacted on self-care and work life balance
Participants speaking about setting of initial involvement and the impact of this- visual memories of lots of people etc	Initial coding of first three interviews Review of post-interview memos and research diary Discussion with supervisory team	Need to strengthen and add to this potential concept, asking for specific first memories and experiences may be needed to elicit this. Some appear to find large settings off-putting- is this a shared experience?	Amendment to interview schedule to add prompts asking about first experiences- can they recall setting, number of people. Was there anything that stands out about that experience as particularly helpful or unhelpful?
Participants speaking about opportunities to meet others in similar roles and seeking this out	Initial coding of first three interviews Review of post-interview memos and research diary Discussion with supervisory team	Individuals seeking this out- perhaps need to explore what about this individuals value or would have found valuable- is it practical support or role model based?	Amendment to interview schedule- added question- was this opportunity available and was it helpful?
Participants speaking about vulnerability within role and balance between this being helpful and unhelpful	Initial coding of first six interviews Review of post-interview memos and research diary Discussion with supervisory team Development of categories	Need to further explore this potential conceptual category- how do individuals navigate this difficult balance? What is the role of the organisation in supporting this?	Amend interview schedule to ask about navigating this balance, is there anything that they found useful from professionals or that they did to put boundaries in place for themselves?

Noting that most of current participants have had extensive involvement spanning years	Discussion with research team Review of research diary	Are participants' initial experiences going to be different if they were 10-15 years ago? Would be helpful to have the perspective of individuals more recently involved for the first time	Ask recruiting organisations to emphasise that involvement does not have to been long standing. Attended SU meeting an organisation to promote involvement from those newly involved.

Quality control

The author referred to accepted guidance from Elliot et al. (1999) in an attempt to ensure the quality, reliability, and validity of this qualitative research. Table 4 provides information on how elements of the guidance were adhered to:

Table 4: Examples of quality control adherence guided by Elliot et al. (1999):

Guideline considered	Method used by current author
Owning one's own perspective	The author was aware of the potential for their own biases to influence the direction and interpretation of the research (see reflexivity section for further details). The author kept a reflexive journal throughout the interviewing process, which allowed them to consider and comment on how their own existing beliefs or assumptions may be influencing the interview process and subsequent coding of data. Regular discussion with the supervisory team aided the process of identifying occasions where individual bias may have been unduly influencing data analysis.
Situating the sample	The author has been mindful of the ethical considerations of providing detailed demographic information regarding the study participants. Sufficient characteristics i.e., age, gender, and number of years of experience in co-production activities has been provided. Demographics that may lead to the identification of individuals have been omitted- this was particularly important given the relatively small participant pool in South Wales.

Grounding in examples	Interview quotations (raw data) have been used throughout the results section of the research to support the author's interpretations and demonstrate their origins. Examples of the coding process have been provided alongside examples of memos and discussion of theoretical sampling.
Providing credibility checks	The supervisory team were involved in the reviewing of coding and the creation of conceptual categories, as well as reviewing and critiquing the emerging theoretical model presented by the lead author (please see Appendix Q for mind-mapping category development shared with research team and Appendix R for earlier version of theoretical model) Regular memo writing provided an audit trial with regards to the development of analytical ideas.
Coherence	The author has provided a clear and accessible diagrammatic model to represent their theoretical model, alongside a written narrative to support this.

Reflexivity

In line with constructivist grounded theory, the author is aware that theories developed within this study are dependent on the author's view, and as such the author cannot achieve separation from the data (Charmaz, 2006). Recognition of this and taking a reflexive stance towards theory evolution; recognising the influence of their own values, assumptions, and previous experiences, is therefore imperative (Charmaz, 2006).

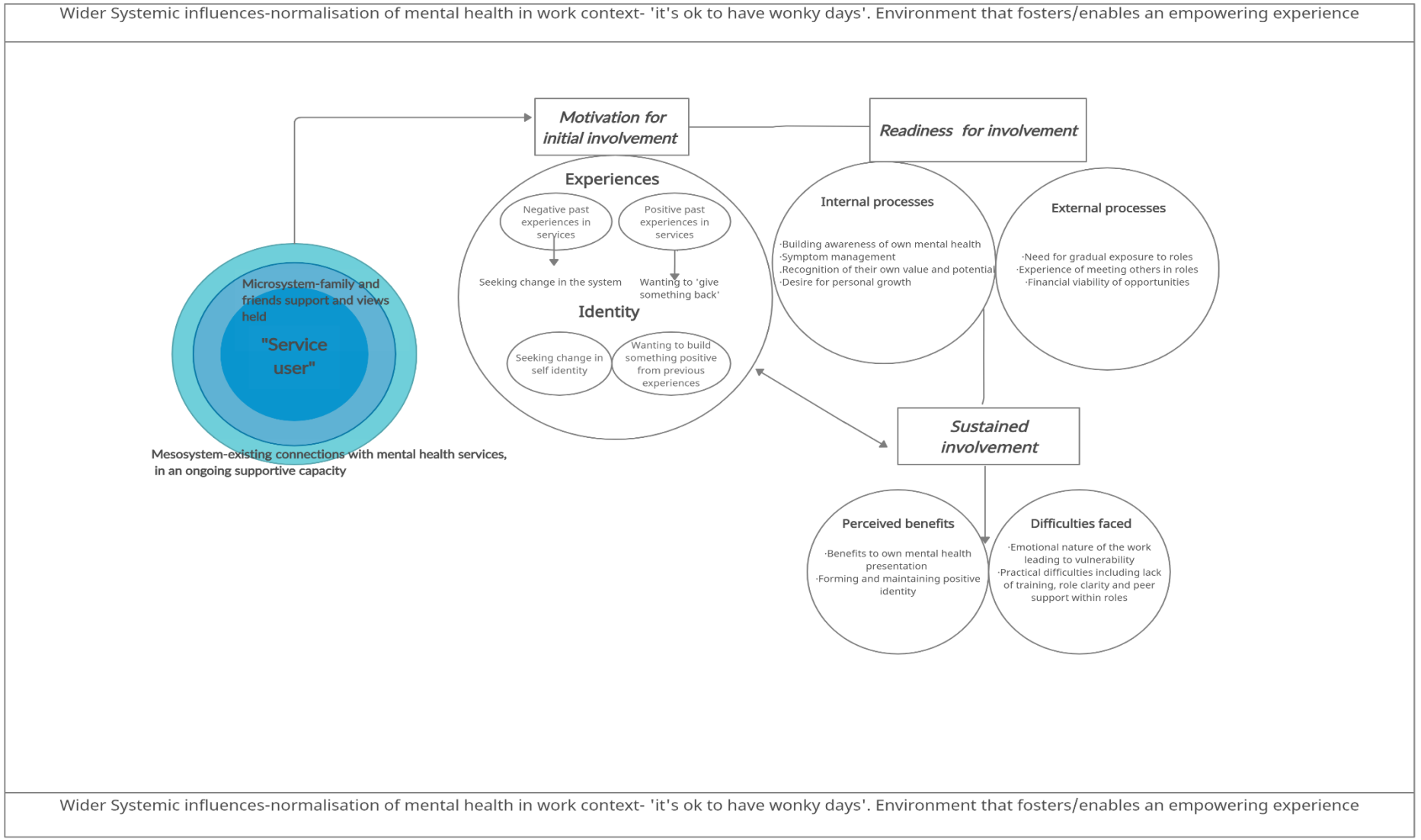
All members of the supervisory team had some form of interest and recognised inherent value in co-production, but none of the team stand to gain or lose from the outcomes of this study. The research supervisors all have experience of working within mental health service delivery and specifically of working with 'experts by experience', with the external supervisor having direct experience of integrating peer mentors into teams. These experiences may have influenced the initial research question, and research supervision discussions. The

author is a 31-year-old white British female who was training to be a Clinical Psychologist. The author has a personal link to co-production in mental health, having a parent who is currently involved in co-production activities in England. The author was aware of the possibility of the research being influenced by her existing 'stories' around co-production and used a reflexive journal to aid the process of ensuring that no overt bias was present in the interpretation of data.

RESULTS

An interpretative theory was developed that focussed on the processes that individuals go through in readiness for involvement in co-production activities (Figure 2). Individuals also chose to speak about factors that sustained their involvement, and as such this element of their journey was additionally explored as interviews progressed. Please note that pseudonyms have been used within the written narrative of the results section.

Figure 2: Conceptual model of service user readiness:



The theory initially recognises that individuals exist within their own 'system', and whilst we are focussing on individuals' experiences, we must acknowledge that individuals are influenced by relationships with both their micro and mesosystem. At this stage of the model, the term 'service user' is adopted, as it represents the point at which contact with mental health services has been in a consumer, rather than provider, capacity.

Prior to their readiness for involvement in co-production, service users need to be motivated to engage, with motivations shaped by previous experiences within services. Individuals who have experienced unhelpful or adverse experiences within services are motivated by wanting to change the system and to improve others' experiences. Conversely, those who had positive involvement may seek to 'give something back' through involvement. Building from these past experiences, there is consideration of how involvement may alter one's sense of identity. Through involvement, 'service users' seek out a more positive, valued identity within society.

The process of readiness for involvement comprises a series of internal factors, alongside external, organisation-controlled processes. The process of becoming 'ready' for involvement requires individuals to have developed an understanding of their own mental health presentation, often through significant engagement with services. Individuals also require a good level of insight into difficulties that they can present with when they are unwell, with plans in place to manage these where possible. Following this, taking the next steps towards readiness, individuals experience an internal desire for personal growth, underpinned by a recognition of their own potential value and the skills relevant to involvement. External processes influencing the process of readiness include organisations providing opportunities for meeting with individuals already in similar roles, in order to provide greater insight as to what involvement might look like in practice. Individuals value the opportunity to get involved at their own pace and to gradually increase this involvement when ready. Finally,

opportunities presented and involvement as a whole need to be financially viable for people wanting to become involved.

Once individuals are involved with services in a role of co-production, their continued involvement is dependent on the balance of perceived benefits and difficulties faced. Individuals can experience an improvement in their own mental health through involvement, but equally can find that the emotional nature of the work can lead to them feeling vulnerable. A positive experience that enables an improvement in mental health is found in roles that provide opportunities to develop a sense of valued occupational and personal identity. More challenging experiences include roles that require individuals to regularly make themselves vulnerable through their work (e.g., through exposure to potentially triggering environments and presentations), without having appropriate measures in place to counteract this, with such measures including providing opportunities for networking with peers, appropriate supervision, and role clarity.

Subsuming the theoretical model are the wider systematic influences at play and, specifically, a broad acceptance that mental health needs apply to all individuals. This includes a recognition that reasonable adjustments should be made with this in mind and is key to fostering an environment in which people feel ready to become involved in roles outside of their own care.

Motivation for initial involvement

This category refers to individuals requiring a level of motivation in order to consider involvement in roles outside of their own care. Individuals spoke about their motivations being driven by their previous experiences of mental health services, with a clear distinction in driving forces reported by those individuals who had encountered negative experiences in comparison to those who had experienced more positive support from services. A commonality between participants was seeking involvement as a way of forming/building a positive identity. Individuals also spoke about being motivated by the idea of being able to be a part of a 'movement for change' within services, as well as potentially being able to support and improve the experiences of those currently accessing mental health services.

Experiences

As alluded to above, participants notably reported their involvement in co-production activities to be driven by their previous personal experiences within mental health services:

Seeking change in the system

Several individuals spoke in detail about their own mental health journey and elements of the current mental health system that they felt were unhelpful, with these experiences driving a desire for change:

"When you've been at the receiving end of this sort of service, and you see the injustice actually see the way people are treated and written off and labelled […] it drives you forward then to actually think, I could do something then too; you know help change the system" (Jimmy)

Others spoke with optimism about wanting to make a difference and feeling that involvement with services, despite initial reservations due to negative experiences, was an effective way to ensure that real change was enacted:

"I've actually been proud to work with people in proactive and positive ways to build bridges […] despite feeling let down at times by the services […] but actually putting that to one side really and thinking well that will change going forward" (Greg)

Wanting to give something back

This category refers to individuals' reports of wanting to contribute positively to service provision, following their own involvement with services. Participants noted being particularly motivated by the notion of improving the experiences of others experiencing mental health difficulties. Several individuals spoke proudly of having the opportunity to use their experiences to 'give something back' to services.

