# Evaluation of the Peer Support Scheme in Southwark

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# Executive Summary

## Background

The Peer Support Service in Southwark was set up in 2009 to help individuals through discharge from the Crisis Services. The service trains and matches peer support volunteers to individuals to provide up to nine months of weekly peer support.

## Aims

This evaluation aimed to examine the impact that the Peer Support Service has had on the key outcome domains of isolation/exclusion, relapse, personal and professional development, self-esteem, and addressing the gap in service user led services within the borough.

## Method

A mixed methods design was implemented. Entrance and exit questionnaires were administered to individuals in the peer support service to assess change over time on the key outcome domains. Staff at the referral team were given a questionnaire to assess attitudes towards service user involvement. Additionally a focus group with four individuals who were currently in peer support was conducted to give a qualitative depth to the study.

## Results

Individuals showed improvements in outcomes measures across the board, although despite generally positive attitudes to their experiences of peer support, few intended to return as peer supporters themselves. However, only a very small number of respondents filled out questionnaires, therefore it is impossible to analyse differences statistically between entrance and exit to the service.

## Conclusions

The extremely small sample size makes it difficult to draw firm conclusions from the data. Further data must be collected before any effects of the peer support service can be shown. The researcher has put these mechanisms in place within the peer support service to allow them to continue with this into the future.

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# 1 Introduction

### 1.1 What is peer support?

Peer support in mental health services can be described in many different ways. A recent, comprehensive definition from Mead describes peer support as "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful" (Mead et al, 2001, p.6).

The key components of peer support are summarised by Bassett et al (2010) as:

- Mutuality
- Solidarity
- Synergy
- Sharing with safety and trust
- Companionship
- Hopefulness
- Focus on strengths and potential
- Equality and empowerment
- Being yourself
- Independence
- Reduction of stigma
- Respect and inclusiveness

These twelve components are linked by their positive focus, and the need for the individual to engage actively with their peer.

### 1.2 The development of peer support

Peer support can be traced back to the 1920s when psychiatrist Harry Stack Sullivan sought out young men who had recovered from severe mental health problems to be aides on the inpatient ward where he worked. He felt that their life experiences would provide sensitivity towards the inpatients that other employees may not have, and that they would therefore be uniquely qualified to work with these inpatients effectively and compassionately (Perry, 1982).

More recently, in the 1980s and 1990s, the Mental Health Consumer Movement in the USA brought individuals who had been inpatients together to protest against the treatment that they had received whilst in hospital. This group of people created mutual support groups and client-led services which served as alternatives to the traditional mental health system. The group later took a more collaborative approach with service providers, without diluting their identity as separate, peer led providers.

Since then, peer support in mental health has evolved to define a wide range of services throughout all areas of mental health, ranging from self-help groups to online buddying systems for individuals too anxious to meet individuals face to face. The number of peer support services has increased globally as systems move to be more recovery focussed and inclusive – two principles at the core of peer support. The number of peer support staff in the US alone has been estimated at over 10,000 (Goldstrom et al, 2005).

**1.3 How does peer support work?**

Peer support has been shown to be useful in a number of ways. Salzer et al (2002) summarise theoretical perspectives that may underpin peer delivered services including: social support, experiential knowledge, social learning theory, social comparison theory, and the helper-therapy principle

- Caplan (1974) characterised social support as consisting of significant others who a) help people mobilize their psychological resources in order to deal with emotional problems; b) share people's tasks; and c) provide individuals with money, materials, tools, skills, information, and advice in order to help them deal with the particular stressful situation to which they are exposed. The idea of supportive relationships acting as protective factors against medical problems was explored by Gottlieb (1981). Later research went further, suggesting that social support acted as a buffer against stressors and adversities as well as mental health problems. A peer support system may expand the size of an individual's supportive network.

- The value of experiential knowledge – where an individual uses their own specialised lived experience to benefit others – also underpins the efficacy of peer support. This knowledge is often unique, but when shared with an individual experiencing similar circumstances the commonalities between the situations may become apparent and resolutions emerge (Shubert and Borkman 1994). Spending time with others who have successfully dealt with their own mental health problems may allow individuals to validate their own coping mechanisms and improve their self-confidence, as well as improving their confidence in health services as they see that it has worked for others.

- Experiential knowledge and social learning theory are closely linked. The latter states that individuals will learn from following the examples of others, and are more likely to do so from credible role models such as peer supporters than from mental health professionals who they do not relate to as well. Peers who spend time interacting with peers who have had positive outcomes enhance their own sense of hope, confidence and self-sufficiency in dealing with their illness (Salzer et al, 2002).

- Social comparison theory follows on from social learning theory as it suggests that two peers form a bond due to commonalities, in this instance due to having a mental health problem. Festinger (1954) posits that this occurs in order to create a sense of normality from their shared experiences that are often perceived to be abnormal by society as a whole. However, the differences between the individuals are also noticed, as well as their similarities. If one of the peers is perceived to be 'doing better', it promotes feelings of optimism and something to strive towards and compete for in the other peer. Conversely, if one is perceived to be 'not doing as well', it provides a frame of reference for the other to see their progress. This theory shows how a peer 'supporter' can benefit from their experiences as well as the peer 'supportee', who will in general be at an earlier stage in recovery than them.

- In a similar manner, the final concept covered by Salzer et al's (2002) summary of helper-therapy can work both ways in peer support. It refers to the idea that peer supporters are no longer reduced to a passive, 'patient' role, but now have agency to adopt socially valued roles serving as role models to other individuals who are at earlier stage in their recovery (Riessman, 1965). The helper feels an enhanced sense of interpersonal competence; feels that they have gained as much as others have gained from them; receives personalised learning; and acquires an enhanced sense of self from the social approval received from

those helped (Skovholt, 1974). Although this idea fits best within a mutual support model of peer support, there is always likely to be some reciprocity in the peer relationship however it is set up, meaning that the designated 'supportee' will experience these positive feelings to some extent as well as the designated 'supporter'.

