How to support peer support: evaluating the first steps in a healthcare community

Key words:
Peer support; self-help; recovery; mental health; evaluation

Although limited, there is emerging evidence of the value of peer support for people with mental health issues. We report an evaluation of a training experience introducing intentional peer support (IPS) to people who use mental health services. IPS is a well developed, specific approach in which the central concept of mutuality redefines help as a co-learning and growing process. This paper aims to explore participants' initial understandings of peer support, assess the impact of the course in terms of subsequent peer support activities and gather reflections from participants concerning what helped and hindered putting IPS into practice.

Thirty people attending a five-day residential course run by the originator of IPS, Shery Mead, were invited to take part in two refresher/follow-up workshops. An independent evaluator (first author) collected data at the start and end of the residential phase, at two months and at five months. Findings are based on 26 people who provided data on at least two occasions.

The course was enthusiastically received and successfully conveyed the fundamentals of IPS. Proportions of people involved in general peer support at the start and end of the evaluation remained similar. At five months, 15 people reported involvement in IPS and one person had set up an IPS group. Being connected to an existing group or network, including maintaining connection with course participants was the most helpful feature in putting IPS into practice. Hindrances included isolation and lack of opportunity. The paper concludes that ongoing support is essential to encourage the post-course development and practice of IPS.

EVALUATION

Ann Ley
Research Psychologist
Devon Partnership NHS Trust

Glenn Roberts
Consultant Psychiatrist
Devon Partnership NHS Trust

Dawn Willis
Volunteer, Stewardship Group, Plymouth Local Involvement Network and Rethink Regional Reference Group

Correspondence to:
Ann Ley
Research Psychologist
Research and Development Department
Devon Partnership NHS Trust
Wonford House
Exeter EX2 5AF

There is a national move towards person-centred and user-led mental health services (Department of Health, 2005; 2006), where people are empowered to better care for themselves, including drawing on naturally occurring sources of community support. The development of recovery-based practice and recovery-oriented services include this emphasis and are seen as a practical response, fully consistent with recent policy drivers and with national and international support (Roberts & Hollins, 2007; Shepherd *et al*, 2008, Department of Health, 2009). National guidance is articulated in the joint position statement, *A Common Purpose: Recovery in future mental health services* (Care Services Improvement Partnership *et al*, 2007), which summaries current good practice and gives clear pointers for the future. This includes identifying the value of the support and example of peers as one of the key themes in recovery and emphasises the importance of peer support as an emerging and future practice (Slade, 2009a). A recently commissioned review of Devon mental health services and progress in Devon Partnership NHS Trust's developments recommended that peer support should be '*routinely offered to all service users and families when they first start using services*' (O'Hagan, 2009).

Peer support is a naturalistic phenomenon, but also refers to a variety of associated concepts and models in the context of mental health and social care services. Slade (2009b) summarises these as peer

10.5042/jpmh.2010.0160

support specialists (people with lived experience of mental health issues who are employed in mental health settings); peer-run programmes (mostly in the US) and mutual self-help groups, the focus of this paper. Emerging research, mostly from the US, provides promising indications for the benefits of peer support in this context. A recent review of 12 studies examined the effect of participation in peer groups supporting chronic mental illness, depression/anxiety and bereavement on measures of psychological and social functioning (Pistrang *et al*, 2008). Positive changes were found in seven studies, including two randomised trials, suggesting greater cost-effectiveness for the peer support groups compared to professional interventions. Benefits reported by others include improved illness management (Powell *et al*, 2001) and personal empowerment (Segal & Silverman, 2002).

Psychosocial process theories underlying peer support include social/emotional support, reciprocal learning, social learning and social comparison, and the helper-therapy principle (Corrigan *et al*, 2008). Corrigan and colleagues (2008) adopt Copeland and Mead's (2004) definition, which underpins intentional peer support (IPS), the model taught in Devon by Shery Mead and described and explored in this paper.