"When the opportunity was there […], I was ready to do that at that stage […] I felt mentally well enough to be able to give something back, I think" (Ffion)

Whilst this was described by many as a largely positive motivating factor, there was also a sense of duty to 'give something back' described by one participant:

"Because I've done so much in so many places with so many people I really, there's a part of me that feels almost as if I might feel mildly guilty if I didn't continue to use that in some way, shape or form" (Brian)

Identity

Participant identity and the transition of this across both their recovery journey and foray into co-production were discussed by all interviewees. Individuals spoke about their identity in relation to their internal sense of self, occupational identity, and wider role within society.

Their identity was thought to be largely shaped by their mental health diagnoses for periods of their life, with involvement in co-production providing an opportunity to move past this and the negative connotations that often still accompany mental health conditions within society.

Seeking change in self-identity

Participants spoke of the unhelpful connotations of being labelled as someone with mental health difficulties by society, with this having a direct impact on their self-perception:

"Really, you're almost treated as second class because you had a label or you're never going to be good enough [...] I worked really hard to come to challenge that myth as well […] I can prove that I can still do things despite having this condition." (Jimmy)

One participant described involvement in co-production as providing them with an opportunity to move away from an unhelpful identity and towards not only a more positive identity, but also a sense of purpose and vocation:

"A person's identity can get tied up, sometimes unhelpfully actually, with that word the service user […] it can be stigmatising or self-stigmatising […] So, it really did help me get […] more of an answer to that social question, what do you do?" (Brian)

Wanting to build something positive from previous experiences

Despite many participants speaking about a desire to move away from the identity of 'service user' due to the negative experiences associated with this, several individuals recognised that their experiences had afforded them a unique perspective that could be used meaningfully:

"It's nice to think that all those horrible and dramatic things that happened could contribute to something good. It's almost like those experiences then have meaning, and certain things happen because they lead you to this certain place" (Jane)

One participant spoke of ‘wearing a mask’ for much of their lives, with peer work allowing them to use their experiences positively as opposed to feeling that they had to hide their lived experience:

“I think as a peer mentor, one of the greatest things that we are allowed to do is be ourselves. […] most of us have been wearing masks for most of our life, trying to placate or trying to fit in […] And the very thing that we've been trying to hide, is the very thing that we are allowed to out” (Ffion)

Readiness for involvement:

Readiness can be thought of as a process as opposed to a singular destination based on participants’ accounts of their journeys. Participants agreed that readiness was an individual process and that there was no clear or right time for people to consider and begin involvement in co-production. In relation to professionals approaching the subject of potential involvement in opportunities, several participants endorsed the concept of ‘planting a seed’. Providing people with sufficient information about opportunities, balanced with ensuring that individuals felt no pressure and remained in control of the process, was an approach endorsed by all.

Internal processes

The current research highlights that many of the factors influencing readiness for involvement are dependent upon a number of internal processes. These processes appear to be non-linear in nature, with process speed and outcome seemingly influenced by the motivational factors underlying the processes:

Building awareness of own mental health

Several participants spoke about going through a process of building their awareness of their own mental health needs prior to involvement. For some, this involved engaging with services and seeking support that they had previously avoided. Through engaging with services, these participants were able to develop a greater understanding of their mental health needs and gain insight into what they needed in order to progress through their recovery journey:

"I knew I had to build up my sort of resilience to the illness. […] I realised that I had, as this happened, gained more insight into the illness and my recovery" (Steve)

Symptom management

Alongside a general level of awareness of their own mental health, participants felt that it was important to have some degree of symptom management. Most participants felt that it was unrealistic, as well as unnecessary, to be 'symptom free' prior to involvement, but recognised that having strategies in place to manage difficulties and being able to live alongside them was key:

"In my experience of working with people […] I've seen them kind of having this balance of being able to take the bad in a different way, being able to kind of work through it and it not be kind of like a crisis" (Clare)

Recognition of their own value and potential

Many people spoke about their experiences as a 'service user' leaving them feeling devalued and lacking in confidence, particularly in relation to their future occupational prospects. People spoke of it taking time for them to begin to challenge this internal narrative:

"All I ever used to tell myself was, your damaged goods […] So, a lot of the work was kind of challenging […] my internal dialogue and what I was telling myself." (Jane)

Desire for personal growth

Alongside the aforementioned internal processes, and linked to the motivational desire of building a positive identity, participants were driven by an internal desire for personal growth, with this desire facilitating their progression from a place of readiness to action:

"I'm really pleased with what I did with my life. You know I didn't just think, oh yeah, I'm a service user […] I'll just stay on these drugs you know…. I think not, I'm not doing that, I knew I had abilities." (Jimmy)

Interviewees also spoke about viewing involvement as an opportunity for learning and developing their skills:

"It was very much looking for a new way forward if you like. […] I thought, I want to sort of learn something new." (Brian)

External processes

Alongside internal processes, interviews revealed a number of factors and processes out of the realm of control of interviewees, with participants describing readiness for involvement being more than an internal process. Individuals described a number of elements of their journey to involvement being influenced by the readiness of organisations to support co-production successfully, and their subsequent ability to foster readiness at an individual level:

Need for gradual exposure to roles

For many interviewees, involvement in co-production activities was viewed as their first step back into a more structured form of occupation and/or employment. For those who had not been in such environments for some time, this was viewed as a potentially daunting prospect.

Many individuals spoke about needing to build up their confidence, and this being helped by receiving support and encouragement from others. All participants endorsed a gradual approach to involvement, with the pace of this being led by the individual:

"For me it was about, one step at a time. You know, dipping my toe back into the […], employment arena […], 'cause I'd been out of it for five years." (Ffion)

Experience of meeting others in roles

A theme throughout interviews was participants' retrospective desire to have met with individuals in similar roles prior to undertaking their own involvement. Several interviewees spoke about having had this opportunity and finding that it provided them with valuable insight into what to expect from the role, a sense of connection and, for some, a role model of sorts. Others who had not had the opportunity to make these connections noted that they would have valued this opportunity:

"I think what I probably would have found helpful is if somebody had told me their experiences of being in that role prior to me going into post." (Jane)

Financial viability of opportunities

An important consideration for many was the practicality of involvement from a financial perspective. Many participants spoke of having been previously employed and having financial responsibilities. Individuals, therefore, had to consider whether involvement was viable in this respect:

"Where we were living at the time, and they wouldn't pay my fuel to get to […] where they wanted me to like cover." (Jimmy)

As well as the practical importance of payment, individuals acknowledged the unspoken message that payment sends within this setting:

"Paying people, I think that's important as well […] to feel valued. They feel like they're doing a job, work really." (Greg)

Sustained involvement

Whilst much of the initial focus within interviews centred around readiness for initial involvement, all participants progressed to discussing involvement beyond their beginnings. Involvement in co-production was a non-linear process for many, with individuals choosing to step in and out of roles for various reasons. Participants described ongoing involvement being dependent upon the perceived balance between the benefits that involvement brought and the more difficult aspects of the roles.

Perceived benefits

Benefits to own mental health presentation

One of the primary benefits of successful involvement was a reported improvement in one's own mental health. Many spoke of this improvement being facilitated by a role that enabled them to make a positive impact on the lives of others and the sense of achievement and purpose that this provided. Participants additionally acknowledged that having an external focus had been a useful aspect of involvement:

"What I found works brilliantly for me is put my focus on other people […], I mean it distracts you from your own stuff and especially if people start to see how you're really helping." (Jimmy)

Alongside the benefits to mental health through involvement in purposeful occupation, several participants commented that their involvement had improved their knowledge of their own mental health condition. Through working in environments where mental health was

often the focus of discussion, and alongside mental health professionals, participants were able to apply their acquired knowledge to their own mental health and recovery.

Forming and maintaining positive identity

Individuals' continued involvement in roles was related to the impact that involvement had on their sense of identity. In order for individuals to remain involved, roles need to provide them with a positive sense of identity. Several individuals spoke proudly about their involvement, with opportunities to act as helpful role models for others being a particularly valued element of building and maintaining a positive identity:

"It also though demonstrates to others that; your vulnerability is your superpower […] you know to be able to become a role model." (Ffion)

Difficulties faced

Emotional nature of the work leading to vulnerability

A common source of inner conflict discussed by participants was managing the level of emotional vulnerability that accompanied their involvement. While on one level, individuals valued being able to use their personal experiences to a positive effect, this was inevitably accompanied at times by a level of discomfort due to the sensitivity of the content involved. Vulnerability within involvement was elicited through disclosure of personal experiences, working with individuals with similar experiences to their own and for some, contact with mental health professionals who they had known in a different capacity:

"Sometimes it can get a bit too much you know with intensity of it […] having been on the receiving end of the system […] I think, oh this is really too close to home […]it can trigger off, you know, unpleasant memories and whatever." (Jimmy)

"I was working with people that had previously restrained me on a ward. And, obviously, that's got a really weird dynamic to it." (Jane)

Practical difficulties

Barriers to sustained involvement and positive experiences within role were numerous. Many of the issues encountered related to organisations failing to provide appropriate and sufficient structures of support. A lack of training was reported by many as a factor that led to them feeling less valued and less competent than others within their organisation. Supervision was valued by participants, yet few reported having access to supervision from a peer or sufficient access to a network of support from peers. Other interviewees spoke of finding a lack of clear role structure and a generally disorganised environment unhelpful, particularly when seeking certainty and security within role:

"I've worked in previous charities where it's chaos actually […] so that's not brilliant when you're trying to survive and work in a chaotic work environment." (Jimmy)

Wider systemic influences-normalisation of mental health in the workplace

Throughout the interviews and interweaved through the processes of motivation for involvement, readiness for involvement and sustained involvement, is an acknowledgement of the wider systemic influences at play. Participants spoke of a need for organisations to support the normalisation of mental health through their actions and approach to supporting individuals with lived experience. Many spoke of valuing organisations that openly normalised mental health and the occurrence of 'wonky days', without dramatizing this and assuming that individuals would need to cease involvement:

"In actual fact, being wonky isn't bad. And it's very reassuring to people who are not as far into their journey as you are, to see that it's okay to have down days. To feel a bit crap and to be honest about it." (Greg)

Individuals valued organisations that were flexible in their approach to support, making reasonable adjustments and providing clear avenues of support and alternative ways of working when this was necessary, without making assumptions about what someone might need:

"And I think that it's been very empowering that, rather than being told that I should take time out […] or do I need to think about medication [...] Asking, what do you need from me […] somebody helping you to sift through, that's not a mental health referral but just sift through what you're doing, going, this is okay." (Denise)

DISCUSSION

In line with the primary aim of the research, this study adds to our knowledge of the psychological processes and factors involved in a service user's journey into co-production. The overarching theory developed suggests that individuals navigate a series of internal processes prior to 'readiness', including developing their self-awareness and re-framing their experiences as a service user as an opportunity for personal growth. Organisations play a key role in facilitating service user 'readiness' through providing opportunities for graded exposure to roles, and liaison with others in similar roles. Sustained involvement is dependent upon an organisation's ability to provide appropriately supportive systems that facilitate personal and professional growth, whilst being mindful of the vulnerability that often accompanies involvement. These central findings, together with the specific themes of the model, make a significant contribution to the research literature around how best to involve service users in co-production, thus fulfilling the second objective of the study; to develop a theory that can be used to inform the development of guidance around supporting service users to become involved and remain involved in co-production activities.

Several stages were identified across individuals' journeys to readiness. A commonality across participants was a perception that involvement in co-production would be an opportunity to develop a more positive sense of identity. This finding echoes previous research by Vandewelle at al. (2018) who found that individuals' forays into peer work are often motivated by a desire to replace the negative label of 'patient with a mental health diagnosis', with 'an individual making a valued social contribution'. Debsyer et al. (2019) made similar links between peer roles and the construction of self-identity in their exploration of the transitionary process of moving from 'patient' to 'peer worker' Within the current study, the desire for change in identity appears to apply at both a personal and societal level. Participants spoke of seeking a change in their internal view of themselves as service users, with this often being driven by the negative experiences associated with this label. This initial motivation was further strengthened by a desire in many to build something positive for themselves and others, with this often being sought out in an occupational setting. This suggests that occupation was deemed to be an important element of forming a more positive sense of self-identity for participants. Research in the field of occupational identity suggests that there is an association between work being perceived as 'a calling' and positive mental health (Skorikov &Vondracek, 2011). The findings of the current study are consistent with this notion, with many speaking of feeling uniquely equipped to take on such roles and benefitting personally from roles that allow them to use their prior experiences for the benefit of others.