**1.4 Difficulties with peer support**

There are, however, some difficulties with peer support. Some research has suggested that the mutual nature of peer support can create difficulties for the peer supporters themselves, who are confused whether their role should be as 'clinician' or 'friend' (Mowbray et al 1996). Similarly, peer supporters can feel that their role is undervalued and misunderstood by services, leading them to seek more compensation for their efforts (Mowbray et al 1996). Peer supporters do not appear to escape the self-stigma that is common within mental health populations. Harding and Zahniser (1994) found that the belief that 'once you are a mental patient you are always a mental patient' was common not just to public and lay providers but also to the patients themselves. Given the sensitivity of individuals engaging in peer support to the attitudes of their peer supporters, it is therefore important to ensure that peer supporters do not hold such beliefs.

From the supportee perspective, this same internal stigma may reduce the likelihood that individuals will engage in peer support, because they can't see what others similar to themselves can offer them as they feel worthless themselves. Similarly, social comparison theory – as discussed in the previous section – could also work in the opposite direction. If one individual is not moving forward as hoped then their peer may become despondent or lose impetus as they compare themselves to their struggling peer.

The efficacy of peer support also depends on the wider attitudes of the service in which it is set. In their review of peer support research, Repper and Carter (2010) note the necessity of a supportive service "through changes in language, practices, procedures and policies consistent with a Recovery-focused approach" (p. 18) in order for its peer support workers to perform to their potential. This suggests system-level change is required in order to allow the change in attitudes over time to continue.

### 1.5 Research into peer support

Studies of peer support schemes for individuals with severe mental health problems tend to have relatively small samples and use qualitative methods. This may be due to the relative infancy of many of these interventions. Additionally, the difficulty in finding a suitable control group, and the ethics of withholding peer support to one group, often prevent experimental methods being used. The highly sensitive and personalised nature of a peer support service could render more invasive experimental methods unsuitable (Resnick & Rosenheck, 2008).

In their review, Repper and Carter (2010) identified only 7 RCTs into the efficacy of peer support (Solomon & Draine, 1995; O'Donnell, Parker & Proberts, 1999; Clarke et al, 2000; Dummont & Jones, 2002; Davidson, et al, 2004; Sells et al, 2006; Rogers et al, 2007). Their findings were unclear and variable because of heterogeneity of the samples, design and outcome measures used.

### 1.6 Can peer support be compared to traditional services?

Studies of peer support have found that in therapeutic groups which are to some extent service-user led/involved, involvement is greater and lasts longer, and drop-out rates are lower than groups without this. For example, Mowbray and Moxley (1997) suggested that peers would be adept at empathising, accessing social services, appreciating clients' strengths, tolerance, and flexibility if working collaboratively with clinical teams. A consistent finding across all of the studies examined within Davidson's (1999) evidence review of peer support was that peers could adequately provide services to others with serious mental illness, demonstrating their ability to occupy important roles beyond their status as mental patients. However, it was noted that more rigorous studies were needed to determine exactly how.

### 1.7 Peer support in Southwark

The Peer Support Service (PSS) was developed in Southwark in 2009 in response to an identification of need by service users and staff within the borough with first matches in June 2011 The scheme aims to help individuals who had accessed the Crisis services (previously known as CREST) prior to discharge. These are adults who had experienced mental distress and had opted for home treatment rather than a hospital admission. From September 2012 the service was extended to

Southwark wards and the Occupational Therapy Service. The aim is for individuals to enter the PSS just before their discharge, as this is the point that clinicians perceived them to be most at risk of relapse, anxiety and encountering other difficulties due to the sudden reduction in support. Individuals were entitled to six to nine months of peer support, deemed to be sufficient time to support them through discharge and for any initial problems experienced post-discharge to be resolved.

The project models itself on the Mental Health Peers Model from Sherry Mead, which states that "It is only in relationships that are constantly negotiated that we build mutual respect and trust. When we consider that both of us have needs and expertise, we learn from each other while taking chances in becoming more vulnerable and consequently more whole" (Mead, 2001, p. 1)

The Southwark PSS can be defined as a 'peer delivered service' (Solomon, 2004), whereby the front-line support is delivered by peers, and clinical and non clinicalstaff provide aid for the peer supporters.

# 2 Aims

The project's aims were originally defined as follows:

i) The project aims to **reduce risk of relapse** post discharge by providing peer support

ii) The project will develop a **peer support project** in line with best practice

iii) The project aims to increase **self-esteem** through 1) supportive groups which are recognised as positively impacting on self-esteem and 2) one-to-one support, which "has considerable benefit to offer to the aim of social integration and ordinary living"

iv) The project aims to **promote personal and professional development** of volunteers and service users through the provision of training and support groups

v) The project aims to **reduce exclusion** by providing social interaction and promoting access to community facilities

vi) This project aims to address the **gap in befriending** in Southwark by delivering a peer support service during transitional periods for service users

These aims fed into five outcomes domains that will be covered by this report. The sixth – the set-up of the service in line with best practice – has already been completed. The five outcomes domains were therefore relapse, isolation, gap in service user-staff collaboration, self-esteem, and personal and professional development. This evaluation will provide a summary of the progress of the project to date, as well as describing the extent to which it has met its aims.

# 3 Method

A mixed methods design comprising exit questionnaires (for participants already using the service), pre-post questionnaires (for those going through the service during the course of the evaluation) and a focus group was used. Data collected in this evaluation will provide a baseline for future long-term follow-ups of the individuals passing through the service.

### 3.1 Exit questionnaires

Exit questionnaires (Appendix 1) were administered by two service user volunteers by telephone. They wrote qualitative responses verbatim wherever possible to capture the richness of the responses.