> *'Peer support is not like clinical support, and it is more than just being friends. In peer support we understand each other because we've "been there", shared similar experiences and can model for each other a willingness to learn and grow. We come together with the intention of changing unhelpful patterns, getting out of "stuck" places, and building relationships that are respectful, mutually responsible, and potentially mutually transforming. Instead of taking care of each other and thinking of each other as "sick", in peer support we build a sense of family and community that is mutually responsible and focused on recovery and social action.'* (Copeland & Mead, 2004)

IPS is distinguished from other descriptions of peer support by its four essential features, which are termed the four tasks: connection; worldview; mutuality; and moving towards. Briefly, connection is about recognising when we are genuinely connecting with another person during an interaction and, importantly, recognising when we are not. Worldview is about helping each other to understand where our attitudes have come from and how we've come to think about things in different ways. Mutuality is about redefining help as a co-learning and growing process. Moving towards is about helping each other move towards what we want instead of away from what we don't want. It is the specific combination of the four tasks that distinguishes IPS from other forms of peer support. In particular, the IPS definition of mutuality is distinctive from more general, lay understandings of this word and also the framework of intentionality. IPS is peer support with a purpose – that of supporting one another in moving towards the life that we wish to lead, based on an intentional style of relationship (Copeland & Mead, 2004).

In the UK, there are a small number of pioneering projects seeking to train and employ peer support workers in statutory settings such as the *Delivering for Mental Health Peer Support Worker Pilot Scheme* (Scottish Government Social Research, 2009), which involved five health boards across Scotland; *Sutton Co-operative for Recovery and Peer Support* (2009), carried out by Sutton Mental Health Foundation (2009); and an evaluation of a peer support specialist training programme, carried out by Sussex Partnership NHS Trust (Gerry *et al*, in press). Our work focuses on peer support within a UK community setting, an area in which there is little published evaluation or research. We describe an IPS course that was run in three stages in Devon in 2007 and attracted national interest (Jackson, 2008). The course was set up for the benefit of the participants and we saw an opportunity to gain additional value by simultaneously embedding a process of independent evaluation and support for the outcomes of the programme. In addition to seeking publication, we planned to disseminate our findings back to the course participants and also within our community of interest as a contribution to the development of recovery-oriented services and ongoing considerations about supporting peer support.

Methods

Course attendance and structure

Funding was provided by combined sources: Devon Partnership NHS Trust, Cornwall & Isles of Scilly Health Community, Somerset Partnership NHS and Somerset Care Trust, Care Services Improvement Partnership, Devon Primary Care Trust and South Devon Community Care Trust. People who used mental health services were invited to apply and places were offered to those who stated they would be willing not only to use IPS for themselves but also to cascade what they learned on the course by developing peer support in their own areas. This was the first IPS course in the UK and 30 people attended: 26 women and four men. Participants came from Devon (16), Somerset (9) and Cornwall (5).

The course was free of charge and consisted of a five-day residential phase, followed by two one-day refresher workshops at two and five months. The residential phase was run by the originator of IPS, Shery Mead and her associate, Chris Hansen. Their teaching was highly interactive but based on Mead's (2005) manual, which contains both the theory and principles of IPS and also exploratory training exercises that offer induction into a well developed and coherent model. Shortly after the end of the residential phase, we invited applications from any participants who were interested in becoming more involved in conducting the evaluation and refresher workshops. We recruited two people (CV & DW), both of whom helped design and facilitate the first follow-up workshop. DW also helped to design and run the second workshop and was involved in the qualitative analysis reported below. In addition to serving the evaluative process, both follow-ups were designed to reinforce the fundamentals of the course and to respond to the stated needs of the participants. The intention was to conduct the evaluation in a way that was consistent with the guiding values of a recovery supportive approach (Devon Partnership NHS Trust, 2009) and therefore empowering to the participants. We were assisted in this by Shery Mead and Chris Hansen who set the tone of the whole process and kindly participated in the five-month follow-up while revisiting the UK.

Evaluation

At the start of the residential phase, the course leaders introduced the evaluation, which was enthusiastically received by course members. The voluntary nature of participation was emphasised and re-emphasised throughout the week and people were given a research number rather than being asked to write their names on the questionnaires. The first author (AL), who was not connected with the course designers, attended and observed the course, both for data collection purposes, but also to learn the principles of IPS, which was important for subsequent qualitative analysis and interpretation. Evaluative data were collected at the start (day one) and end (day five) of the residential phase, at two months and at five months. The aim of the evaluation was to:

- explore participants' understandings of peer support, self-perceptions of what they had to offer and feelings about undertaking IPS
- assess the impact of the course in terms of subsequent peer support activities by five months
- gather reflections from participants concerning what helped and hindered them putting this learning experience to work in peer supportive relationships.