Alongside a desired change in internal sense of identity, participants commented on the change in perception from society through their involvement in co-production activities, with one individual noting that they finally felt able to answer the question 'what do you do?'. The desire for the social normalisation achieved through being able to answer, 'what do you do?" links to Wolfensberger's principle of 'social role valorisation' (1983,2011). Social role

valorisation refers to the issue of certain groups within the population being stigmatised and excluded as a result of being viewed unfavourably in relation to their role and contribution to society. Social role valorisation principles aim to enhance wider societies perception of such groups and their value through education and normalisation. For many in the current study, involvement in co-production activities appears to have provided them with a sense of validation of their personal competencies and experiences, as well as providing them with a valued social identity through involvement in occupational activities.

Building on the theme of identity, in the current research, participants spoke of the challenges of 'juggling various hats', with involvement requiring them to develop a professional/occupational identity whilst retaining aspects of their 'service user' identity. For many within the current study, holding these dual roles was a challenging feat, particularly when in organisations that lacked clear expectations regarding their involvement. Despite this challenge, participants spoke of valuing a role within which they felt able to use their own experiences and remain their authentic selves. These findings are consistent with research into post-traumatic growth in mental health recovery, which identified 'sense of self' as a key component of recovery and perceived post-traumatic growth, specifically in relation to beginning to integrate and value their lived experiences (Slade et al.,2019). The current research further adds to our existing knowledge by highlighting the importance of organisations providing role clarity and opportunities for meeting with others in role, both of which appear to help define and strengthen professional identity formation.

The findings from this research are consistent with several elements of the CHIME framework of personal recovery (Leamy et al., 2011) commonly adopted by recovery colleges in the UK. The CHIME framework refers to five key components involved in personal recovery from mental health difficulties (connectedness; hope and optimism; identity; meaning and purpose; and empowerment). As well as the aforementioned findings

from this research about the process of developing a more positive self-identity (which is an important construct in the CHIME framework), a sense of connectedness with others with similar experience was also highlighted by participants as being important across their journey into co-production, with individuals seeking contact with peers prior to involvement, as well as valuing ongoing opportunities for support. Social comparison theory (Festinger, 1954) proposes that we determine our own personal and social worth through making comparisons between ourselves and others. In the context of previously being labelled a 'service user', it is logical that individuals would seek out others with similar past experiences in order to make these social comparisons. Alongside this theory, social learning theory (Bandura, 1977) would suggest that seeing others being successful in their endeavours when there are perceived similarities with ourselves, can increase our own self-efficacy and self-esteem through vicarious reinforcement.

For many participants, seeing and speaking to others in similar roles provided confidence that this was an achievable feat. This finding was consistent with previous research by Moran et al. (2013) who, in the context of exploring motivations for involvement of peer support workers in mental health settings, noted that peers sought out opportunities to connect with others in-role. The current research also endorses Moran's concept of participants' need to develop a sense of their own worth prior to feeling able to 'give something back to others' using their own lived experience. The current research has added depth to our existing knowledge of this concept, with participants describing processes of building awareness of their mental health, and developing symptom management strategies, as necessary processes prior to being in a position to successfully engage in co-production work.

Prior research has indicated the potential challenges experienced by service users in co-production roles as they negotiate multiple identities, including balancing their 'personal self', 'occupational self' and relationships with others (Cabral et al., 2014; Simpson et al.,

2017). The current research adds to this existing understanding by highlighting the particular challenges posed for individuals through exposure to emotive content and triggering environments. Participants spoke of the emotional vulnerability that often accompanies co-production activities and the delicate balance between vulnerability and portraying their authentic selves within role.

The present study identified that individuals go through several 'stages' on their journey to readiness, and that at times this journey may be non-linear in nature. The findings overlap with the trans-theoretical model (TTM) of behaviour change (Prochaska & DiClemente, 1982). The trans-theoretical model of behaviour change, originally developed and used within clinical and health psychology settings, has increasingly been used and adapted when exploring 'readiness to change' for interprofessional collaboration (Schirazi et al., 2018). The original TTM proposes five stages of readiness for change, with associated cognitions and expected cost vs benefits analysis taking place at each stage. Whilst the classic TTM model can be criticised in relation to its lack of explicit consideration of the wider social context within which change is taking place, it provides a relevant and useful framework within which to position the findings of the current research. Table 5 demonstrates how the findings of the current research map onto the original stages of the TTM:

Table 5: Stages of the TTM

Stage of TTM	How this maps onto the current theoretical model
Pre-contemplation-no intention of 'change' or recognition of the need for change	Identity as 'service user'- no consideration of co-production or involvement at this stage. Often a negative self-image/identity. Not feeling 'ready' to consider any role outside of their own care.
Contemplation- aware that a 'problem' exists but no commitment to action	Consideration of whether there is sufficient motivation for involvement- this will often involve reflecting on own previous experiences and whether an individual is seeking a form of 'change' either in the system, their identity or both.
Preparation- intent on taking action, begin planning	Internal preparations: Having/building awareness of own mental health needs and symptom management. Following this, recognising the value of their experiences and viewing/re-framing of using own experiences as a means of obtaining personal growth. External preparations: Organisations providing opportunities for individuals to meet with others in similar roles and to build up the level of their involvement. Social comparison theory may apply at this stage. Organisations need clear financial plans in place to support long term integration of roles to make involvement appealing.
Action- active modifications to behaviour-putting the decision into practice	Initial involvement through meeting with others in similar roles and developing confidence and competence, building up level of involvement. Social learning theory may apply at this stage-vicarious building of confidence as well as direct learning from observing others' practice.
Maintenance-sustained change	Sustained involvement is dependent upon the benefits of involvement outweighing the difficulties. Benefits of involvement may include an improvement in own mental health through various factors including improved self-identity and social connections.
Termination-return to previous behaviour	Individuals who ended their involvement may return to role as 'service user' and this identity- otherwise may seek out entirely different identity removed from the arena of mental health if ongoing involvement has left them feeling too emotionally vulnerable to continue involvement in this area.

In summary, the current research provides a greater depth of understanding, as well as new insights into the processes navigated as service users consider and become involved in co-production activities. Whilst the findings have commonality with the existing research, the study has provided new insights in relation to the significance of the emotional content of involvement, as well as highlighting the importance of organisations being 'ready' for involvement. The insight provided is valuable, particularly given that previous research has highlighted that unsuccessful involvement can prove damaging to individuals (Gates & Akabas, 2007).

Finally, whilst much of the previous research risks bias through employing samples of individuals successfully involved in co-production, the current research has sought to avoid such bias, including individuals with a variety of experiences, several of whom had chosen to (historically) cease involvement.

Limitations

The current research was reliant upon participants' retrospective accounts of often complex processes. Several participants had been involved in activities for a number of years and had held a number of positions within various organisations. This wealth of experience, whilst valuable, may have led to participants discussing their more recent experiences as opposed to their first steps into involvement. This limitation may be further exacerbated by a potential selection bias, as due to the nature of the inclusion criteria, participants are likely to have been those currently within roles and thus likely to be feeling positive about their involvement. This potential bias may have influenced participants accounts of their early experiences and the subsequent interpretation by the author. Although several participants had ceased involvement at points, all had successfully navigated the processes and challenges associated with readiness for involvement at least once. It would have been valuable to gain

the views of individuals who had for whatever reason been unable to achieve or sustain readiness. This perspective would have added valuable information to the model and theory around what is needed both at an individual and organisational level to enable successful involvement.

The sample of participants were all recruited via existing links with third sector organisations and snowball sampling, which led to the inclusion of several participants with NHS experience, however it did not consider involvement in statutory mental health services specifically.

The current research involved participants who have been involved in co-production in South Wales. Caution therefore needs to be taken with generalising the findings of this study to other areas of the UK and beyond.

Despite the aforementioned limitations, efforts were made by the author to recruit a varied sample of participants. Theoretical sampling was employed in an attempt to include individuals with more recent initial involvement, as well as several amendments being made to the interview schedule as areas of interest emerged.

Research Implications

Given the current drive within the NHS to increase and improve co-production within mental health services, future research may seek to explore NHS service involvement specifically. This may further inform the creation of service specific guidance around recruitment of individuals with lived experience.

Although there were attempts in the design to probe for the challenges that service users have likely faced within their roles, future research should consider interviewing individuals who had considered involvement but not moved into an ‘action’ phase, as well as those who have had previous involvement and have chosen to cease this.

Finally, further research may seek to build on the theorised link to the TTM by using the model to inform the development of a tool/framework to determine service user readiness for involvement. The model could additionally inform research aimed at developing guidance around what support structures are required at an organisational level for supporting co-production (i.e., by informing initial guidance that could be further developed through professional consensus research using the 'Delphi' method).

Clinical implications

There are several clinical implications directly resulting from this research. Firstly, organisations need to consider how they can facilitate opportunities for individuals to have contact with others with lived experience at all stages of their involvement in co-production. Organisations may wish to adopt a mentor style system, where individuals beginning their role are linked in with someone already in a similar role. Ideally, this mentoring relationship would begin prior to formal involvement in order to provide individuals with a sense of what involvement might look like.

Secondly, organisations need to consider the messages that are sent, both overtly and covertly, in relation to mental health in the workplace. Several participants spoke of a desire to normalise mental health within the work environment. Work environments where mental health was openly discussed facilitated a sense of safety in disclosing when they were struggling. Similarly, participants spoke about valuing reasonable adjustments being offered e.g., the option of a later working day if 9-5 working days were challenging. Organisations may wish to consider implementing well-being plans for all members of staff, not just those with lived experience. These plans would include information on what an individual might need from the organisation when they are struggling and how they prefer to be supported. Well-being plans for all would serve to normalise mental health needs in the workplace and

encourage organisations to think pro-actively about reasonable adjustments that may need to be introduced when an individual is struggling. For service users specifically, well-being plans could be a way of identifying potential vulnerabilities, allowing for proactive strategies to be put in place to manage these e.g., if it is identified that an individual finds visiting a specific hospital ward uncomfortable, this can be avoided.

Thirdly, organisations need to consider providing formal role specifications and clear information regarding the parameters of involvement for peers. Many individuals spoke of seeking a sense of identity from their involvement, it may be that providing this formalisation of involvement may aid this identity development, as well as providing containment in what can be an anxiety provoking period of change for many.

Alongside the specific implications formulated above, the current review has highlighted the value of seeking the views of individuals with lived experience. Further co-produced collaborative research concerning the support that individuals would value at various stages of involvement would prove valuable in co-producing specific protocols and guidance.

CONCLUSION

As demonstrated by the theoretical model proposed, individual readiness for involvement in co-production is a complex process which may be non-linear in nature. The decision to become and remain involved is an individual process, with no 'one-size fits all' approach emerging in relation to supporting individuals in this endeavour. Whilst the journey to readiness takes place within the individual, it is apparent that a number of external organisational and systemic factors have a significant impact on this process. With organisations increasingly seeking to involve those with lived experience in co-production activities, the current research has important clinical implications.

Declaration of interest statement

The author declared no potential conflicts of interest with respect to the research.

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APPENDICES

Appendix A: Journal of Mental Health author guidelines

Retrieved from: Submit to Journal of Mental Health (tandfonline.com) on 19/04/22

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Preparing Your Paper

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- Should be no more than 4000 (excluding abstracts, tables and references) words
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- 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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Appendix B: Prospero registration (with amendment confirmation):

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Thu 15/07/2021 14:00
Dear Miss Patton,

Thank you for submitting details of your systematic review "What are the contributing factors to a positive experience for those involved in peer support/co-production roles in mental health settings? A meta-ethnography" 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: CRD42021256491

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%7CPattond1%40cardiff.ac.uk%7C0e35ac5d7e5649c924af08d947907405%7Cbdb74b3095684856bdbf06759778fcbc%7C1%7C0%7C637619508015576875%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=zGbVrApcPG%2FvgknXQml8WYTDo6fVqzObW8palwVEtxU%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,

Ruth Walker
PROSPERO Administrator
Centre for Reviews and Dissemination
University of York
York YO10 5DD
e: CRD-register@york.ac.uk
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CRD-REGISTER <irss505@york.ac.uk>
Fri 05/11/2021 13:56

Dear Miss Patton,

Thank you for submitting amendments to your systematic review record CRD42021256491 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%7CPattond1%40cardiff.ac.uk%7C457a44fa1a3b47302c2a08d9a0641113%7Cbdb74b3095684856bdbf06759778fcbc%7C1%7C0%7C637717173923593301%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=Il9Q%2FxL2%2F6zGQfZ5%2BRCaO2eQVsdBo8NYsCd4dvH488o%3D&reserved=0.