The exit questionnaire asked individuals about their feelings about their peer support coming to an end (Q1), as well as what had been important to them and how the project had helped them (Q2 and 3). Service users were asked whether they would recommend the service to another service user, and what could be improved within the service if they were not happy with it (Q7). Respondents were invited to rate on a scale of 1 – 5 how happy they had been with the service overall (Q9).

The questions within the questionnaire covering the 5 outcome domains were as follows:

1. **Relapse** was measured subjectively and retrospectively by asking individuals whether the peer support had helped them with crisis situations; whether they had suffered a relapse; and who had noticed that they were becoming unwell (Q4, Q4a and Q4b).
2. The **isolation** domain was measured by an individual's perception of their access to services; whether peer support made them feel that they were more able to access community facilities; that they were introduced to new projects by their peer supporter; and that their personal relationships had improved (Q3b).
3. The **gap in user/staff collaboration and peer support projects** within SLaM was examined in a number of ways. Firstly, answers to questions 1, 2, 3, 7, and 9 provided perceptions of the success of the project (one of the key components of this outcome). More specifically, individuals were asked whether they felt that the peer support project was user led, and whether this made it more effective (Q6 and Q6a). Finally, a short attitudinal questionnaire (Appendix 3) was given to the crisis (home treatment) team who had referred people to the service, about their attitudes to peer support. This examined their feelings about service user involvement when they first heard about the PSS and their attitude on a scale of 1 – 10

from “not at all in favour” to “completely in favour” in comparison with their thoughts and attitudes about it today. This was designed to detect any changes in attitudes during the time of PSS being active within the borough.

4. **Self-esteem** was measured by asking how individuals had felt their levels of self-esteem had changed since starting the project (Q3a). The Warwick Edinburgh Mental Well Being Scale (WEMWBS) (Tennant et al, 2007) was also given at exit interview. This allowed comparison across the group on a standardised measure rather than relying on a singular, explicit question on self-esteem.
5. **Personal and professional development** was measured by asking individuals whether they felt that peer support had helped them to achieve their goals (Q5). The questionnaire also tapped into this domain by asking whether they had plans to enter education, employment, volunteering, another support scheme, or other activities now they had finished the scheme (Q5a). It also asked whether an individual planned to return as a peer supporter themselves (Q8).

No one was contacted to answer the exit questionnaires if they had been referred to the service before January 2012. This ensured that the longest that an individual had been out of the service before being asked the exit questionnaire was three to four months (left service July or August, asked questionnaire October or November).

**3.2 Entrance questionnaire**

In liaison with the staff at the PSS, we introduced an entrance questionnaire (Appendix 2) containing equivalents of Q1-4 of the exit questionnaire, and the WEMWBS (Appendix 4) to be delivered to individuals as they started the scheme. This allowed pre – post comparison of individuals to be made going forward and outcomes to be measured more accurately.

No one was contacted to complete the entrance questionnaires if they had entered the service before September 2012. This meant that all participants asked the entrance questionnaire were within their first month of the service when they gave responses.

All data from the questionnaires was inputted into Excel and analysed using SPSS v15.0.

**3.3 Focus group**

To complement this data, a focus group with 4 individuals was held. This group consisted of 2 individuals who had been in the scheme for some time, and 2 individuals who had left the scheme. This allowed a comparison of experiences and perspectives. The focus group was designed to be

relatively unstructured to allow the free flow of conversation and maximise case studies and creative thinking. However, the following topics were covered at some point within the conversation:

- What is your most memorable experience of the peer support service?
- How did peer support help you?
- What makes a good peer supporter?
- Would you want to do peer support yourself?
- Do you see peer support as an alternative to other mental health services?
- With peer support do you need other mental health services at all?
- Did the peer support service ever help you to stay well, or to stay out of hospital?

The focus group was transcribed and analysed for key themes using NVivo v10.

# 4 Results

### 4.1 Demographics

The peer support scheme had 73 referrals between June 2011 and March2013. The highest rate of referrals reached 10 per month in February 2013. Of these 73 referrals, 38 been matched to and received peer support.

The peer support scheme does not routinely record age or ethnicity, instead preferring to get to know individuals' interests and personalities in order to match them most effectively with a peer supporter. However, gender is noted on the referral. 70 referrals included gender information and of those recorded, 40 (54.8%) of referrals were female and 30 (41.8%) were male.

At the time of writing, only a small number of individuals have filled in the entrance and exit questionnaires. The entrance and exit questionnaires were created in December 2012 as the old-style questionnaires (which had only been administered to a few individuals) did not serve purpose. Table 1 shows the total numbers of participants who completed questionnaires.

**Table 1: Questionnaire completion rates**

| **Component of Questionnaire** | **Number of Participants** |
|---|---|
| Entrance Questionnaire | 12 |
| Entrance WEMWBS | 11* |
| Exit Questionnaire | 11** |
| Exit WEMWBS | 15 |

*one participant refused to complete WEMWBS

**one of these questionnaires is incomplete

***4 participants only completed exit WEMWBS

Of these participants, only two both entered and exited the service within the period of data collection. Only one has a full complement of data. In the absence of a sufficient number of paired results to allow full pre-post statistical analysis, we will use this example as a case study to view change over time at an individual level. This can be viewed at the end of the results section.

Due to the small dataset, this analysis will focus on examining and comparing descriptive elements of the two cohorts at the start (where applicable) and at the end of their time in the peer support service. Their overall feedback on the service, and then in each of the key outcome domains will be

reported. This will be reinforced with qualitative data from the focus group analysed and presented thematically.

**4.2 Opinions of the Service**

Both entrance and exit cohorts were asked comparable questions to ascertain trends in opinions before and after peer support. When asked how they felt about starting peer support, entrance cohort respondents were in general quietly positive with lots of *'OK'* responses, and one stating *"it could benefit me and it's good to meet someone who has been through it"*, although one respondent felt nervous. Asked how they felt peer support went, the exit cohort's responses were similarly positive, with some individuals stating that they felt it had run its course - *"I'm feeling it's sort of natural as I am back at work"* – and others happy that they could keep in touch with their peer supporter, for example stating that *"it was a good experience and I am a bit sad, but we are still friends".* Only one individual reported being *"a bit surprised"* that the support had ended.