We adopted mixed methods, using a simple quantitative approach to measure various activities related to peer support. Qualitative methods have a tradition in formative evaluations, providing understanding of both processes and outcomes; they also enable the exploration of unanticipated issues as they arise (Ritchie & Lewis, 2003). Therefore, we used qualitative methods to explore participants' understandings, self-perceptions and feelings about the possibility of undertaking IPS and also to understand any difficulties that might emerge when it came to putting IPS into practice. Both types of data were gathered using self-completion questionnaires designed for the evaluation.

Procedure and measures

Quantitative

At the start of the course, we asked the question '*Are you currently involved in peer support? (If so, please briefly describe)*'. At two months we asked if people had attempted IPS; with how many people; whether or not they had reread the course manuals; and the extent to which they had passed on IPS information. We also asked people to identify the benefits of peer support and assessed the current level of interest in both peer support in general and IPS in particular.

For the five month refresher, we contacted all those who had attended the course and invited them to give suggestions for useful activities on the day. This was done by post and followed up by telephone or email. During these informal conversations, many people reported involvement in peer support that they did not think fell under the category of IPS. We thought it important to explore this, particularly as the ideas that underpin IPS (the four tasks) can be used to some extent in peer support of any sort. Therefore, at five months we attempted to clarify these activities by asking about involvement in both what we termed 'general' peer support and IPS. We also asked the extent to which people had been able to use the four tasks, whether or not they had reread the course materials and to how many people they had passed IPS information.

Qualitative

At the start and end of the residential phase and at two months, participants gave written answers to the following three questions.

1. What do you currently understand by peer support?
2. What do you believe you have to offer peer support?

3. How do you feel about being involved in peer support?

At two months, we also asked people to record what had helped and what had hindered the learning and development of peer support in practice. The answers to these questions were summarised during the lunch break by DW and CV, both of whom helped facilitate the day. Their summary was fed back to those attending and discussed. We also had a general discussion entitled '*Where do we go from here?*', which elicited suggestions from the group regarding activities to facilitate the development of peer support. These suggestions were summarised on a flip chart. All outputs of this nature were subsequently circulated to all of the original participants.

At five months, there were written descriptions of peer support activities undertaken since the course, ways in which people had been able to use the four tasks and the main hindrances to practising IPS.

Response

Four people gave data on only one occasion, therefore the evaluation is based on 22 women and four men (n=26) who completed the residential phase, gave written consent for their data to be used anonymously for evaluation and provided data on at least two occasions. The number of people providing information at two months was 19/26 (73%) and 23/26 (89%) at five months. Sixteen people provided data at every stage (62%).

Data analysis

Quantitative data were entered into SPSS to generate descriptive statistics, which are summarised below. Where continuous data are skewed, the median is reported along with the interquartile range (IQR).

For the qualitative data, one of the course participants (ZW) transcribed the anonymous written answers, which were entered into NVivo software. The data analysis was done by AL and DW. Using the constant comparison method (Glaser & Strauss, 1967), we independently created codes from within the data. These codes were compared, discussed, combined or discarded. Where there was disagreement over the codes or their content, discussion took place until agreement was reached. Using the same process, codes were then clustered into categories. We then went on to independently code one-third of the transcripts, chosen at random. The level of agreement was extremely high. Any small differences were of omission rather than disagreeing over the use of a particular code. AL then coded the remainder.

Results

At the start of the course, 16/26 respondents (62%) reported involvement in peer support. Involvement was described as mostly informal, taking place either among friends or in a group setting, including regular meetings in one another's homes. Group involvement also included attendance at regular meetings of larger groups. Where mentioned, activities included listening, hospital visits and sometimes extensive practical support.