Best wishes for the successful completion of your review.

Yours sincerely,

Susan Sutton
PROSPERO Administrator
Centre for Reviews and Dissemination

University of York
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https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.york.ac.uk%2Finst%2Fcrd&data=04%7C01%7CPattond1%40cardiff.ac.uk%7C457a44fa1a3b47302c2a08d9a0641113%7Cbdb74b3095684856bdbf06759778fcbc%7C1%7C0%7C637717173923603297%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=Mq7vzG22XJTUcQtBaXleLXhAY%2Fe9EfdGoEDRag%2FnsZ8%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.

Email disclaimer: https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.york.ac.uk%2Fdocs%2Fdisclaimer%2Femail.htm&data=04%7C01%7CPattond1%40cardiff.ac.uk%7C457a44fa1a3b47302c2a08d9a0641113%7Cbdb74b3095684856bdbf06759778fcbc%7C1%7C0%7C637717173923603297%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=rC4stILHaNl%2Bl%2FahKCfNGocrr7gET%2FsYiQtQCca6a8E%3D&reserved=0

Appendix C: Example search terms and Boolean operators

Example of search terms used:

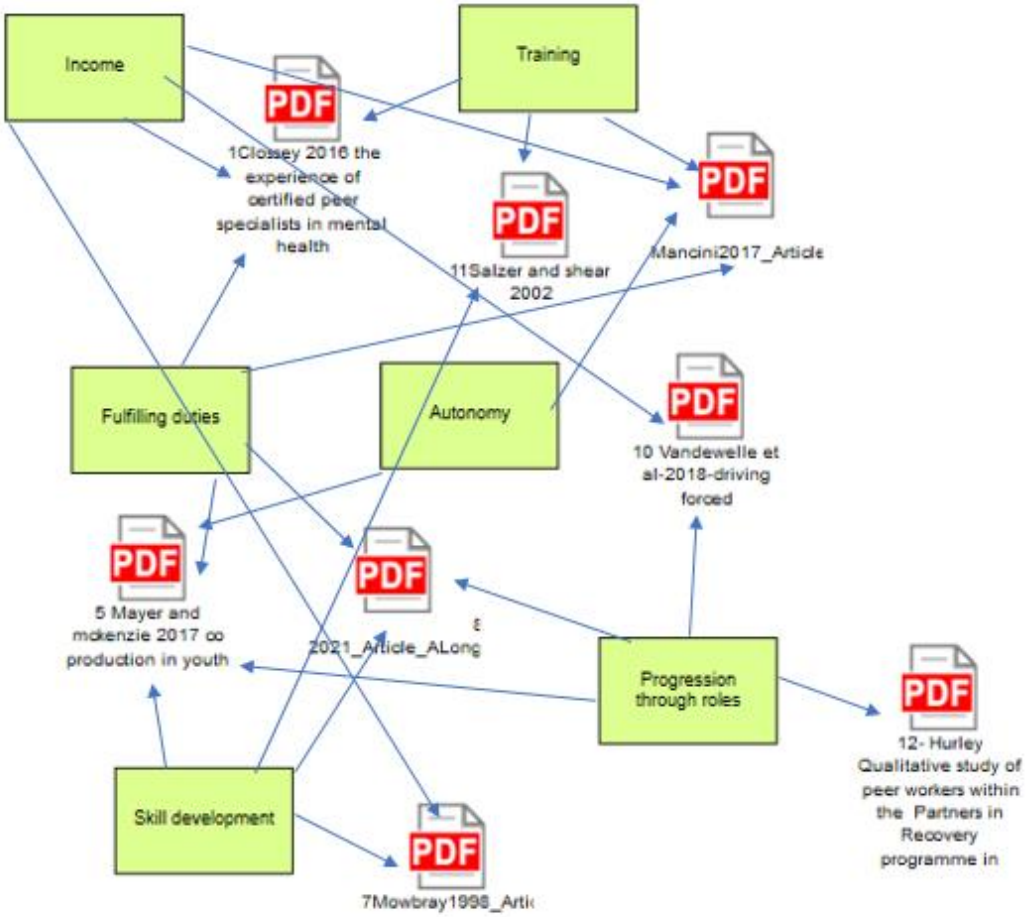
Scopus:

((TITLE-ABS-KEY ("peer provider*")) OR (TITLE-ABS-KEY ("peer specialist*")) OR (TITLE-ABS-KEY ("peer service*")) OR (TITLE-ABS-KEY ("co-production")) OR (TITLE-ABS-KEY ("co creat*")) OR (TITLE-ABS-KEY ("peer support"))) AND ((TITLE-ABS-KEY ("mental health service*")) OR (TITLE-ABS-KEY ("psychiatric service*")))

Web of science:

("mental health service*") OR ("psychiatric service*") OR ("expert by experience") AND ("peer provider*") OR ("peer specialist*") OR ("peer service*") OR ("co produc*") OR ("co creat*") OR ("co design*") OR ("peer support") OR ("peer mentor*") OR ("service user involvement") OR ("recovery college*")

Appendix D: Example concept development map- *'Professional development'*



Appendix E: Example of stage 5 of meta-ethnography- translating the studies into one another

Key:
<u>Underlined- Core theme in paper (second order construct).</u>
Italics- quote from participant in paper (first order construct)
Unformatted text- commentary from researcher in paper.

Common concept identified in stage 4 (emerging third order constructs):	Clossey at al. (2016)	Forbes et al. (2021)	Kido and Kayama. (2017)-
Integration within the team	<u>Organizational integration</u> At the end of the interviews all respondents were asked whether they felt they were well integrated into the organization that employed them. Three worked specifically for a consumer run organization. Three others worked for a psychiatric rehabilitation program staffed extensively by peers, but the organization offering the program was not consumer run. All of these workers reported that they felt integrated. The remaining seven worked in traditional mental health settings. Three respondents discussed feeling disconnected from their employing organization. One noted that she felt integrated into her particular program but not into all aspects of the organization. Three respondents felt their agency integrated them and overall they felt supported.	<u>Role integration</u> Participants expressed the challenge of bringing a different, new perspective and role to a mental health team. *"Decades have passed, and this challenge has resulted in widespread incomplete role integration. It's a consequence of us trying to fit into medical models that are ::: antithetical to how peer support actually operates because a lot of it (peer support) is based on self-help, we push the envelope- we push people's buttons, this makes it difficult for us to be*	Did not endorse this concept

		able to integrate ourselves into models that are trying to support us but ultimately can't move beyond how they view the world (L061 White other, PSS 1–3 years, very satisfied, bachelor's degree)." In the experiences of PSS, steps toward role integration were achieved by NPS helping to construct role clarity, supporting role adaptation, and negotiating jointly the challenges of maintaining practice boundaries.

Common concept identified in stage 4 (emerging third order constructs):	Mancini (2017)	Mayer and Mckenzie (2017)	Moran et al. (2012)
Integration within the team	Inclusion Inclusion refers to peers' sense of being a full member of the team or organization. Inclusion refers to how well peers 'fit in' with the team and how much they are included in team activities, events and conversations. The level of inclusion reported by peers varied greatly across the interviews. Some peers reported that they were viewed as equal team members and had supportive relationships with their supervisors and teammates. For instance, one peer stated: *"Team leader support is key because the leader is going to give the cues to how you fit in with the team. It was just a given that I was an essential part of the team. I've never felt like I wasn't"*	Feeling valued While the agency expressed was individual, the approach was also profoundly collective. The words 'alongside' and 'together' were prevalent in all participants' accounts, underpinned by mutuality; of young people, experts by experience and colleagues learning from each other. Participants described the trusting and accepting relationships they had developed with colleagues	Person-centred, recovery-oriented work environment. A work culture that endorsed respect and openness made participants feel part of the workforce, accepted, and "normal." In such environments, supervisors and colleagues were mindful of participants' recovery orientation and became willing to apply recovery practices in clinical situations, such as "changing a treatment planning process" and "having people at their treatment planning meetings." They were willing to "use human experience language and not label people" and "describe the situation [as] opposed to making judgments on someone and give them negative labels." One peer provider described her experience in this work culture: *"It's different. They treat you like you're an adult, first of all. [Laughter] And anything goes as long as it's appropriate. And*

	basically, there's a lot of respect that goes on both for your illness and who you are as a person. They don't separate out your diagnosis and then treat you, you know what I'm saying. They don't treat you like your diagnosis; they treat you like a whole person"

Common concept identified in stage 4 (emerging third order constructs):	Mowbray (1998)	Kuek et al. (2021)	Debyser et al. (2019)
Integration within the team	Did not endorse this concept	<u>Early beginnings</u> While it might have been clear in policy that the PSS were to be integrated into the clinical teams, the degree to which the practice was adopted appeared to depend more on the personal comfort level of those interacting with the PSS. Participants felt that effective communication and being proactive with their supervisor and the team were essential in clarifying their roles within the group	<u>Balanced deployment of positive attributes</u> They describe situations where they feel heard and recognized as a peer worker, where they are listened to and receive opportunities to develop themselves personally and expand their networks. For some participants, being able to do peer work at the unit where they were a patient was motivating and built their confidence. These examples of positive experiences signal to the peer workers that the organization supports them, and this further stimulates their personal recovery process. *(Participant 11) "For me it is the case that the contacts between the care providers and me are very positive. From the moment something goes wrong, a few people immediately jump in to look at the problem, to think about possible solutions. This also gives me support, which is also very important for my recovery process. Because before, I had never experienced such collegiality in my life."*

Common concept identified in stage 4 (emerging third order construct):	Vandwelle et al. (2018)	Salzer and Shear (2002)	Hurley et al. (2018)
Integration within the team	Does not endorse this concept	Does not endorse this concept	Does not endorse this concept

Appendix F: CASP tool lead author example:

CASP
Critical Appraisal Skills Programme

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Kido and Kayama- rating of 6.5

Paper for appraisal and reference: .....

Section A: Are the results valid?

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

Yes	x
Can't Tell	
No	

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

Comments:

Clear and detailed introduction and statement of study aims and objectives as well as consideration of relevance

2. Is a qualitative methodology appropriate?

Yes	x
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:

Qualitative appropriate given aims of the research,- to explore subjective experiences

Is it worth continuing?

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

Yes	
Can't Tell	x
No	

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

Comments:

Have not discussed in sufficient detail reasons for chosen methodology,
No discussion of other methods that were considered and why descriptive methods were chosen and how these were appropriate

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

Specific participant pool used and this was appropriate given the aims of the study

5. Was the data collected in a way that addressed the research issue?	Yes: Can't Tell: x 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:

Unclear regarding how the interview schedule was formed and followed and no mention of recording of the interviews

6. Has the relationship between researcher and participants been adequately considered?	Yes	
	Can't Tell	
	No	x

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:

No commentary provided or reflexivity included regarding the researchers position and potential biases, would have been beneficial given the specific setting and potential professional links to this

Section B: What are the results?

7. Have ethical issues been taken into consideration?	Yes	x
	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:

Clear statement of appropriate ethical considerations and measures in place, ethical approval stated

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8. Was the data analysis sufficiently rigorous?

Yes	
Can't Tell	x
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:
Lacks detail regarding the analysis process- would not be replicable from this description

9. Is there a clear statement of findings?

Yes	x
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:
Clear and well structured discussion of findings and implications as well as limitations

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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:

Given the specific population within the research it is likely that the findings will be particularly helpful at a local clinical level

CASP tool second reviewer example**:**

Paper for appraisal and reference: Mancini 2018

Section A: Are the results valid?			
1. Was there a clear statement of the aims of the research?	Yes Can't Tell No	x 	HINT: Consider • what was the goal of the research • why it was thought important • its relevance
Comments:			
2. Is a qualitative methodology appropriate?	Yes Can't Tell No	x 	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:			
Is it worth continuing?			
3. Was the research design appropriate to address the aims of the research?	Yes Can't Tell No	x 	HINT: Consider • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Critical Appraisal Skills Programme

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

5. Was the data collected in a way that addressed the research issue?	Yes	X
	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: **Thorough description of methodology given including interview schedule, analysis, data saturation.**

:

6. Has the relationship between researcher and participants been adequately considered?	Yes	
	Can't Tell	
	No	X

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: **Researcher doesn't appear to address their own position / reflexivity**

Section B: What are the results?