When asked what would be important about peer support, the entrance cohort stated that the chance to meet someone who understood them was key, for example *"meeting others with a lived experience in the same boat on the way to recovery"*. The reduction of isolation was also important, with a *"regular meeting set up"* mentioned, as well as the poignant comment of simply *"anyone can be lonely".* This question was posed retrospectively to the exit cohort, and similar themes were observed, although the specificities of how isolation could be reduced were replaced with more general *"reduced my isolation"*. The most salient theme within the exit cohort, however, was the idea of 'having someone there' – *"…to fall back on", "…to have a conversation with", "…taking the time to support me"* – whatever the reason for it, it was the presence of another person that rang true with these individuals.

Both cohorts were also asked about what the project could, or did, help them with. Those entering the service gave quite specific responses to this, ranging from meeting people – *"to continue to have someone to communicate with"* to help engaging with activities – *"getting back into work or some sort of adult education"*. Several respondents were not sure about their answer to this question. In the exit cohort, a key achievement of peer support was an increase in confidence, for example *"it helped me to regain my footing and move forward again".* This cohort's responses were in general more emotive e.g. *"tremendously, I have a new friend, I have met people I can fall back on…"*, rather than specifying practical elements of help as the entrance cohort had done.

Of the 11 respondents from the exit cohort, 10 (90.9%) stated that they would definitely recommend the service to another service user, and the remaining 1 (9.1%) said that they probably would recommend the service, suggesting a high level of satisfaction with it.

When asked what could be done to improve the service, there were only 3 relevant responses. One was *"more time"*, and the other two surrounded the match of the peer support pairing, for example *"My match wasn't as good as I might've been - I'd like someone more 'outgoing'"*.

Finally, individuals were asked to rate their experience of peer support on a scale of 1 – 5. All 11 respondents rated the service at 3 or above, with the majority rating it at a full 5 points (mean=4.64, s.d.=0.67).

**4.3 Specific Outcome Domains**

***Relapse***

One of the project's targets was to reduce relapse by 10% after one year. In the absence of full relapse data, individuals were asked whether or not they had suffered a relapse in the past six months.

7/11 (63.6%) of the entrance cohort stated that they had suffered a relapse in the past six months, compared to just 2/10 (20.0%) of the exit cohort. This shows a lower proportion of relapse after PSS, though relapse may have been a common feature of individuals' journey into peer support. No control group was available to compare the exit cohort with, which would have made a more meaningful comparison.

Another target was that 25% of relapses of those using the project to be identified by users themselves within the peer support service.

Respondents were able to select multiple options for this question to capture the complexity of identifying a relapse. Of the two individuals that had suffered a relapse during the past six months who had been through peer support, both identified the relapse themselves, and one also stated that their peer supporter had noted that they were becoming unwell. This shows that 100% (of the very small sample) fulfilled this outcome. This compares to the entrance cohort where 2 (28.6%) identified the relapse themselves and 1 (14.3%) was helped by someone from the peer support service. However, in addition to this, 2 participants (28.6%) stated that their family/friends, and 3 (42.9%) professionals, had identified their relapse.

The exit cohort was also asked whether they felt that peer support had helped them with crisis situations. Of the 10 respondents, 6 (60%) stated that they felt that it had been useful. It is possible that the four who did not feel that it had been useful may not have experienced a crisis situation during their time in PSS. When asked to comment how it had been helpful, responses were that the PSS was there – *"ringing up and checking up on me"* – or that they had learnt new knowledge *"I don't always recognise it, but I have learnt new techniques".*

***Isolation***

The second outcome domain was looking to tackle isolation. The target which was set was that at least 50% of users would feel more able to access community facilities, that they were introduced to new projects and services by their peer supporter, and that they felt that they had better personal relationships due to peer support. The exit cohort was asked these three questions. Of the 10 who responded, 8 (80%) said that they would feel more able to access community facilities (1 said no, and 1 wasn't sure); 6 (60%) felt that they had been introduced to new projects and services (4 said that they hadn't been), and 8 (80%) said that they had better personal relationships due to peer support (2 said that they hadn't). This exceeds the target of 50% on all questions for the exit cohort, though caution is needed in interpreting these findings because of the small sample.

***Gap in user/staff collaboration and peer support projects within SLaM***

The exit cohort was asked whether or not they felt that the service had been user led. Of the 10 respondents, 8 (80%) stated that they thought it was, with 1 (10%) saying that they did not feel it was, and 1 (10%) stating that they were not sure. When asked whether they felt that being service user led had made peer support a more effective service, 6 (60%) stated that it had, but the remaining 4 did not answer the question. The outcome target was that 75% of respondents assert that the user led nature of the project has made the service more effective, and therefore this was not achieved by the current exit cohort, but a larger sample is required to more accurately determine if this target has been met.

Improving staff attitudes towards a service user led environment was also a key component of this outcome domain. One initial target was that 50% of staff would show a more positive attitude towards user led services following briefing by the peer support service.

To further assess the effect of peer support on this outcome, a questionnaire was given to members of the Home Treatment Team within SLaM who had referred individuals through to the PSS. Unfortunately there was a very low take up and only three responses were received. From these responses however, all viewed service user involvement very positively. One staff member

responded that *"I was very enthusiastic as I am a service user who is employed by the trust as a service provider"*, indicating that the Trust already place an emphasis on service user involvement. Of the two respondents who answered the question "Has the peer support service changed your attitudes towards service user involvement?", both responded that it had. The other respondent stated that they already had a maximally positive attitude towards service user involvement before the start of the peer support service. These traits bode well and should be investigated further with a larger cohort of staff members.