Two months

Twelve out of 26 (46%) said that they had had a go at IPS with a median of four people (IQR=8). Nine people (35%) had reread the IPS manual that had been provided with the course. Fifteen people (58%) had passed on information about IPS to a total estimate of 93 others. Four people had not passed on information. On a scale of zero (I'm no longer interested) to four (I'm committed to participation), those providing data at two months were asked to say how interested they were in continuing IPS and also how interested they were in continuing peer support in general. The median response to both questions was 3 – very interested (IQR for IPS=1; IQR general peer support=2).

Five months

Twenty out of 26 (77%) reported having been involved in general peer support with a median of 10 people (IQR=12). Fifteen people had been involved in IPS (58%) with a median of three people (IQR=5). Most involvement in both general peer support or IPS was on a one-to-one basis, but there was also group involvement for both types. One person had set up a peer support group specifically along IPS lines, and others had introduced IPS ideas to pre-existing groups. Two people described their role as paid peer support workers. One of these had set up a members group, whereby members subsequently supported each other as peers, meeting regularly. She also had personal one-to-one contact with two other people.

On a scale of zero (not at all) to three (most of the time) the reported mean levels of use of the four tasks were high for both general peer support and IPS. General peer support (n=20): connection 2.60 (SD 0.68); worldview 2.30 (SD 0.92); mutuality 2.25 (SD 0.85); moving forward 2.55 (SD 0.51). For IPS (n=15), the mean levels were: connection 2.53

(SD 0.64); worldview 2.53 (SD 0.83); mutuality 2.40 (SD 0.91); moving forward 2.73 (SD 0.46). Some groups were described as using three of the four tasks, but without the notion of IPS mutuality. Nineteen people (73%) had passed information to an estimated 211 others. Three people had not passed on information. The larger audience can probably be explained by the number of talks given by course participants.

Qualitative findings

The main categories relating to questions one to three at day one, day five and two months are described below with a small number of typical quotes as illustrations.

Question one: what do you currently understand by peer support?

At the start of the residential course (day one), people's understanding of peer support was captured by two main categories: helping/rescuing and mutuality. Many people saw themselves in the role of 'rescuer', providing support and help, being there for someone in crisis and listening to them.

> *'Helping other people in whatever way possible to get through a bad patch and to be there for them afterwards.'*

> *'To find out what people need and meet this need.'*

> *'To encourage them to stay "well". To suggest positive things that may help them.'*

Another prominent theme described equality and mutuality from having a shared experience.

> *'A form of self-help involving listening to others who suffer from similar problems and they, in turn, listen to you.'*

> *'Networking, buddying and befriending people with same experience.'*

A few people either described or hinted at a mutuality based on working together, sharing strengths and providing a mutually beneficial relationship.

By day five, there were definite shifts in emphases, with the fundamental ideas of IPS being reflected in the text. People wrote about the four tasks, both in a general and specific way that indicated that they had absorbed these ideas. In contrast to the start of the course, there were very few direct references to 'help' and many references to a relationship. The most notable shift was in terms of mutuality, defined above as '*redefining help as a co-learning and growing process*'. There was evidence that peer support was now understood in terms of an alternative approach to working with people. Examples of the main categories are shown below.

Mutuality

> *'A mutual relationship with agreed boundaries where both/all parties can learn and grow.'*

> *'A two-way street. Not one person telling another what to do. If both are not gaining, it's not working.'*

The four tasks

> *'Being connected, looking from a worldview, seeing each other as being equal. Giving support to each other in a mutual way to move forward to hopefulness and growth.'*

> *'It is about a hopeful positive open situation of moving towards what each wants for themselves in their lives, not a retrospective or a fearful "getting by" or moving away from.'*

Alternative approach to working with people

> *'Prior notion of "stronger" supports "weaker" blown away on the wind – wow!'*

> *'It's a way of being that operates from hope, not fear.'*

For the most part, the latter emphases were still present after two months. However, there were a few responses that indicated a drift back towards 'rescuing', modified by some of the IPS ideas, eg.

> *'To learn to help other people to get through their setbacks in life. Also to know how to protect yourself in doing this.'*

One person did not change her view of what IPS was about, maintaining her self-perception as 'rescuer' from the start to the end of the evaluation.

Question two: what do you believe you have to offer peer support?