7. Have ethical issues been taken into consideration?	Yes	X
	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:

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8. Was the data analysis sufficiently rigorous?

Yes	X
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: Clear description of analysis process including coding and theme development

9. Is there a clear statement of findings?

Yes	X
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:

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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: **Research appears to make a useful contribution to existing knowledge by making clear implications for practice.**

Appendix G: Participant information Sheet

Participant Information Sheet

Title of Study:

'Psychological Factors in Service User Readiness for Co-production: What Helps and Hinders the Journey'

Principal investigator: Diane Patton, Trainee Clinical Psychologist.

Supervisors: Dr Christopher Hobson, Clinical Psychologist.

Dr Laura Freeman, Clinical Psychologist.

Contact details: Clinical Psychology Training,

School of Psychology, Tower Building, 70 Park Place, Cardiff,

CF10 3AT

Telephone: 029 2087 0582

We would like to invite you to take part in this research study to find out about your experiences of becoming involved in a co-production role within a mental health setting.

The interview will take around an hour. When all of the interviews have been completed, Diane Patton will submit this study as part of her training in Clinical Psychology.

To help you to decide whether the study is one that you would like to take part in, we have included some further information below about the purpose of the research and what it will involve. Please take some time to read through and discuss with others if you wish. If you have any questions, please contact us through the details above.

Thank you for reading the information and your interest in the study.

What the study is about

We want to explore the experiences of service users (within the arena of mental health settings) who have gone on to be involved in co-production roles within mental health-related

services (including through third sector organisations and educational settings). In particular, we are keen to find out about the kind of experiences that help or hinder people feeling ready to get involved and help them to feel supported to stay involved.

We hope that all of this information will help inform how services go about supporting individuals to become involved in roles outside of their own care in the future.

Why I have been asked?

You have been asked whether you might be interested in taking part because you are currently (or have recently been) working within a co-production role. The organisation you are involved with have identified you as someone who might have some interesting things to say on this topic. We will talk to the first 10-15 people who agree to take part.

Do I have to take part?

No. There is no obligation for you to take part in this study, please only agree to be involved if you want to. If you begin the interview you are still able to stop at any time without giving a reason. If you don't take part or decide to stop, it will not affect any of the services that you are involved with.

What will happen if I agree to take part?

If you decide to take part we will arrange for a mutually convenient time for the interview to take place. The interview will take place remotely via Zoom or Microsoft Teams. The researcher can provide support with accessing/setting up this technology prior to the interview if necessary.

On the day of the interview you will join a remote session with Diane Patton, who will go through the information sheet again and then a consent form. If you are happy to go ahead you will be asked to sign/type you name on the consent form and email it back to the researcher. Your information will be kept securely, and your anonymity will be maintained at all times.
During the interview you will be asked to talk about your experiences of being a service user who has gone on to take on a role of co-production. The interview will take around an hour.

The potential benefits and disadvantages of taking part

We hope that you will find it interesting to think about the 'journey' to co-production that you have been on. Hearing about your experiences will provide useful information for services when think about how best to go about involving service users in co-production in the future. Following the interview, we would like to send you (via post) a £15 gift voucher of your choosing to thank you for your time. You will receive this voucher regardless of whether you decide to withdraw from the study following the interview.

If talking about any of your experiences becomes upsetting for you, we will stop the interview and check whether you feel you need any extra support for the issues that have arisen. With your permission, I would then talk to Dr Christopher Hobson about potential avenues for further support.

Will what I said be kept confidential?

If you take part in the interview all of the information that you give us will be kept confidential, that is, private from other people who are not listed researchers. The only reason that your information would not be kept confidential is if you said something in the interview that meant that you or someone else was in danger. For example, if you said that someone you knew was in danger, or that you were going to hurt yourself, we would have to share this information with the researcher's supervisor and any professionals involved in your care to make sure that you and others were kept safe.
The consent form is the only form that will have your name on it. It will be kept in a password protected document on the researcher's password protected laptop.
Your interview will be typed up within a month and then the audio recording will be deleted. All of the information from the interview, including the background information sheet and the typed up interview will be numbered and contain made up names. All computer files will be password protected and only accessible by the lead researcher and her two supervisors listed below. You can ask for your interview to be withdrawn from the research up until the audio file has been deleted (one month after the interview) as after this stage data will have been made anonymous. You will therefore be unable to withdraw your consent once this anonymisation has taken place. No original names will be used in the typed-up interviews and any quotes used will contain made up names.

What will happen to the results of the study?

The things that you and the other people talk about in the interviews will be put together and the researcher will try to understand and summarise the factors involved in peoples decision to become involved in a role of co-production. This information will hopefully help services to think about how they support individuals to get involved in similar roles in the future.

The results will be submitted as part of Diane Patton's training in Clinical Psychology. They may also be written up and published in an article and presented to people who work and research in similar areas. Small quotes from some interviews might be used to make a certain point, but a made-up name will be used to protect your identity. No information that could identify individuals will be used.

If you wish to have information about the results of the study please let Diane Patton know

and she will send you a summary of the results as soon as they are available.

Who is sponsoring the research?

Cardiff University is sponsoring the research.

Who has said that the study is ok to go ahead?

The research study has been reviewed and approved by the School of Psychology Research Ethics Committee at Cardiff University. If you have any concerns or complaints about the research you can contact the School of Psychology Research Ethics Committee in writing at:

Secretary to the Research Ethics Committee
School of Psychology
Tower Building
70 Park Place
Cardiff
CF10 3AT
psychethics@cardiff.ac.uk

If you would like more information about the project, please feel free to contact us:

Diane Patton
Trainee Clinical Psychologist, Postgraduate student.
South Wales Doctoral Programme in Clinical Psychology
11th Floor, School of Psychology, Tower Building,
70 Park Place,
Cardiff,
CF10 3AT
Email: PattonD1@cardiff.ac.uk
Tel: 029 2087 0582

Academic supervisor:

Dr Christopher Hobson

South Wales Doctoral Programme in Clinical Psychology

Cardiff & Vale UHB

Email: HobsonCW@cardiff.ac.uk

Tel: 029 2087 0582

Clinical supervisor:

Dr.Laura Freeman

Clinical Psychologist

Email: Laura.Freeman@wales.nhs.uk

Appendix H: Participant consent form

Consent form

Title of Study	**'Psychological Factors in Service User Readiness for Co- production: What Helps and Hinders the Journey'**
Principal investigator:	Diane Patton, Trainee Clinical Psychologist.
Supervisors:	Dr Christopher Hobson, Clinical Psychologist.
	Dr Laura Freeman, Clinical Psychologist.

1. I understand that my participation in this project will involve taking part in an interview, of around an hour long, where I will be asked about my experiences of becoming involved in co-production.

2. I have read and understood the information sheet and have been able to ask any questions I have.

3. I understand that participation in this study is entirely voluntary and that I can withdraw from the study up until one month after the interview has taken place. This will not affect my access to services.

4. I understand that I am free to ask any questions at any time. I can discuss any concerns with Diane Patton or the University Ethics Committee.

5. I understand that the information provided by me will be kept securely and confidentially. I understand that this information will be held no longer than necessary for the purposes of this research.

6. I understand that the interview will be recorded and the audio transcribed (typed up) and that the audio recording will be destroyed upon transcription. The transcript will be held anonymously, using made up names, so that it is impossible to trace this information back to me individually.

7. I understand that any quotes used from my interview included in the research will be kept anonymous with personal information changed where necessary to make sure this is achieved.

8. I understand that the researcher will share information with their clinical supervisor if they are worried that I am at risk of harming myself or if someone else is in danger.

9. I understand that if I feel distressed during the study that I discuss avenues for gaining extra support with the researcher.

10. I also understand that at the end of the study I will be provided with additional information and feedback about the purpose of the study.

I, _____ consent to participate in the study conducted by Diane Patton, School of Psychology, Cardiff University with the supervision of Dr Christopher Hobson and Dr Laura Freeman.

Signed:

Date:

Privacy Notice:

The information provided on the consent form will be held in compliance with GDPR regulations. Cardiff University is the data controller and James Merrifield is the data protection officer (inforequest@cardiff.ac.uk). This information is being collected by Diane Patton. This information will be held securely and separately from the research information you provide. Only the researcher will have access to this form.

Appendix I: Participant de-brief sheet

Debrief form

Title of Study:

Psychological Factors in Service User Readiness for Co- production: What Helps and Hinders the Journey.

Thank you for taking part in this study. The information that you have provided in your interview will be put together and analysed with the other interviews collected for this research. We hope that the results from this study will help us to understand more about the factors that individuals consider during their journey from service user to a role within co-production.

This information could be useful for mental health organisations/services to consider when supporting future clients who may wish to consider a role of co-production. The study results may also provide information for services when considering the training that they put into place to support service users moving into a co-production role.

If the interview has caused you distress, please contact us so that we may explore avenues for you to gain extra support.

The consent form that you signed will be kept in password protected document and is only accessible by the researchers. The audio recording of our interview will be transcribed and then destroyed. Your general information sheet and typed up interview will be kept

anonymously. You can withdraw from participation up until the audio recording is typed up (one month after the interview), because it will then contain made up names.

If you wish to have information about the results of the study, please let Diane Patton know and she will send you a summary of the results as soon as they are available.
If you have any further questions, please contact us:

Researcher: Diane Patton
Trainee Clinical Psychologist,
Postgraduate student
South Wales Doctoral Programme in Clinical Psychology,
11th Floor, School of Psychology, Tower Building,
70 Park Place, Cardiff, CF10 3AT
Pattond1@cardiff.ac.uk

Academic Supervisor: Dr Christopher Hobson
Clinical Psychologist
South Wales Doctoral Programme in Clinical Psychology,
11th Floor, School of Psychology, Tower Building,
70 Park Place, Cardiff, CF10 3AT
HobsonCW@cardiff.ac.uk

If you have any concerns or complaints about the research, you can contact the School of Psychology Research Ethics Committee in writing at:
Secretary to the Research Ethics Committee
School of Psychology, Tower Building
70 Park Place, Cardiff, CF10 3AT
psychethics@cardiff.ac.uk

Appendix J: Amendments to interview schedule:

Second round semi-structured interview schedule (amendments highlighted)

Thank you for agreeing to be interviewed today and taking the time out of your day to share your experiences. Today I will be asking you some questions about your experiences of being involved in services in a co-production role.

Definition of co-production: Co-production in mental health settings refers to a process in which service users, carers and staff work together as equal partners towards shared goals (Social Care Institute for Excellence 2015). Relating to the term "co-production" are various levels of user involvement with services including roles such as 'Expert by Experience' and 'Peer Support Worker', as well as initiatives such as 'Service User Networks' and 'Recovery Colleges'.

To start with it would be useful if you could tell me the nature of your involvement to date, ie.one role or several, how long have you been involved and briefly what your role involves?

- ***Can you tell me about how you came to be involved in your current role?***

- ***Can you tell me what it is like starting out in an 'expert by experience' role in co-production? From initial analysis of interviews, some people's first experiences have been within quite large meeting settings, was this the case for you?***
  -Can you recall what settings your first few kind of involvements took place in?
  -Was there anything about these early experiences that stands out to you as being helpful or helpful?

- ***Before you had experience of being in the role, were you aware of these types of roles and what were your thoughts on this type of involvement?***

- ***What was going on in your life prior to becoming involved in co-production?***
  -How would you describe the person you were then?
  -What drew you to the role at this time?

- ***If you can recall, were there any experiences you had that shaped or influenced your readiness for this type of role?*** -
  -Were there any specific steps you took in preparation for beginning your role?
  - What happened next… was anyone else important/involved in getting started?
  -Who if anyone influenced your decision to become involved?
  - Can you tell me a little about what influence they had on you?

- ***Can you tell me a little about any hopes and fears you had?***
  -Was there anything that helped you regarding the fears?

- ***As you look back on your experiences in the role, how has the reality of involvement in co-production compared to what you thought it might be like?***

- *Are there any specific events/instances that stand out in your mind?*
- *What do you enjoy most about your role?*
- *Were there any particularly difficult aspects of taking on your role?*

- ***Were there any times that you reconsidered your involvement/your role in co-production?***

  -What helped you to continue your journey at these points?
  -Are there any particular things/people that have been helpful at these times?
  -What keeps you going on a bad day at work?
  -

- From analysis of my first few interviews, there have been mixed opinions regarding the often ad-hoc and self-employed nature of the work, with some finding that it provides flexibility, whilst for others it has lead to potentially taking on lots (perhaps too much) work, Do you have any thoughts on this nature of the role/does this apply in your case?