***Self esteem***

The Warwick Edinburgh Mental Health Well Being Scale (WEMWBS) was given to all participants before and after using the PSS. Within this measure are questions relating to self-esteem, including 'I've been feeling useful'; 'I've been feeling good about myself'; and 'I've been feeling confident'.

The entrance cohort (n=11) had a lower mean score (mean=38.64, s.d.=10.22) than the exit cohort (n=15) (mean=42.8, s.d.=10.87).

Of the ten individuals who answered the self-reported self-esteem question, 8 (80%) stated that their self-esteem had 'got a lot better' since starting peer support, with 1 stating that it had got a bit better, and 1 that it had stayed the same. No respondents thought that there had been a decrease in their levels of self-esteem since starting with the project. This meant that the target of 75% of service users to report an increase in self-esteem was surpassed according to this measure, with 90% of respondents showing this result, though the small sample indicates that this finding should be interpreted with caution.

***Personal and professional development***

The exit cohort was asked whether peer support had helped them to achieve their goals. Of the 8 that answered, 4 (50%) said yes, and 4 (50%) said no. The primary explanation for a negative response was that they did not set goals (at least in so many words) at the start of the peer support e.g. *"didn't really set any apart from getting well".*

The exit cohort was also asked about their plans after the PSS. They could give more than one answer to reflect the multiple activities that they could engage with. Of the 9 people who answered this question, 5 (55.6%) were planning on returning to employment, 2 (22.2%) planned on completing voluntary work and 1 (11.1%) was seeking education. 1 (11.1%) had no plans at the moment, and another 2 (22.2%) stated that they were doing something else – 1 had plans to become an advocate and the other was taking various ideas on slowly. The target set out in the

outcomes document was that 40% of users would return to employment, voluntary work, or education. This target was reached by those intending to return to employment alone (55.6%),however it must be noted that intention is not the same as action and these figures are therefore not representative of what actually occurred.

Of 10 respondents, only 2 (20%) individuals intended to return to become peer supporters, 6 (60%) said no and the remaining 2 (20%) stated that they were not sure. For this cohort, the target of 30% of users returning to become a peer supporter was therefore not met.

**4.4 Focus Group**

The focus group consisted of four individuals who had accessed the peer support service. Three were currently mid-way through their support (one of these individuals had a two month extension granted from the 6 month initial period), and the other had finished. The individual who had completed their support had subsequently trained to be a peer supporter, although at the time of the group had not actually supported anyone.

The researcher noted that the focus group progressed fairly logically and according to the series of questions within the discussion guide. Data was therefore analysed thematically, and findings are described below.

***The personal qualities of a peer supporter:***

The group mentioned empathy as a key quality for a peer supporter - *'not everybody understands mental health so the fact that they have been through it – it helps'*.

The individual needed to be a good listener, as well as open minded and non-judgmental. One respondent described time with their peer supporter as *"it's like hanging out with somebody that you're not worried about how you censor in the conversation, (you're) able to know that most of the elephants in the room are covered"*

***Matching support – similar or different?***

There was a lot of discussion surrounding whether or not the peer supporter and peer supportee needed to be similar. The consensus was that *"it just depends on the character of the person. It doesn't mean you have to be similar or share similar experiences as long as that person is willing to help and be understanding".* One participant remarked that in fact, differences could be beneficial,

stating "*if there are differences then the peer supporter can perhaps observe something in you, or you can observe something in them that might be problematic'*

The perspective was summarised by the description – "*She's an older lady, in her 60's, and she's great. So my peer supporter has probably got very little to do with me, but we share some hobbies, we share some interests, so we can actually talk about them"* – as long as there is common ground and a willingness to share, it doesn't matter if the more traditional 'similarities' are present.

***The mutuality of the relationship***

All respondents were keen to stress the two way nature of the peer support relationship – as one respondent said their peer supporter was *"like a friend, that's the best way to describe it".* Respondents saw this mutuality as empowering for them as well as the peer supporter, for example describing *"a sense of hope that you can actually come out of various places that one may sink into – you can actually keep each other above ground".* They were happy to defer to the peer supporter's experience, without negating the potential for growth - *"there is a sense of they have more experience, they have been trained, but it's a two way process because friendship is building in certain respects"*

***Boundaries***

With this mutuality came a blurring of boundaries. All respondents commented on this, for example "*there's a certain dry wit going on between me and my peer…it's an unsolicited comment that sort of pops out and we realise how we've both been there…the question is whether that's normal or whether that's slightly breaking the rules by how much one brings to the table".* The consensus seemed to be that the nature of the support was very similar to a strong friendship, and as such lines were blurred.

***Language used in peer support***

From the absence of jargonistic NHS terms to being able to talk candidly about mental health without fear of upset or misinterpretation, respondents found the language used within peer support to be very helpful. For example, one individual commented *"If I was to say to a family member…'I'm feeling depressed today' (they) would think 'oh you're just having a bad day' but your peer supporter they know that it's a problem, it's an illness, it's not something that you can just brush off'*

***Flexibility of the service***

The option for the service to be a flexible one was seen as very positive. The empathy and mutual relationships took away a great deal of the stigma surrounding this being a mental health service; but meeting out in the community helped this even more. This was summarised in one respondent's view *"we've switched to a greasy spoon, since its away from the mental health that puts it into a much better situation where we are talking much more about what we are doing. I don't have to concentrate on mental health and all that sort of stuff if we meet somewhere totally different – we can just talk about things in general. But I think that when you are in an environment, which is about mental health you tend to talk about mental health more"*

***Peer support ending***

Participants were comfortable with peer support ending. This was either because they felt ready to leave the service "*At this stage I feel ok about it – I feel stronger, can stand on my own feet",* or more frequently because they felt that they would be able to ask for an extension beyond the initial six month period. This outlook was a great comfort, but was somewhat taken for granted – *"it depends on your state of mind, how well you are not able to see the person any more – if you feel ok your time is up then ok but if not you can get an extension".* The other major theme surrounding peer support ending was the ability to keep in touch with the peer supporter on an informal level *"my peer supporter says we will still be friends though, let's just do this for six months but we will still be friends'".*

Respondents spoke extensively about wanting to remain involved or connected in some way with the service, suggesting ideas such as *"I would like it if it became something that continued to be part of my life – so people who are volunteers end up having several peer supportees".* Another stated that "once you finish with your peer supporter you still want to feel included" and this was clarified as meaning in a more integrated way than the weekly drop-in sessions. Respondents suggested informal meet-ups *"a group of volunteers could get together and do a certain project – 4 or 5 or 6…if someone took responsibility for meeting up that would be a different service"* as a way of achieving this.