At the start of the course, three main categories emerged in answer to this question: personal

experience, personal qualities/positive attitudes and personal skills. These categories are illustrated as follows.

Personal experience

'As I have suffered from a mental illness for a long time, I can offer understanding and support to others in the same/similar situation.'

'Experience of the mental health system from both sides – worker and service user.'

Personal qualities and positive attitudes

'To share, to be positive and to be non-judgemental.'

'An open mind and heart.'

'A drive and determination to help others in their recovery.'

Personal skills

'Capacity to listen.'

'Help them to see many different ways of seeing their issues without advising them.'

The dominant category of personal experience emphasised at the start of the course was replaced by course knowledge and skills by day five. The emphasis on personal qualities and positive attitudes was sustained and also expanded to include references to the idea of peer support as a relationship. Personal skills included more mention of self-awareness, as illustrated below.

Course knowledge and skills

'An openness to reflecting own feelings in order to be equal and a willingness to share worldwide view.'

'Within my professional role as a support time and recovery worker and as a facilitator for a self-help group, I could transfer these skills to my toolbox. But I will also be using it in general day-to-day relationships as these are great principles to live by.'

Personal qualities and positive attitudes

'Willingness to look at a different way of being within relationships.'

'I feel able to enter a relationship without having preconceived judgements about what to expect and indeed what the other person is like and wants. I love diversity. I am curious and enjoy relationships in which I feel comfortable enough to be uncomfortable.'

Personal skills including self-awareness

'An ability to listen and appreciate other worldviews, and being aware of difficulties I may have with accepting some differences.'

'After this training I feel that I am more scared about peer support and how much is expected of me. I realise that this can be solved by learning to negotiate boundaries and not letting people overstep them.'

After two months, the dominant category was personal qualities and positive attitudes. The next category was course knowledge and skills but these were emphasised less than they had been at the end of the residential phase.

Question three: how do you feel about being involved in peer support?

Answers to this question at both the start and end of the residential course were overwhelmingly positive, encompassing excitement at the prospect of learning new skills which, along with the lived experience of mental illness, they would be able to use to help others.

Day one: positive feelings

'Very excited. A shortcut to recovery and greater hope. Also a personal reward from being of help to others who may possibly avoid the trap of having to work it out the hard way as some of us did.'

'Positive. Very empowering. We, the service users, live our "illness". We go to places many professionals have little or no experience of in reality or the psychological/spiritual impact and its aftermath.'

Day five: positive feelings

'I have enjoyed the training and have realised how interesting this work is. It is a safe way of being supportive in a relationship and I feel comfortable with the ethos of two people being equal and honest with each other.'

'Moving towards … hopeful. Organic self says "yes". Feels "right".'

A small proportion of people had a mixed response to the question, primarily describing concerns about their own ability in terms of either competence or practical restrictions such as physical problems. By day five this proportion had increased slightly.

Day one: mixed feelings

'Concerned about upsetting others and not understanding their needs, but hoping to learn more.'

'It is good to be useful but I have a tendency to overdo things and to absorb problems and not stand back enough. Plus, I have just given up work through anxiety problems of my own.'

Day five: mixed feelings

'Confident. The need to balance my needs against those of others. Need to spend a little more time "getting it".'

'It is something I have always wanted to do. I just hope I can do it properly.'

'Very uncertain. On the one hand I feel that I know a lot more about the subject but I also feel as if I can't do it. I want to do it but worry I will either give too much or take too much.'

Most responses given at the first refresher workshop remained positive after two months – again with a small number of mixed feelings, for example:

'Very excited. At last something that I can see that will and does work. I wish to be further involved in delivering, setting up and receiving IPS along with three others from the course. We are working together to deliver training. However, it is quite daunting to try to find a way to earmark funding to pay us to deliver this and it would be helpful if someone from the trust could help with this.'

'Very uncertain but keen to take it forward. In practical terms, I am not sure where to start. Though I am not currently involved in peer support per se, I do have a number of peer-type relationships that could be developed. I need to keep going and believe in myself.'

The benefits of peer support

At two months, participants identified the following benefits.