- *How have you maintained a healthy work life balance or has this been tricky at times?*
- *Have there been occasions where you have felt under pressure to get involved with things? Was this pressure felt internally (pressure you put on yourself to take lots on) or pressure put on externally by others (perhaps professionals or loved ones)*

- ***From your experiences, when might be a good time in someone's recovery journey to talk to them about co-production?***

- ***How, if at all, has being involved in your co-production role changed you?***

- *Personally, emotionally, mental health, relationships, confidence?*

- ***Looking back on your experiences now, what advice would you give to someone about to start within a co-production role?***

-Others I have interviewed have told me that they found it helpful to meet with someone in a similar role prior to involvement, did you have this experience?

- ***What advice would you give to someone (perhaps a professional) looking to support or encourage someone to take on this type of role?***

- *Are there any experiences of working with professionals that you have had/approaches that professionals have taken that you found particularly helpful or unhelpful?*

- ***Is there anything else you think I should know to understand your experiences better?***

Appendix J continued: Final round interview schedule (further amendments highlighted):

Initial draft semi-structured interview schedule

Thank you for agreeing to be interviewed today and taking the time out of your day to share your experiences. Today I will be asking you some questions about your experiences of being involved in services in a co-production role.

Definition of co-production: Co-production in mental health settings refers to a process in which service users, carers and staff work together as equal partners towards shared goals (Social Care Institute for Excellence 2015). Relating to the term "co-production" are various levels of user involvement with services including roles such as 'Expert by Experience' and 'Peer Support Worker', as well as initiatives such as 'Service User Networks' and 'Recovery Colleges'.

To start with it would be useful if you could tell me the nature of your involvement to date, ie.one role or several, how long have you been involved and briefly what your role involves?

- ***Can you tell me about how you came to be involved in your current role?***

- ***Can you tell me what it is like starting out in an 'expert by experience' role in co-production? From initial analysis of interviews, some people's first experiences have been within quite large meeting settings, was this the case for you?***
  -Can you recall what settings your first few kind of involvements took place in?
  -Was there anything about these early experiences that stands out to you as being helpful or helpful?
- ***Before you had experience of being in the role, were you aware of these types of roles and what were your thoughts on this type of involvement?***

- ***What was going on in your life prior to becoming involved in co-production?***
  -How would you describe the person you were then?
  -What drew you to the role at this time? What did you hope might be achieved for you and others from being involved in this role?

- ***If you can recall, were there any experiences you had that shaped or influenced your readiness for this type of role?*** -
  -Were there any specific steps you took in preparation for beginning your role?
  - What happened next… was anyone else important/involved in getting started?
  -Who if anyone influenced your decision to become involved?
  - Can you tell me a little about what influence they had on you?

- ***Can you tell me a little about any hopes and fears you had?***
  -Was there anything that helped you regarding the fears?

- ***As you look back on your experiences in the role, how has the reality of involvement in co-production compared to what you thought it might be like?***

- *Are there any specific events/instances that stand out in your mind?*
- *What do you enjoy most about your role?*
- *Were there any particularly difficult aspects of taking on your role? Some people interviewed have said that it exposes their vulnerability, and this is a good and difficult thing at times...is this something that you relate to?*

- ***Were there any times that you reconsidered your involvement/your role in co-production?***

  -What helped you to continue your journey at these points? What strengthened you or supported you to carry on?

  -Are there any particular things/people that have been helpful at these times?

  -What keeps you going on a bad day at work?

  -

- From analysis of my first few interviews, there have been mixed opinions regarding the often ad-hoc and self-employed nature of the work, with some finding that it provides flexibility, whilst for others it has led to potentially taking on lots (perhaps too much) work, Do you have any thoughts on this nature of the role/does this apply in your case?

- *How have you maintained a healthy work life balance or has this been tricky at times?*
- *Have there been occasions where you have felt under pressure to get involved with things? Was this pressure felt internally (pressure you put on yourself to take lots on) or pressure put on externally by others (perhaps professionals or loved ones)*

- ***From your experiences, when might be a good time or important factors in someone's recovery journey to talk to them about co-production?***

- ***How, if at all, has being involved in your co-production role changed you?***

- *Personally, emotionally, mental health, relationships, confidence?*

- ***Looking back on your experiences now, what advice would you give to someone about to start within a co-production role?***

Others I have interviewed have told me that they found it helpful to meet with someone in a similar role prior to involvement, did you have this experience?

- ***What advice would you give to someone (perhaps a professional) looking to support or encourage someone to take on this type of role?***

- *Are there any experiences of working with professionals that you have had/approaches that professionals have taken that you found particularly helpful or unhelpful?*

Appendix K: Ethical approval from Cardiff University

Ethics Feedback - EC.21.01.12.6221R

psychethics <psychethics@cardiff.ac.uk>
Sat 13/02/2021 02:37
To:

- Diane Patton <PattonD1@cardiff.ac.uk>

Cc:

- Christopher Hobson <HobsonCW@cardiff.ac.uk>

Dear Diane,

The Ethics Committee has considered your revised PG project proposal: Psychological Factors in Service User Readiness for Co-production: What Helps and Hinders the Journey (EC.21.01.12.6221R).

The project has been approved on the condition that researchers remove the name 'Matt Cooper' from the consent form as he no longer is the incumbent of this role. James Merrifield is now the data protection officer and should be contacted to establish the correct phrasing in relation to the 'Privacy Notice'.

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

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CF10 3AT

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Appendix L: Transcript excerpt

Excerpt 1:

I: Okay. Can I ask, before you were involved in these types of roles, so, I know you were saying you were kind of, you were under CMHT yourself, were you aware that these kind of opportunities existed or did somebody point you in the direction of say, becoming a peer support worker, or how did you – how did you become aware that such things existed? Was it your own research or -?

P: It was like, it was completely random; so, basically, I was out – I was out of employment for six years; I spent three years in hospital and then I was homeless and yeah, I was just out of employment for a really long time. And then it was just completely random. I was having a really difficult day, so I rang a duty CPN and that was just saying that – you know, I am really bored of just being in my flat like every single day; like every single day is the same, really isolated. And she was like, oh a peer support worker post has just come up here, like you should apply, like you should go for it.

And, I was like, oh, okay. Like I – I wouldn't have found it if she hadn't of pointed it out to me and the post actually closed like that night. So, I was like, oh God, quick, let's go for the job. So, it was, I mean you could say it was random, but – but yeah, that's basically how I ended up applying for it. And then, obviously, I got that job.

I Yeah. And did you know – obviously you didn't know until the day that that role was available, but did you know that even those kinds of opportunities kind of came up? Or did you have any thoughts on those kinds of roles?

P I knew they existed, but I think, I think maybe my preconceived idea of those types of roles were that peers would like, almost be in voluntary roles or on very, very low-paid roles purely because of the peer aspect. So, initially I was even quite shocked. I was like oh, it's a Band 3. I was like flipping heck, I was like – now, like, my view on that has completely changed, but I think, yeah, I think I knew they – I did know they existed, I just didn't, I mean, I didn't realise that you could like make a career out of it or anything.

But there's – like peer support work in England is like massive. They've got – they've got, I think it's 87 recovery colleges and we've just opened the first one in Wales. So, it kind of shows like how far behind we are in terms of what England are doing with peer support work. Like they've – yeah, I'm not sure exactly how many they've got; but I know in Cardiff and Vale there's, I think there's, yeah, there's – there's three within the CMHTs in the whole of Cardiff. So, yeah, we're pretty far behind.

So, it was – it's good to be part of something that's like quite exciting and I guess, I guess it is ground-breaking in terms of Cardiff and Vale services really. It's not ground-breaking in England but it is ground-breaking for us. Yeah.

Excerpt 2:

I: Thinking about your own kind of readiness, I guess as part of your journey for taking on these roles, can you remember were there any specific experiences that shaped or influenced you feeling ready to kind of, take that next step and next part of your journey. So do you remember taking any steps towards it, or was there anybody kind of important involved in you deciding to kind of make that next step?

P: Yes, yeah there was. So, there was a couple of people actually, and so I was always very uhm, cautious about what I would be able to uhm achieve, you know, or whether I should dip my toe in the water. What is the consequence going to be? What if I fail? What am I going to feel like?

I: Yeh of course

P: Am I going to slide back downhill type thing you know. And for me I needed some people cheerleading me. I think behind me, you know, and it was my family. So my husband and my mum and they were always very, very supportive and encouraging and said go for it, why not? Why can't you go for it? You know what's the worst that could happen? And also, my psychologist, who was X I was fortunate, I feel to have her cheerleading me, you know, so she, she said to me before, just on our last session before we said goodbye. I so, uhm, you know it felt really difficult after seeing it for two years to say goodbye. And I can remember her hugging me and saying to me I don't believe this is goodbye. I think it's just aurevoir.I think it's only for now that I, I believe she said that we will continue and whatever that relationship looks like some it we will continue a relationship of some kind and I got this feeling I might work with you one day, she said, and then lo and behold, she points me in the direction of a job, yeah and so for me it was, I want to make people proud I want, I wanted to make my family proud. I wanted to make her proud, you know. And when I say that I, I noticed a lump coming into my throat. Yeah, it I think yeah, having people behind me who were telling me who were confirming to me, you are ready, you know you are ready. Just try and be confident in yourself. Find that brave spot you know just to push yourself forward and see what happens, you know, so yeah, that they were, they were. They were a number of people. Yeah, lovely.

I: Thank you. And I know you said that I guess he didn't really have set expectations cause you weren't quite sure what to expect, but I guess, has the reality of your involvement matched up with what you were kind of hoping it was going to be like or

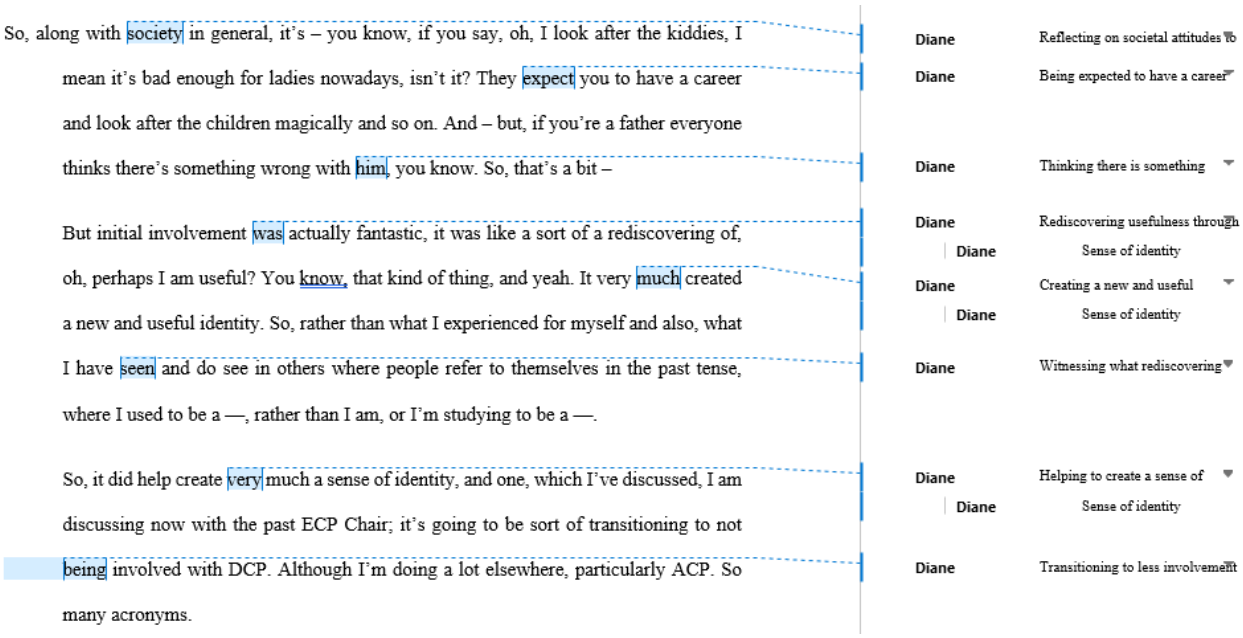
how is it different. Yeah, what's the reality been like in comparison with what you were expecting those years ago I guess.