***Would you be a peer supporter yourself?***

Despite the fact that participants had clearly gained a great deal from the peer support service, most held the opinion that they did not want to become a peer supporter themselves. Citing either the time commitment *"the idea that it's 2 hours a week doing this – I don't think I would be able to do 2 hours a week, I don't know how to sustain a conversation for that long"* or their own problems *"I*

*have a tremendous appetite for mental health – I just don't see myself being well enough"* as a barrier. Respondents thought that it was a positive step, but could not perceive themselves fulfilling the role *"I like the idea of being trusted to do that sort of thing but I am not sure if I am the right person to do it".*

***The training for peer supporters***

The participant who had already completed training was able to brief others on what the training had entailed, and from this they could evaluate whether their peer supporters seemed to be using what they had been taught. The trained participant commented *"It (the training) covers a lot of things – confidentiality, everything you need as a peer supporter, I've not actually been in the role yet but if I look at my peer supporter I think he is probably following everything that he is supposed to"*. Another participant said that he could see how his peer supporter was *"helping me mentally in my faults – just very helpful, I wouldn't be able to come here on my own".*

***Peer support and other services***

Participants were mixed about whether they would rather have peer support or other services. One individual stated that they *"would rather have peer support than psychology"*, and another added *"if you fancy going to the gym and you need confidence to go they can come with you – you can't ask your psychologist to do that with you!"* The level of trust in a peer supporter was also higher than for other professions in the medical field, which *"scares you as you don't want to reveal certain things as it could lead to something else".* However another said that *"I've had no problems so far – haven't seen anything that needs to be done differently – but they are not psychologists or therapists they are just peer support so I think we need to take that into consideration".* This use of *'just peer support'* suggests that at least amongst some, peer support is not seen as an equal contender to other more traditionally trained professionals.

The conclusion of this part of the discussion was that peer support complemented other services – that group work was important, as well as charities. One participant summarised opinions on this matter by saying that both medical and peer support sides *"contribute to staying well – part of staying well is not being too much on your own, too much in the eye of the target, getting the balance right – get a balanced relationship with peers, with group stuff, with other people – its striking a balance".*

***What could be done better?***

Participants were on the whole very positive about the peer support service. A point that was mentioned was the handling of the time period between referral and match, or if an initial match does not work out. One individual described the interlude between two peer supporters as 'being on the scrap heap' – indicating a potential feeling of rejection that may be prevalent within these clients.

Another topic that emerged in several guises throughout the discussion was they wanted a fuller service out of peer support – *"I don't want to feel like it's a halfway house service, want to feel it's a full service, then it is comparable to something offered by the Trust".*

However, this was not a case of expecting employees to extend the service in set ways. Instead it was perceived as something that evolved in an organic manner. More flexible meetings and groupings of peer supporters and supportees was suggested, with one participant brainstorming *"subsecting different things with different people, making it informal, break it down, manageable groups…more mutual, it would be the people that you get on best with – it depends – you don't know who you are going to get on with, you have to meet them".*

Another said that peer support could be *"part of a larger service – not seen the horizons of the service yet – there is a bigger landscape there but I don't know what it is – it should be a larger thing, it needs to continually developed, don't know how to quantify that, don't know what to suggest, some way of having a long term involvement with somebody and support is healthy – but it depends what that means for the other side – be nice if it became something bigger than itself, it seems like something".*

The goal of all of these ideas were for continued recovery, with the final comment on this topic coming from a participant who stated that *"if you start to trust who you are with, and they say it's short term therapy and it stops after 6 months, the question is how much of this is short term therapy and how much is about long term health?"*

***Case Studies***

These extracts describe the most memorable aspects of the peer support service for each participant.

Participant 1:

*"I think what stands out for me is when I first met my peer support – the difference between how I was when I first met my peer support and how I was towards the end – I think it was like a recovery process that had an impact on my peer support- she felt that she had really seen a big difference in me, encouraged me, it gave me that confidence again to know that I was coming back to myself, just the experience of meeting someone when you weren't really yourself until the point where you are getting back to how you were before"*

Participant 2:

*"We meet on a Monday and it's a bit of a shock to the system to meet for a lunch – but I am always aware that I am making that effort, and it's probably one of the few things that I am making that effort towards the way my life is at the moment…in terms of the event element of it, it is actually stronger than I give it credit for. Peer support is my Monday morning wake-up call''*

Participant 3:

*"The train line was down and we managed to get a bus – we saw the train was not running and we just went to the bus stop and went back...panic but then relief…if I hadn't had the peer supporter there I would have struggled to do that…they just said stuff to calm down and was there"*

Participant 4:

*"In the summer…I think it was July…we went to the park – the one right here, think it's 'R' Park, and just chilled out, sunbathed, just chilled, and that was a big deal for me because I kinda shut out a lot of my friends because I felt embarrassed about my illness and it was just nice to let my hair down. Just general hanging with a friend, that's how it felt".*

As can be seen by the varied and emotive subject matter and language used, peer support has been an individualised and personally impactful experience for all of them.

# 5 Discussion

### 5.1 Outcomes

The evaluation of the Southwark PSS suggests that the service is associated with positive outcomes in all five of the domains listed on the proposal: relapse, isolation, user-led services, personal development and isolation.

A smaller proportion of clients had **relapsed** within the previous 6 months on completing the service than when entering the service. Of those in the exit cohort that had relapsed, a higher proportion identified their relapse either themselves or with the help of someone else involved with peer support.

Users felt that the service was **user led**, and that this was a good thing. The service also seemed to have had a positive impact on Trust staff attitudes to user led services.

WEMWBS levels were higher in the exit cohort than the entrance cohort, and clients stated that their self-esteem had improved since starting peer support, suggesting that the service had a positive impact on **self-esteem** (although the entrance and exit cohorts are not directly comparable). Comments on the qualitative aspects of the questionnaire and within the focus group also showed trends about regaining confidence as a product of peer support. This ties in with Shubert and Borkman's (1994) findings that spending time with an individual who had experienced the same problems as you, but was now attaining positive goals, helped a client's self-confidence.

**Personal development** targets were met, with the majority of the exit cohort reporting plans to return to work, volunteering, or education. However, there were not a high number of individuals who reported an interest in becoming a peer supporter themselves.

Finally, the exit cohort reported that their peer support had helped them to feel less **isolated**, with the majority of respondents believing that they had been introduced to new schemes and felt more confident in personal relationships thanks to peer support. The mutuality and dependability of the peer support relationship was a crucial element to this, as cited in both the focus group and the qualitative components of the questionnaire.

In addition to these domain specific conclusions, the users of the peer support service reported that they would recommend it to another service user and were in general highly satisfied with the service as a whole.

**5.2 Limitations of this evaluation**

The data available to the researcher was not extensive, or comprehensive, and this will have had an impact on the results. As explained in the methods section, new questionnaires had to be created to serve the purpose of this evaluation, which significantly compromised the fieldwork time. Additionally, only a small number of respondents (26) were included within the study. This was unavoidable due to a short timescale and the need to change the questionnaires at the start of the project. Statistical analysis on the majority of the outcomes measures was not possible and the descriptive statistics and trends within the entrance and exit cohorts make inferences difficult. The quality of the data also limits conclusions we can draw. The data was collected by two service user researchers who, where possible, recorded qualitative responses verbatim. However, it has been apparent from the raw questionnaire data that this was not always possible. This means that researcher bias in recording the information may be present, as the most salient points and words were noted rather than the exact words of the interviewee.

There were also some mix-ups in the administration of questionnaires. As is common when setting up a new system, there were teething problems. Some participants were asked the exit questionnaire whilst having only been in the service for a week which proved quite confusing for them, and their data had to be discarded. As time progresses, and the service user researchers become more familiar with the routine of data collection and inputting, these issues should dissipate and allow a higher quality of data to be collected.

To gain the maximum number of responses possible, individuals who had been out of the service for up to 4 months were also asked to fill out the exit questionnaire retrospectively. The benefit of hindsight, as well as any experiences since they completed their time with peer support may skew their responses.

It has been seen from this evaluation that peer supporters received training before commencing their duties as a peer supporter, and were quite clearly defined as 'the helper' within their role. However, it is widely documented that within all peer support there is a bi-directional relationship of support, which benefits both members of the dyad known as 'helper therapy' (Riessman, 1965; Skovholt, 1974). This evaluation took into account the opinions of the clients who received peer support, but did not examine the experiences of the peer supporters themselves. However, without asking these individuals directly it is not possible to be certain of the full picture of the peer support dyad. Future evaluations of the scheme should also take into consideration the viewpoint of these

crucial stakeholders, especially to understand opinions such as whether or not they feel that the scheme is 'service user led'.

**5.3 Recommendations**

***Continued research:***

Due to the small sample size, it has not been possible to reach firm conclusions on the performance of the service, and therefore recommendations are tentative.

- Data to be collected over a longer time period to develop a cohort of at least 25-30 individuals who have completed both entrance and exit questionnaires with WEMWBS.
- Collect demographic data for this cohort to allow exploration of any trends at this level of analysis, providing indicative findings about the effectiveness of peer support in different subgroups.
- A fuller and more comprehensive pre-post analysis to be completed using this information
- Continued development of training for service users to lead this data collection and input process

Several service users have been trained in how to efficiently and accurately collect and input data to allow the evaluation process to continue whilst embracing the user-led philosophy of the peer support service. A full protocol document for data collection has been created by the researcher for the PSS team to refer to.

***Intention to return as a peer supporter:***

Although clients were on average very satisfied with the scheme, and definitely likely to recommend it to another service user, only 20% of the exit cohort said that they would return as a peer supporter themselves. This was echoed in the focus group, with concerns about time commitment and not being ready or suitable coming into play.

- Focus on recruiting new peer supporters
- Produce leaflets/information material such as "So you are thinking of becoming a peer supporter" which addresses some concerns that clients may have regarding converting from supportee to supporter
- Evaluate merit of offering peer support training as standard at end of time within service

***Matching client to peer support:***

- Focus on matching individuals as closely as possible (Festinger's 1954 social learning theory)
- Continue matching on personality traits and interests
- Formalise process of having regular updates with unmatched individuals to ensure that they do not feel rejected if a match has not been made as quickly as they would have liked.

# 6 Conclusion

This evaluation has found tentative signs that the Peer Support Service is producing positive outcomes in Southwark. Due to the lack of robust quantitative data, the researcher has focussed on the fuller qualitative perspectives of the focus group. Those involved were positive about peer support and saw the potential for it to expand in the future. However, more data needs to be collected to confirm this in due course. By setting the Peer Support service up with usable entrance and exit questionnaires, and training individuals within the service on data collection and entry techniques, the researchers hope that this data will be gathered in time. This will allow a fuller picture of peer support to be built up, and more generalizable conclusions to be drawn.

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# 8 Appendices

APPENDIX 1

# Exit questionnaire

This questionnaire is designed to understand your thoughts on the Peer Support project that you have recently been involved with.

Please take your time when answering the questions, and try to be completely honest when you answer them. Your feedback is really valuable to help us understand how the service is running and if there is anything that we can do to make it better.

If you do not wish to answer any of the questions for whatever reason, you do not have to.

## Thank you for your time.

1. How do you feel that your peer support is coming to an end?

2. What has been important to you about peer support?

3. How do you feel that the project has helped you?

3a. Since starting the project, do you feel that your levels of self esteem have (please tick the relevant box)

Got a lot better ☐

Got a bit better ☐

Stayed the same ☐

Got a bit worse ☐

Got a lot worse ☐

3b. Due to the scheme do you feel that…

| | Yes | No | Don't Know |
|---|---|---|---|
| You are more able to access facilities within the community | ☐ | ☐ | ☐ |
| You have been introduced to new projects and services by your peer supporter | ☐ | ☐ | ☐ |
| You have better personal relationships than you used to have | ☐ | ☐ | ☐ |

4. Did peer support help you with crisis situations? If so, how?

4a Have you had a relapse during your time in the peer support project?

Yes ☐

No ☐

4b If yes, who identified the fact that you were becoming unwell?

You yourself ☐

Your peer supporter or someone else within the project here ☐

A family member or friend ☐

A professional ☐

Someone else (please specify) _____ ☐

(please tick all that apply)

5. Did peer support help you achieve your goals? If so, how?

5a What are your plans now that you have finished this peer support scheme?

Education ☐

Employment ☐

Volunteering work ☐

Other support scheme ☐

Other activity ☐

Something else (please specify) ☐ _____

I don't have any plans at the moment ☐

(Please tick all that apply)

6 Do you feel that the peer support project is user led (that you and other individuals accessing the service have control over how it is run)?

Yes ☐
No ☐

6a If yes, do you feel that this has made it a more effective service?

Yes ☐
No ☐

7. Would you recommend the project to another service user?

Yes, definitely would ☐

Yes, maybe would ☐

No, maybe wouldn't ☐

No, definitely wouldn't ☐

If you have not been happy with the project, how could it be improved?

8. Do you plan on returning to be a peer supporter at this scheme yourself?

Yes ☐
No ☐
Don't Know ☐

9. Now considering all of these factors, how would you rate the support you received on a scale of 1-5 where 1 = very poor and 5 = excellent.

1 ✯ 2 3 ✯ 4 5 ✪

Thank you! Your responses are really valuable to us and the service as a whole!

APPENDIX 2

# Entrance questionnaire

This questionnaire is designed to understand your thoughts on the Peer Support project that you have recently become involved with.

Please take your time when answering the questions, and try to be completely honest when you answer them.

If its OK with you, we will be asking you some similar questions when you leave the service, in order to find out how you found the service and what has changed for you during your time here.

Your feedback is really valuable to help us understand how the service is running and if there is anything that we can do to make it better.

If you do not wish to answer any of the questions for whatever reason, you do not have to.

## Thank you for your time.

1. How do you feel about starting peer support?

2. What is important to you about peer support?

3. What things do you want the project to help you with?

4a Have you had a relapse during the past 6 months?

Yes ☐

No ☐

4b If yes, who identified the fact that you were becoming unwell?

You yourself ☐

Your peer supporter or someone else within the project here ☐

A family member or friend ☐

A professional ☐

Someone else (please specify) _____ ☐

(please tick all that apply)

Thank you! Your responses are really valuable to us and the service as a whole!

# Peer Support in Southwark - Questionnaire for Staff

This questionnaire is looking at your perceptions of the peer support service in Southwark. Please write thoughts, feelings or comments in the comments spaces – anything at all that you feel is relevant. If you do not wish to fill in any of the questions you do not have to do so.

1) Do you remember first hearing about the Peer Support service in Southwark (formally known as CREST) around two years ago?

Yes ☐ If you have answered yes, please continue to question 2

No ☐ If you have answered no, you don't need to answer the following questions.

2) Think back to before you first heard about the Peer Support service in Southwark.
On the scale below, please mark how favourable were you about the idea of service user involvement?

Not at all in favour Completely in favour

1 2 3 4 5 6 7 8 9 10

2a) Tell us how you felt about service user involvement. Think about how familiar you were with it, whether you had encountered it before, and anything else you would like to mention.

Now thinking about your current attitude. On the scale below, please mark how favourable you are now about the idea of service user involvement?

Not at all in favour Completely in favour

1 2 3 4 5 6 7 8 9 10

3a) Tell us how you feel about service user involvement now. Think about how familiar you are with it, and anything else you would like to mention.

Thank you for your time!

# The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

**Below are some statements about feelings and thoughts.**

**Please tick the box that best describes your experience of each over the last 2 weeks**

| STATEMENTS | None of the time | Rarely | Some of the time | Often | All of the time |
|---|---|---|---|---|---|
| I've been feeling optimistic about the future | 1 | 2 | 3 | 4 | 5 |
| I've been feeling useful | 1 | 2 | 3 | 4 | 5 |
| I've been feeling relaxed | 1 | 2 | 3 | 4 | 5 |
| I've been feeling interested in other people | 1 | 2 | 3 | 4 | 5 |
| I've had energy to spare | 1 | 2 | 3 | 4 | 5 |
| I've been dealing with problems well | 1 | 2 | 3 | 4 | 5 |
| I've been thinking clearly | 1 | 2 | 3 | 4 | 5 |
| I've been feeling good about myself | 1 | 2 | 3 | 4 | 5 |
| I've been feeling close to other people | 1 | 2 | 3 | 4 | 5 |
| I've been feeling confident | 1 | 2 | 3 | 4 | 5 |
| I've been able to make up my own mind about things | 1 | 2 | 3 | 4 | 5 |
| I've been feeling loved | 1 | 2 | 3 | 4 | 5 |
| I've been interested in new things | 1 | 2 | 3 | 4 | 5 |
| I've been feeling cheerful | 1 | 2 | 3 | 4 | 5 |

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)