- Counteracts 'trappedness' and avoids boxes, eg. diagnostic labels.
- Peer support is personal rather than medical.
- You can take it as far as you wish.
- Different ways of telling the story (as opposed to automatically telling it in medical terms).
- Moving towards what you want instead of moving away from something that you do not want.
- Envisaging wellness rather than illness.
- Moving away from being a rescuer or victim and relying on the past as an excuse.
- Not being responsible for the other person is very liberating.
- Not being afraid of what other people say and learning more about being open and honest.
- Changes how we relate to each other.
- Being yourself. Creates a space to be with yourself and with another person now – in the present.
- Based on giving as much as receiving.
- Helps us to move forward in society – peer support is a way of getting away from being stigmatised and judged by other people, especially in a small community.
- IPS gives coping and communication tools.

The above list provides an interesting expansion of the original perceptions of participants when they started the course.

What helped and what hindered putting IPS into practice

At two months, the most helpful feature reported was being part of an existing group or network. Such membership provided opportunities both to share knowledge about IPS and to use it. Remaining connected to people on the course and coming to the workshop were also seen as helpful. The residential course had given people the confidence to talk about and present information on IPS to other people, either in an individual or group setting. Also related to confidence was a realisation that they were already practising some of the skills without having named them with IPS terminology. Rereading the manual, thinking about the course and trying out new skills were also cited as helpful. Listening better, tolerating silence and remaining connected, not having preconceived ideas about people, and the realisation that being open and honest has an impact were specifically mentioned. Another important category related to changed

perceptions, such as realising that they were responsible for themselves, but not for other people. This was experienced as the lifting of a considerable worry or burden in some peer relationships. Several people wrote of the utility and benefit of IPS in everyday relationships.

Hindrances identified at both two and five months were isolation, lack of opportunity, including not finding someone to engage with mutually and not having any existing group in which to introduce or use IPS.

> '[There is] *no one in my area to help me try to set up an IPS group. I haven't got enough training experience to teach others even if I did find a few people to set up a group. Not having any contact with anyone from the group as I don't feel that I am local enough and I don't have internet access to keep in touch with anyone.*'

For some, this lack of support was linked specifically to a lack of funding for training, development and supervision. There were also comments regarding lack of confidence, lack of time, how their own health and stressful life events hindered their progress, and there was a belief that professionals are not receptive to the idea of peer support. For some, their eagerness to introduce IPS was met by a lack of enthusiasm in peers who had not been on the course.

The same hindrances were identified at five months, with a few interesting additions from a small minority who hinted at some confusion, difficulties and dislike of both a formal model of peer support and some of the terminology. The confusion centred around the difficulties of distinguishing IPS from friendship, the idea that it was necessary to be involved in a group in order to use it and the idea that people needed to be 'well' before embarking on IPS. Dislike of the formal model was indicated by comments concerning using the four tasks in a natural or organic way and not wanting to use the terminology. There were also a few comments about the difficulty of mutuality when one person was in a paid role and other comments indicated that mutuality was missing from the relationship described.

Suggestions to help facilitate the development of peer support included: looking for further funding; undertaking peer support with peers and within existing groups; creating a social firm; running workshops; raising awareness via a newsletter; simplifying and customising the course to a UK audience; keeping in touch and sharing ongoing understanding and identifying peer support 'champions' or other supportive people.

Study limitations

These include the short-term nature of the evaluation, small sample size and lack of scope to examine the important question of the extent to which peer support is helpful to those who undertake it. However, this was a study of a naturalistic learning experience, there are very few studies of peer support to date in the UK and our work may contribute to an understanding that could lead to more systematic and larger, mixed method research studies.

Discussion and conclusion

National and international guidance clearly identifies peer support as a highly desirable process and practice to cultivate in the context of the wider emphasis on recovery-oriented services. Peer support appears to be both an expression and a carrier of the ambitions for cultural change in mental health and social care services that are implied in becoming 'recovery oriented' and holds hope of being associated with a wide range of desirable mental health and well-being gains (Corrigan & Ralph, 2008; Slade, 2009a).

Our experience of engaging in the first steps of seeking to facilitate peer support initiatives through the teaching of a specific model by its originators found that it was associated with high levels of interest and commitment from course participants. The qualitative data indicate that the course was successful in terms of conveying the basics of IPS and also in inspiring participants. The benefits identified at two months reflect both the detailed emphases of the course and also the wider advantages that peer support can offer, including empowerment, the valuing of personal experience through story-telling, enhancing wellness and developing new types of relationships (Randall & Salem, 2005). The numbers of people who attempted to put IPS principles into practice are encouraging. The difference in the median number of people with whom participants reported general peer support and IPS at five months indicates that they perceived a difference between the two types. There was an interesting shift away from a rescuing stance, but the tendency to return indicates that the IPS definition of mutuality is a difficult concept for people to sustain. From a learning perspective, this difficulty is likely to be exacerbated by the lack or perceived lack of opportunity to practice. It is only through putting IPS into practice that the important task of mutuality will come to be understood and the capability of new relationships achieved. This is not to diminish the mental health benefits and

satisfactions that can be gained from helping others – the helper-therapy principle (Magura *et al*, 2003; Roberts *et al*, 1999) – but this type of help differs from the intention of IPS.

In terms of lessons learned, there is clearly a need for regular, easily accessible ongoing support after the course. An alternative would be to spread the course out over a longer period of time and to build in more opportunities for practice and support along the way. It is also possible that the course could have been better targeted – a basic requirement could have been for all participants to already be engaged in peer support in a group setting. At the start of the course, 62% reported existing involvement in peer support. The main hindrances to putting IPS into practice included not having an existing group in which to introduce or use IPS. Despite applicants expressing confidence that they would be able to subsequently use the skills gained on the course, it would seem that without identified work roles or organisational support for the development of peer support groups, it is very difficult to use or sustain it in isolation. Even if people are part of a group, being the only person who went on the course and having to explain IPS to other group members and engender some enthusiasm is a challenging process in the absence of ongoing training and supervision, at least in the short term. Some form of collateral support is required that can meaningfully encourage the development of peer support without compromising its essential independence and user-led or person-centred values. This is an inherently difficult balance to achieve. Our experience was that those who embarked on this learning experience appreciated it greatly, but their engagement or ongoing commitment to IPS diminished over time. However, those involved in setting up the learning opportunity were deeply reluctant to sustain peer support by having it professionally led.

The emerging practice in some areas of employing people with experience of services as peer support workers or facilitators may be a practical compromise between the idealism of IPS as a self-sustaining cultural change, and the need at the present time for ongoing support for peer support from people employed to provide it. In the light of the experience described in this paper, Recovery Devon, the leading collaborative forum for recovery developments in Devon, identified the setting up of paid peer support as a priority (O'Hagan & Slade, 2009). Much has already been gained from the recently published evaluation of the Scottish experience of employing peer support workers (Scottish Government Social Research, 2009) and we look forward to hearing the outcomes of other UK and international projects that are at various stages of development.

Peer support is a promising and emerging area. However, to be able to recommend a simple, clear and useful approach, it is in need of greater attention, further exploration, and experiences need to be shared with other peer support groups. There is a need to consider the competing merits of specific model such as IPS or a more general approach, but any option will need to be culturally appropriate, securely commissioned and supported. Support should include both supervision by those who really understand peer support and evaluation so as to embed it within an ongoing process of learning and development and fulfil its potential as one of the major strands of future recovery-oriented services. Within IPS, the further exploration of 'mutuality' is of particular importance to the future success of this model; there are unresolved conflicts between deployment of IPS in its pure form and its application in developing paid peer support workers or incorporation into peer provided services in statutory settings. Future research could usefully explore the meanings of mutuality.

Acknowledgements

Many thanks to all the course participants who allowed their data to be used for evaluation. Special thanks to Zena Winter who cheerfully, voluntarily and accurately typed up all the written responses needed and also to CV for her help in running the follow-up workshops. Finally, we thank Shery Mead and Chris Hansen, not only for providing an inspirational residential course, but for volunteering their time for the final refresher workshop.

References

Care Services Improvement Partnership, Royal College of Psychiatrists & Social Care Institute for Excellence (2007) *A Common Purpose: Recovery in future mental health services*. London: Social Care Institute for Excellence.

Copeland ME & Mead S (2004) *Wellness Recovery Action Plan and Peer Support*. Brattleboro, VT: Peach Press.

Corrigan PW, Mueser KT, Bond GR, Drake RE & Solomon P (2008) *Principles and Practice of Psychiatric Rehabilitation: An empirical approach* (pp359–378). New York: The Guilford Press.

Corrigan PW & Ralph RO (2008) Introduction: recovery as consumer vision and research paradigm. In: RO Ralph & PW Corrigan (Eds) *Recovery in Mental Illness: Broadening our understanding of wellness*. Washington, DC: American Psychological Association.

Department of Health (2005) *Creating a Patient-led NHS: Delivering the NHS Improvement Plan*. London: Department of Health.

Department of Health (2006) *Our Health, Our Care, Our Say: A new direction for community services*. London: Department of Health.

Department of Health (2009) *New Horizons: A shared vision for mental health*. London: Department of Health.

Devon Partnership NHS Trust (2009) *Putting Recovery at the Heart of All we do. What does this mean in practice?* Devon: Devon Partnership NHS Trust.

Gerry L, Berry C & Hayward M (In press) 'I have got more of a hope for services as a whole now than I had before': an evaluation of peer support specialist training programme. *Mental Health Practice*.

Glaser BG & Strauss AL (1967) *The Discovery of Grounded Theory*. Chicago: Aldine.

Jackson C (2008) Peer to peer. *Mental Health Today* February 10–12.

Magura S, Laudet AB, Mahmood D, Rosenblum A, Vogel HS & Knight EL (2003) Role of self-help processes in achieving abstinence among dually diagnosed persons. *Addictive Behaviors* **28** (3) 399–413.

Mead S (2005) *Intentional Peer Support: An alternative approach*. Plainfield, NH: Shery Mead Consulting.

O'Hagan M (2009) *Recovery in Progress: Future recovery-based services, descriptions, examples and evidence*. Unpublished. Available from glenn.roberts@nhs.net.

O'Hagan M & Slade M (2009) Support from peers and staff support in assisting recovery. *Recovery Devon Newsletter*. (Spring) 10–11. Available from: www.recoverydevon.co.uk (accessed February 2010).

Pistrang N, Barker C & Humphreys K (2008) Mutual help groups for mental health problems: a review of effectiveness studies. *American Journal of Community Psychology* **42** (1–2) 110–121.

Powell TJ, Yeaton W, Hill EM & Silk KR (2001) Predictors of psychosocial outcomes for patients with mood disorders: the effects of self-help group participation. *Psychiatric Rehabilitation Journal* **25** (1) 3–11.

Randall KW & Salem DA (2005) Mutual help groups and recovery: the influence of settings on participants' experience of recovery. In: RO Ralph & PW Corrigan (Eds) *Recovery in Mental Illness: Broadening our understanding of wellness* (pp173–205). Washington, DC: American Psychological Association.

Ritchie J & Lewis J (2003) *Qualitative Research Practice: A guide for social science students and researchers*. London: Sage.

Roberts G & Hollins S (2007) Recovery: our common purpose? *Advances in Psychiatric Treatment* **13** (6) 397–399.

Roberts LJ, Salem D, Rappaport J, Toro PA, Luke DA & Seidman E (1999) Giving and receiving help: interpersonal transactions in mutual-help meetings and psychosocial adjustment of members. *American Journal of Community Psychology* **27** (6) 841–868.

Scottish Government Social Research (2009) Evaluation of the Delivering for Mental Health Peer Support Worker Pilot Scheme. Available from: http://www.scottishrecovery.net/Peer-Support/supporting-resources.html (Accessed February 2010).

Segal SP & Silverman C (2002) Determinants of client outcomes in self-help agencies. *Psychiatric Services* **53** (3) 304–309.

Shepherd G, Boardman J & Slade M (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

Slade M (2009a) *100 Ways to Support Recovery: A guide for mental health professionals*. London: Rethink.

Slade M (2009b) Peer relationships. In: *Personal Recovery and Mental Illness: A guide for mental health professionals* (pp103–113). Cambridge: Cambridge University Press.

Sutton Mental Health Foundation (2009) *Sutton Co-operative for Recovery and Peer Support*. Sutton: Sutton Mental Health Foundation.