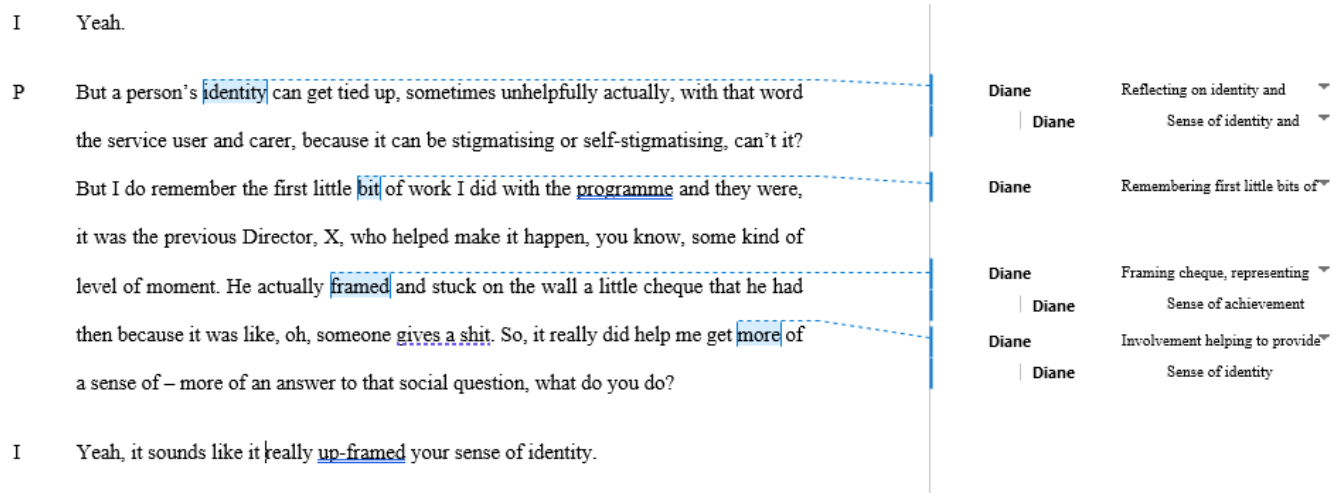
P: Yeah, so I think for me it, when I realized it's been like a stepping stones, if you like. uhm so for me I was setting myself small goals trying to keep in the moment if you like and not run let my mind run away with me so it would be like as long as like I'm getting to work, that's a huge thing for me, you know. And so all these achievements were things that I was working on day by day, week by week, in the role, and I think with regards to UM being actually doing the job. I think I was always afraid that I wasn't doing enough. I was always afraid that people would say well, what she here for you know there'd be judgments of, I don't see what she's bringing, I don't see what and so in my mind I was always very aware that people were and when I say people I think staff and teams who were scared of the peer mentor role maybe because of experiences they'd had previously with a peer mentor. I think I was afraid that they were gonna, I don't know, rally against me you know, uh, and I wouldn't be able to. Like I said, two out of 12 nurses you know were supportive in the first six months with me so I felt like I was up against it and felt like, how can I even try to make this role succeed when the struggle was just for the nurses and the staff to engage with me you know, before I couldn't even get to service users. And because you don't get to service users unless the clinician has introduced you to that person.

I: Yes of course

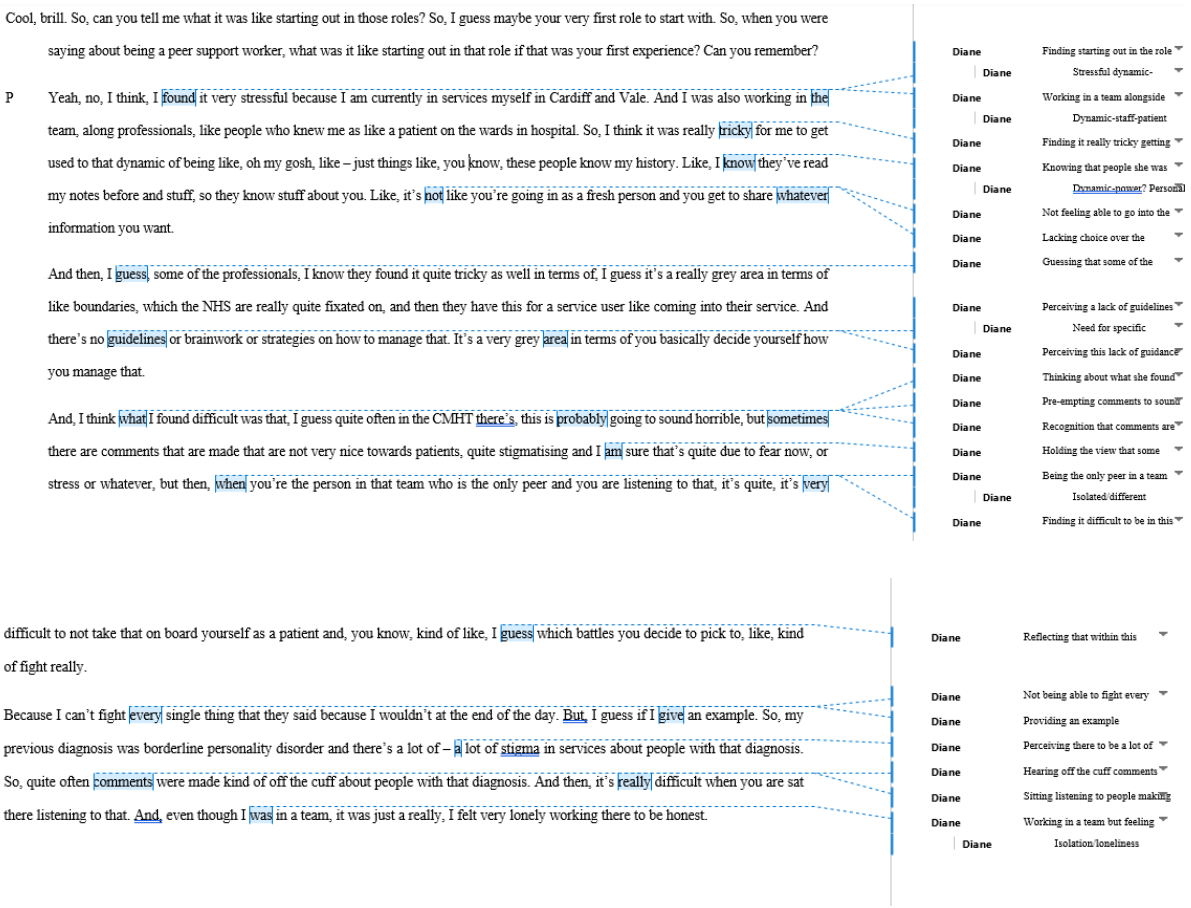
P: So I think that that was that was a big thing for me. That was a big worry. For me I was pleasantly surprised, I think when they did start realizing that yeah, that this role is, it can be used in a really productive way I think. Uhm, as long as I was able to in my mind, as long as I was able to at some at some level have a voice and be here so whether that be around an MDT table, you know once a week and whether that was at a conference, whether that was in front of boards of directors, you know whether that was in front of teams, different teams. And services, whether that was in front of service users and in any event. So, I think for me it was, as long as I was able to have a voice to some degree. And then I felt like I was doing something for the cause of peer mentoring in a positive way

Appendix M: Examples of coding within Microsoft word- '*Comments' function used for initial line by line coding, reply to comments function used for focused coding*





Second transcript example:



Cool, brill. So, can you tell me what it was like starting out in those roles? So, I guess maybe your very first role to start with. So, when you were saying about being a peer support worker, what was it like starting out in that role if that was your first experience? Can you remember?

P Yeah, no, I think, I found it very stressful because I am currently in services myself in Cardiff and Vale. And I was also working in the team, along professionals, like people who knew me as like a patient on the wards in hospital. So, I think it was really tricky for me to get used to that dynamic of being like, oh my gosh, like – just things like, you know, these people know my history. Like, I know they've read my notes before and stuff, so they know stuff about you. Like, it's not like you're going in as a fresh person and you get to share whatever information you want.

And then, I guess, some of the professionals, I know they found it quite tricky as well in terms of, I guess it's a really grey area in terms of like boundaries, which the NHS are really quite fixated on, and then they have this for a service user like coming into their service. And there's no guidelines or brainwork or strategies on how to manage that. It's a very grey area in terms of you basically decide yourself how you manage that.

And, I think what I found difficult was that, I guess quite often in the CMHT there's, this is probably going to sound horrible, but sometimes there are comments that are made that are not very nice towards patients, quite stigmatising and I am sure that's quite due to fear now, or stress or whatever, but then, when you're the person in that team who is the only peer and you are listening to that, it's quite, it's very

Diane Finding starting out in the role
Diane Stressful dynamic-
Diane Working in a team alongside
Diane Dynamic-staff-patient
Diane Finding it really tricky getting
Diane Knowing that people she was
Diane Dynamic-power? Personal
Diane Not feeling able to go into the
Diane Lacking choice over the
Diane Guessing that some of the
Diane Perceiving a lack of guidelines
Diane Need for specific
Diane Perceiving this lack of guidance
Diane Thinking about what she found
Diane Pre-empting comments to sound
Diane Recognition that comments are
Diane Holding the view that some
Diane Being the only peer in a team
Diane Isolated/different
Diane Finding it difficult to be in this

difficult to not take that on board yourself as a patient and, you know, kind of like, I guess which battles you decide to pick to, like, kind of fight really.

Because I can't fight every single thing that they said because I wouldn't at the end of the day. But, I guess if I give an example. So, my previous diagnosis was borderline personality disorder and there's a lot of – a lot of stigma in services about people with that diagnosis. So, quite often comments were made kind of off the cuff about people with that diagnosis. And then, it's really difficult when you are sat there listening to that. And, even though I was in a team, it was just a really, I felt very lonely working there to be honest.

Diane Reflecting that within this
Diane Not being able to fight every
Diane Providing an example
Diane Perceiving there to be a lot of
Diane Hearing off the cuff comments
Diane Sitting listening to people making
Diane Working in a team but feeling
Diane Isolation/loneliness

Appendix N: Example of category and concept development through coding:

Raw interview extract	Initial coding	Focused coding	Category	Theoretical concept
"Yeah. I think the last two women who I've worked with, who have been kind of line manager roles, have always asked if I've – I'm not afraid of saying if I'm not great. I think it's quite empowering to be honest about where you're at, and both of the women that I've worked with recently, X and X will always ask the question, what do you need from me? And that can be anything. It could be time out. It could be, I need you to be understanding if I respond in ways that don't seem like I'm myself. I may need to come and sit in your office and sob. I, I may need someone to bring me tea and biscuits. And all of those things have been okay things to ask and okay things to say"	Line managers asking about how you are and being able to say if you aren't great	Feeling supported by management Feeling able to communicate current needs	Avenues of support Openness to Mental health within the workplace	Normalisation of MH within the workplace
	Being asked the question, what do you need from me?	Having open conversations about support		
	Feeling empowered by being asked what do you need as opposed to being told what to do	Feeling empowered by being asked about individual needs	Individualised support	
	Individuals not trying to fulfil any other role than being themselves	Being able to be oneself	Authenticity within role	

Appendix O: Example post-interview memo:

Example 1:

Very interesting hearing about the massive difference in experience between the cmht and recovery college role. I think it definitely suggests that services themselves will have an impact on how ready the person feels once they have entered the role, do they feel supported enough to feel 'ready' and is there ever such a thing as ready? This interview brings up some of the possible benefits of involvement- social and personal MH benefits of involvement- but do people realise this prior to involvement and use it to decide whether or not they feel ready? Interesting to consider whether the anticipated benefits outweigh the potential anxieties of making yourself vulnerable emotionally through work. I found it interesting hearing about this participants experiences of personal therapy and support from a psychologist and how this related to their later involvement in co-production-must not get too fixed on the idea of Psychologists specifically being involved in supporting people to feel ready- this could potentially lead me down quite a biased line of questioning and I am of course biased in relation to the role of Psychologists.

I also noticed the temptation to ask more 'therapy' type questions so will have to look out for this. I guess it is a different way of being for me to find myself, playing the interviewer as opposed to the therapist. It was also really interesting to hear how co-production has changed over the years. I do wonder whether it may be tricky for people who have been doing this for quite a while to recall the initial signs and feelings of 'readiness'.

Example 2:

I noticed how much more at ease I felt during this interview than some of the others. Perhaps because I have completed a few interviews now and feel a bit more in the swing of things! I'm starting to feel more comfortable with following my gut as the interviews are progressing and following the lines of questioning that feel right for the participant. This in particular felt like a really insightful and rich interview and I got a real sense for the journey that the participant had been on. Some of the responses raise the question of whether you need the stability that others talk about to feel ready to get involved, for this person, the readiness and stability appeared to come through the involvement itself- but would suggesting it this early on be too soon for other people? I can see arguments on both sides, let people know early on that there are opportunities and instil them with hope, but equally, is this going to be overwhelming and imply that there is pressure on someone to get 'better' quickly. It will be interesting to hear what others opinions are on this. Most of the participants I have spoken to so far seem to have had quite varied experiences in several roles, with some being more positive than others. I think I may need to consider whether the readiness I am asking them about is starts again in a sense for each role rather than just looking at readiness for their very first involvement?

Appendix P: Conceptual category development memo:

'Wanting to build something positive from past experiences'

Participant quote exemplifying the category:

"So, it was about rediscovering a new identity, which, or a new vocation, which used what was valuable to me rather than just threw it all in the bin and didn't necessitate my doing something, which wasn't 'me' in inverted commas" Brian

This category has been developed through constant comparison with the data, codes, memos, categories, as well as through discussion with the supervisory team. The category falls within the subsuming category of 'motivations for involvement'. Although the research and interviews had a focus on exploring readiness for involvement, participants have spontaneously spoken about their individual motivations for wanting to get involved- as a desire and motivation to get involved logically must come before considering whether or not you are ready. Part of the interviews involved asking participants what was going on in their lives prior to and at the point of considering involvement. Many people chose to speak about their own mental health journeys and involvement with services. For many this had understandably been a challenging and for many, unpleasant time of their lives. Many have spoken about the impact that involvement in services, and the reception and treatment received from others, had on their own identity and self-esteem.

Participants have spoken about reaching a point in their journeys where they have wanted to move forwards and towards a different sense of identity. At times people have understandably wanted to entirely remove themselves from the label of 'service user' due to the negative connotations assigned to this by society. However, for many in the current research there has been a recognition over time that their experiences afford them a unique set of skills (LINK TO INTERNAL PROCESS- RECONGITION OF OWN VALUE) and that it may be to their own and others benefit (LINK TO CHANGE IN THE SYSTEM?) to use their experiences for good rather than trying to ignore them.

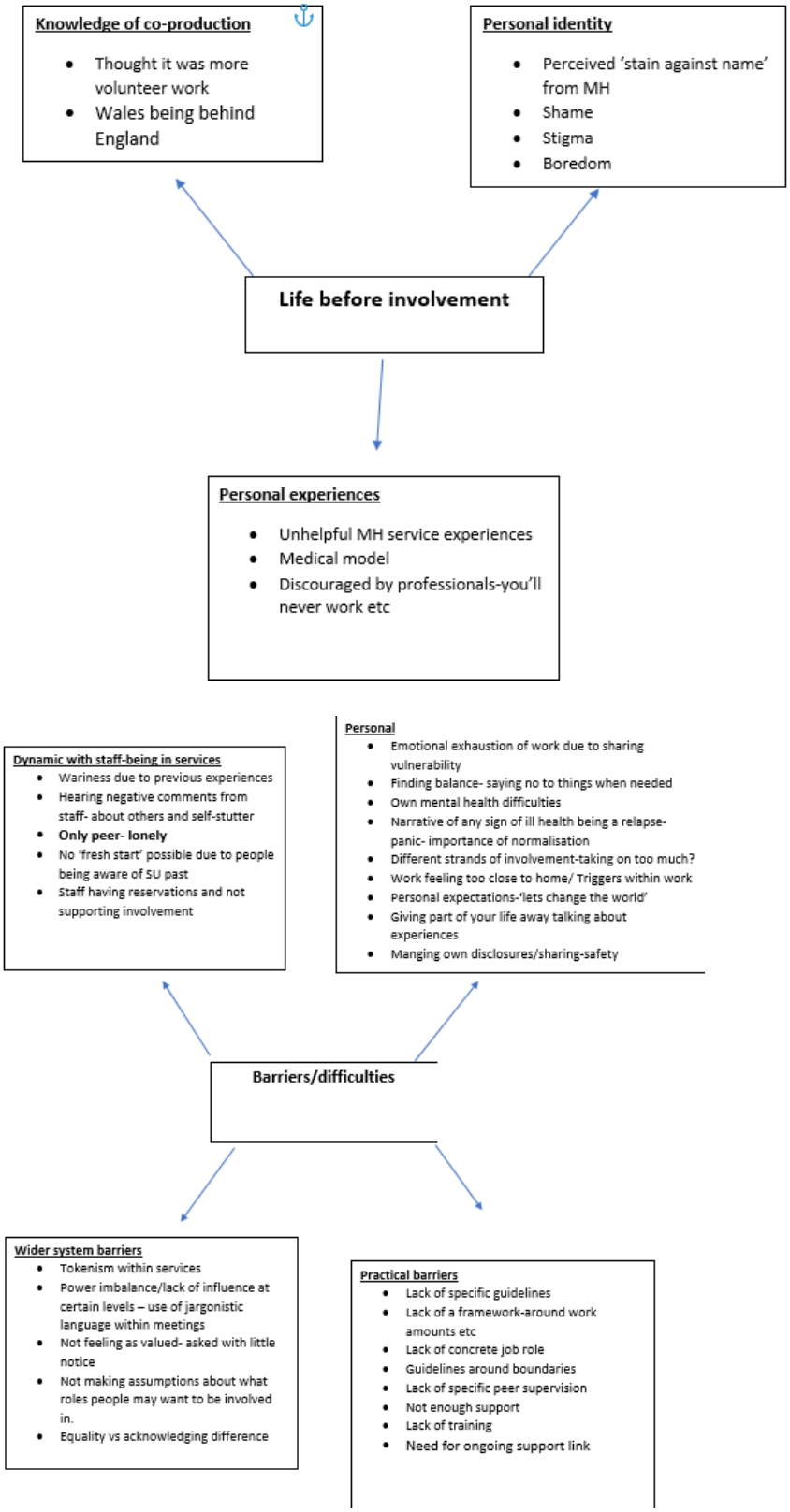
For some individuals in the study, this process of increased awareness of value of experiences and wanting to use this to forge a more positive identity for themselves has been an internal one, though for others it has been the support and encouragement of loves ones and at times professionals, that has brought them to this place. When considering involvement/early on within role- meeting with individuals with lived experience currently within role (LINK to EXTERNAL PROCESS) may help to reinforce the belief that experiences can used to build something positive:

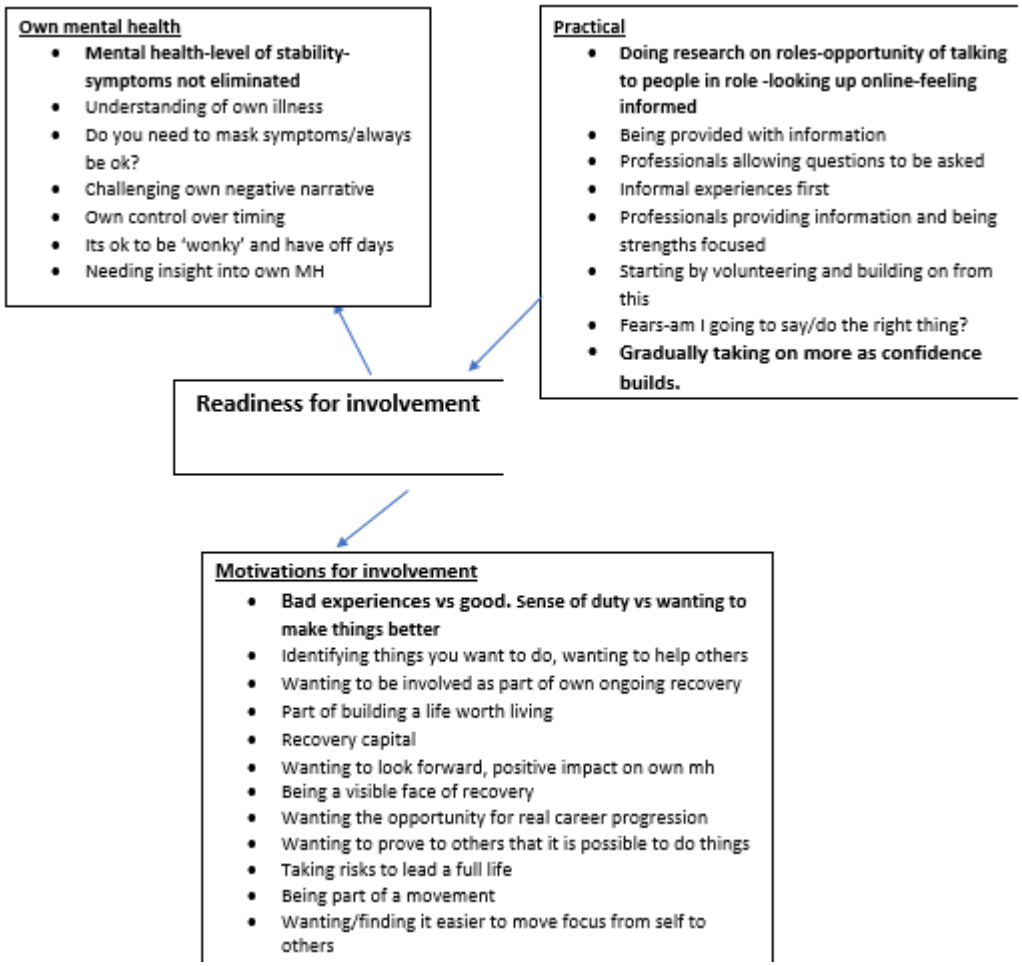
"This distressing time I could turn into a positive. I don't know how the hell I'm going to do that, and I don't know how I go about it but this person sat in front of me is telling me I have qualities with my lived experience that are really valuable and I could help somebody like she or he is doing with me" Ffion

Looking at the elements of interviews where participants have gone on to speak about sustained involvement, it seems that opportunities to 'build something positive', if these continue to be available, can lead to the formation and maintenance of a positive identity (LINK TO- SUSTAINED INVOLVEMENT). However, using one's own personal experiences within role as part of building something positive can run the risk of crossing over into becoming unhelpful for some. Several participants spoke about needing to find a balance between using their experiences positively without becoming overwhelmed by the nature of the work-which can often mean that they are asked to share sensitive parts of themselves and their experiences (LINK TO- SUSTAINED INVOLVEMENT- VULNERABILITY OF ROLE):

"Of course they want to know you know what it was like for you as a service user and also to UM social workers doing their a MPH training what it's like to be sectioned, which is not a very nice experience and I you know, I will talk to them as honest as I can but afterwards I could go and have a cup of coffee or something and chill out because you always feel that you're giving part of your life away. You think you know, why am I telling all these people like? But it is what it is with me, it's what always drives me is 'cause I want to bring about change and I think if my story can somehow influence change in some small way then that's kind of worthwhile" Jimmy

Appendix Q: Example of mind-mapping of theoretical concepts as they emerged:




Own mental health
Mental health-level of stability-symptoms not eliminated
Understanding of own illness
Do you need to mask symptoms/always be ok?
Challenging own negative narrative
Own control over timing
Its ok to be 'wonky' and have off days
Needing insight into own MH
Practical
Doing research on roles-opportunity of talking to people in role -looking up online-feeling informed
Being provided with information
Professionals allowing questions to be asked
Informal experiences first
Professionals providing information and being strengths focused
Starting by volunteering and building on from this
Fears-am I going to say/do the right thing?
Gradually taking on more as confidence builds.
Readiness for involvement
Motivations for involvement
Bad experiences vs good. Sense of duty vs wanting to make things better
Identifying things you want to do, wanting to help others
Wanting to be involved as part of own ongoing recovery
Part of building a life worth living
Recovery capital
Wanting to look forward, positive impact on own mh
Being a visible face of recovery
Wanting the opportunity for real career progression
Wanting to prove to others that it is possible to do things
Taking risks to lead a full life
Being part of a movement
Wanting/finding it easier to move focus from self to others

Appendix R: Example of early version of theoretical model: