An interpretative qualitative study into the experiences mental health peer mentor of an inner city mentoring and advocacy service

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Research Aticle

An Interpretative Qualitative Study into the Experience's Mental Health Peer Mentor of an Inner-City Mentoring and Advocacy Service

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Abstract

Research aims: The aim of the study was to investigate participants' experiences of an inner-city peer mentoring service, Mentorship, Advocacy, Support, Hub (M.A.S.H), with a particular focus as to why the mentors decided to become involved.

Findings: Two main findings reported in this paper are that the mentors valued the experience of being involved with M.A.S.H and consequently expressed great disappointment when the organisation was not refunded. Additionally, mentors placed great emphasis on the specific reasons why they themselves chose to become involved with M.A.S.H.

Conclusions: That the informal social aspects of M.A.S.H were highly valued by the mentors and that they choose to become mentors for reasons that stretch beyond mental health. This should be borne in mind when considering future mental health peer mentoring services.

Key points

1. Due to the unique model of mental health peer mentoring that M.A.S.H provided and the examination of the mentor's experiences this paper contributes to the literature on mental health peer mentoring, informing the development of peer mentoring services in the UK and abroad.
2. Peer support and mentoring that M.A.S.H successfully offered was on a de-facto group basis. If mentoring is understood as a formalised process of support for people with mental health problems then group mentoring by robustly trained mentors is a viable model for future practice.
3. Mentors chose to take on the role for a variety of idiosyncratic reasons and future mental health peer mentoring services should bear in mind that people take on the role do so for reasons that stretch beyond mental health.

Introduction & Background

This study investigated the experiences of mentors involved with Mentorship, Advocacy, Support, Hub (M.A.S.H.), a mental health peer mentoring project in inner city Birmingham, funded by the West Midlands police. M.A.S.H involved training, ongoing support and advocacy to enable members to support each other's mental wellbeing and prior to commencement, all the mentors were trained by M.A.S.H steering committee. The plan was for there to be two strands; Saturday social groups, with food, music, outside speakers and mostly importantly, the company of others. These sessions happened regularly and proved popular with mentors and mentees. They were held in an NHS primary care facility, in an area of high social and economic deprivation. The second strand of work which was proposed, but never realised, was that robustly trained volunteer mental health peer mentors worked individually people who were experiencing mental health crisis. The individual peer mentoring never occurred because of delays in getting appropriate security checks completed and a lack of uptake from potential mentees. In February 2017 M.A.S.H ceased to exist in this form due to financial pressures.

From Pinel's work within the moral treatment movement in 18th century France onwards, there have been different forms of peer mentoring services (Davidson et al., 2012) and consistently literature has highlighted its benefits in mental health. Globally, many patients have taken up new opportunities to work within Mental Health Services (MHS) in recent years and in various roles. Peer mentoring and support has mainstreamed within MHS, where peers are contracted or employed, often providing one-to-one support for people (O'Hagan, 2011). Such services increased in popularity with a total of 896 service user groups across England being identified at the turn of the century, 79% of those engaged in self-help and mutual support (Wallcraft et al., 2003).

Many diverse terms are used in the literature; for example, peer support, peer mentoring and advocacy, all roles being similar but comparable. Bradshaw (2006) noted two categories of peer support/mentorship; informal, similar to drop in centres or voluntary services where individuals discuss their own mental health experiences and formal; where an individual is paid to mentor an individual whether they have experienced mental illness or not. Mentoring is defined by Jolliffe and Farrington (2007) and Finnegan et al, (2010) as the development of a relationship between two individuals in which the mentee learns from the mentor, model's positive behaviour and gains experience, knowledge or skills. Furthermore, for Finnegan et al, (2010) peer mentoring implies that the mentors and mentees have a similar background or experiences. Mentoring is different from support in the formality of the work; Peer support is the support provided and received by those who share similar attributes or types of experience. A concept analysis by Dennis (2003) defined peer support as an informal process between individuals in which peer supporters seek to promote health and build people's resilience. Given the ambiguity of their role within M.A.S.H it is of note that the participants in this study referred to themselves as mentors.

U.K government reports highlight the positive influence that peer support has on mental health outcomes. In 2009, an evaluation of peer

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Received: Oct 31, 2018; **Accepted:** Nov 09, 2018; **Published:** Nov 12, 2018

support in Scottish MHS demonstrated a positive impact for service users (Scottish Government Social Research, 2009). Furthermore the 2011 policy document 'No Health Without Mental Health' (DoH, 2011) recognised the benefit of paid employment in MHS for those who had experienced mental health problems. The Independent Mental Health Taskforce advocate for the expansion of peer support within MHS (IMHTF, 2016), however there is concern that the traditional controlling values of statutory MHS continue to operate and that these values may compromise the 'role integrity' of peer support (O'Hagan, 2011).

Forchuk et al., (2007) and Lawn et al., (2008) demonstrate that peer support workers positively influence admission rates. Further, Clarke et al., (2000) and Davidson et al., (2004) both highlight that outcomes from peer support programs are on a par with, or better than, non-peer staff interventions. Studies have found that peer support programs can improve the physical health of people with mental health problems (Bates et al., 2008; Cook et al., 2009) and improve self-management skills (Crepaz-Keay & Cyhlarova, 2012). Davidson et al., (2012) concluded that developing peer support networks is crucial in efforts to end discrimination and deprivation experienced by people with severe mental illnesses. However, there is limited literature, neither on the experience of mental health peer mentoring nor on why people choose to become mentors.

The study's aim was to investigate the participants' experiences of M.A.S.H.

The subsequent objectives were:

- Why did mentors choose to become involved with M.A.S.H?
- Has involved with M.A.S.H changed the way participants understand mental health and recovery?
- What, if anything, does M.A.S.H provide which statutory mental health services do not?
- Has involved with M.A.S.H changed the participant's relationship with statutory mental health services?

Method

The study was conducted with consent of the M.A.S.H management committee, to whom the primary investigator fed back to on the study's progress regularly. As the primary investigator is an employee of the University of Birmingham the study was approved by the University's ethics committee (ERN_16-0900).

Mentors were interviewed about their experiences of involvement with M.A.S.H. The research interviews were analysed using Interpretative Phenomenological Analysis (IPA), investigating both individual experiences and also looking at themes that run across mentors' experiences.

Participants chose where they were to be interviewed, chose their own research names and it was at the participants' discretion whether to declare their age. Each participant was given a participant information sheet, read and signed a consent form prior to commencing the study. Both documents explained that participants could withdraw from the study without providing an explanation. There was a semi-structured interview developed around the study's aims and objectives. The research interviews were recorded; transcribed and analysed using IPA methodology in an attempt to understand participants' lived experience (Smith et al., 2009) of being involved with M.A.S.H. Audio recordings were listened through several times to stimulate emergent themes and the texts closely examined for greater depth of meaning and interpretation, identifying and labelling emerging themes and meanings. The text was then coded and the codes clustered. Interpretative themes were generated from the clusters and subsequently these themes were dialectically related to excerpts of the text in a cyclical process. The data analysis process was as reflective as possible and included interpretation from the researchers upon the emergent themes. The resulting material was sufficiently anonymised to ensure that it was difficult to deduce who the participants were.

Guba and Lincoln (1994) suggest four criteria to indicate the trustworthiness of a qualitative study: 'Internal Validity' (Does the study make sense?; does the research data support the reported findings?); 'External Validity' (Does the study correspond to the reader's preconceptions of the world?); 'Reliability' (Did the study have a robust methodology?); and 'Objectivity' (Was the researcher distanced and neutral enough?). The study met all of these criteria.

As the primary investigator's findings were qualitative and interpretative, a system of findings checking was required. Three people, a mixture of academics and stakeholders in M.A.S.H, checked the interpretative findings against original transcripts.

Findings

In the term 'mental health peer mentoring service' there could be a presumption that the mentors had a history of mental illness, however this was not necessarily the case.

The findings examine the mentors' individual experiences before looking in greater depth at themes that run across the participants; in particular the mentor's experiences and reasons for becoming involved.

Elizabeth

Elizabeth had worked as a mental health nurse but, in her opinion, had lost her job after being discriminated against because of her mental illness. Borne from her person experiences Elizabeth became involved with M.A.S.H because she was motivated to help people and wished to address the stigma associated with mental illness. Elizabeth embraced the informal atmosphere; believing it to be aspirational and encouraging people to think about the future which Elizabeth believed statutory MHS did not. A recurring theme from Elizabeth was her dislike that statutory MHS were always letting people down.

Sarah

In addition to being a mental health trust employee and a service user herself, Sarah had been involved with three mental health charities prior to becoming involved in M.A.S.H. Aware of the impact of government cuts on MHS, she saw M.A.S.H offering support that was not being provided by traditional MHS. Additionally, she believed that people with mental health problems are often more inclined to talk to those with lived experience, opposed to mental health professionals. In Sarah's opinion talking to mental health professionals was often stigmatising, without addressing why she believed this other than that M.A.S.H was not stigmatising. Sarah felt that, people were often reluctant to talk to their families as families don't understand, "*if they haven't been through it themselves*." Sarah felt strongly that there was a

Table 1: Details of mentor participants

Name	Age	History of mental illness?	Occupation
Elizabeth	Mid 50s	Yes	Retired mental health nurse
Sarah	33	Yes	Peer support worker for local NHS trust
Pat	59	No	Retired district nurse
Alpha	40s	No	Advocate in the police service
Fiona	Late 50s	Yes	Retired job centre employee

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need for people with mental health problems to feel supported and that due to austerity cut-backs, stigma and lack of understanding MHS were not currently doing this.

Pat

Pat had worked as a health visitor but despite being described as a peer mentor Pat had limited personal lived experience of mental illness other than living with a partner who was mentally ill and taken his own life.

Pat was very civically involved in a number of other capacities and her involvement with M.A.S.H needs to be understood within that context. Pat questioned whether people didn't engage with M.A.S.H (and other civic projects) but concluded that it was easier to let other people act on your behalf and described M.A.S.H as, "*a very worthwhile project*."

Pat's involvement with M.A.S.H changed her attitude towards mental illness, and she had become more appreciative that mental illness could happen to anyone. Whilst she believed that stigma against mental illness was changing in the UK thanks to celebrities speaking out, there was still more that could be done and was happy talking about mental health in an effort to address stigma.

Alpha

The detail and thought that Alpha put into the answer about why he became involved with M.A.S.H was striking; becoming involved in the M.A.S.H project was due to his faith and within that the desire to empower people, *"I've always worked with people who need to be empowered.", "From my faith*." Alpha spoke about racism in terms of 'exposure' and saw parallels with the stigma associated with mental health. Noting that people who stigmatise those with mental health problems had rarely been exposed to mental health issues linking a point he made that he was the only black man working in his police station. Alpha described his colleagues not being used to meeting and talking to black people who have not been involved in crime and therefore were suspicious of him.

Fiona

Fiona saw a disconnection between 'black' men, MHS and society since the days of slavery. Fiona became involved in M.A.S.H, following a strong desire to help people. However, both as a Mother and as a former job centre employee she could see how black men were alienated from mainstream society and consistently negatively stereotyped. Fiona believed this spilt into MHS where black men do not feel understood by services who, in turn, perceived them as mad and violent. Fiona also acknowledged that trust had broken down between young black men and MHS. Therefore, Fiona believed there was a need to develop links which help services engage with black men (and vice versa).

"*Because MASH is, if it correctly developed it can be quite a big and useful tool.… If you've got young people that have a history of being stigmatised… by the system. If you've got people coming into job centres that are being labelled as being potentially violent, being up on off the street and locked up and killed and everything else because of their mental health. Then you need something that's going to actually bridge that gap*."

However, Fiona saw the problems of black men in society as running much deeper than this,

"*I've had a number of relatives that were enslaved. And that has come down throughout history to us. And it actually impacts on the mental health of our, of us and our children with us. And it's as though the effects of that impacted with the way that were treated in society now and the young guys that are out there, not achieving, having to live with this*."

This quote serves as Fiona's explanation of why black men disengage from society and MHS, also highlighting her desire to try and address the issue.

What are the participants' experiences of M.A.S.H?

All the participants saw M.A.S.H as being beneficial and took pride in the work they were doing. Fiona said that,

"it's showed me some, some more possibilities. I've worked in Job Centre for 20 years and I've never ever felt as supported as I do in this group." "And appreciated, my skills are appreciated and used".

The Saturday Social group that M.A.S.H provided was hugely appreciated; all participants believed that the service users who attended the sessions felt supported and enjoyed its social aspects. Significantly, the positive milieu was commonly mentioned with reference made to the food, music and positive atmosphere as well as being non-judgemental. The mentors did not feel the stigmatising effects of mental illness when they were at M.A.S.H and felt people weren't judged. Both Alpha and Pat highlighted that if there had been a mental health professional in the room it would have altered the whole group dynamic.

Each participant projected a positive experience of M.A.S.H although expressed frustration over the limited contact with those put forward for mentoring. All mentors acknowledged that traditional one-to-one mentoring had not happened. A common theme of the mentor participants was that the workload was "slow", there being 31 potential mentees who had chosen not to individually work with a mentor, the reasons for which are not firmly established.

Why did the mentors choose to become involved with M.A.S.H?

Participants placed the greatest emphasis and importance on why they chose to become involved in MASH, with the five mentors giving interesting and divergent reasons for their participation. In IPA terms, this is the 'gem' of the research (Smith et al., 2009). Smith's (2011) IPA research encourages detailed examination of particular parts of research transcripts, where the researcher believes that the extracts are particularly poignant. All mentors based their involvement with M.A.S.H on personal experiences, though not particularly mental health experiences. All participants talked of their role with additional facets, one spoke of spiritual support and recognition, another spoke of being a "*civic duty*" to help others whilst two spoke of racism within the social fabric of British society including MHS and participants spoke of the on-going need to address the on-going stigma that is associated with mental illness and the need to provide "*desperately needed services*". What is of note is the divergence and that mental health is not the primary concern.

Elizabeth had two reasons for being involved with M.A.S.H; she hoped that by sharing her own lived experience of mental illness could help others who were struggling. Elizabeth believed that she had been the victim of discrimination because of her mental health, saw M.A.S.H as an organization able to address the stigma associated with mental illness. Similarly, Sarah saw M.A.S.H addressing stigma as everyone involved understood mental illness, which she said wasn't true of statutory MHS. Sarah had been involved with M.A.S.H and an organization that pre-dated M.A.S.H, because she believed that there is a reluctance to talk about mental illness within the British African Caribbean community. However, austerity cuts in statutory MHS meant people were no longer adequately supported to do this whereas M.A.S.H addressed this.

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Pat's primary motivation for involvement was her perceived civic responsibility to engage with her local community and as such her involvement with M.A.S.H needs to be understood in a wider context. In some respects, Alpha was similar to Pat; he had been involved with organizations aiming to help people from socially disadvantaged backgrounds; helping people in police custody, prisoners, youth work. Alpha's work had a spiritual dimension; he felt a spiritual compulsion to help people who were disadvantaged, "*My main reasons really are my passion for people who are disadvantaged*." In this context that he was drawn to M.A.S.H, considering it tackling the stigma associated with mental illness. Fiona had a strong desire to help people; to address the disconnection between 'black' men and MHS and society, her involvement with M.A.S.H providing a link that helped services engage with black men and vice versa.

One key theme was that though participants felt M.A.S.H addressed the stigma of mental illness and was non-judgmental, none adequately explained why or how. Perhaps the best explanation is that the Saturday social events were not attended by any professionals, whom according to Alpha would immediately add a layer of judgement because they have to do risk assessments whenever they have contact with service users. Sarah believed that people with mental health problems are often more inclined to talk to other people with mental health problems as opposed to mental health professionals.

As regards the objectives '*Has involvement with M.A.S.H changed the way the participants understand mental health and recovery?', and 'Has involvement with M.A.S.H changed the participant's relationship with statutory mental health services?'* all of the participants were asked questions around these objectives. However, their responses were not illuminating as all the participants believed that their involvement with M.A.S.H. had neither changed their understanding of recovery nor their relationship with statutory MHS.

Discussion

The mentors found their involvement with M.A.S.H to be positive; enjoying the ambience and social aspects which were felt to be non-stigmatising and non-judgemental. They recognised that traditional one-to-one peer mentoring was not happening; however, this did not stop them providing support and mentorship on a group, as opposed to individual, level.

That mentors believing their involvement with M.A.S.H had neither changed their understanding of mental health and recovery nor their relationship with statutory MHS is an interesting point. The mentors set out to be peer mentors and a primary objective of this would be to learn from each other (Salkeld et al., 2013), suggesting that participants potentially had fixed views on the nature of mental illness and that they learned nothing from their experience and interaction with people with lived experience of mental illness. Whilst presumably this is not the case however, it is an interesting finding; potentially suggesting that they have set, and implicitly stigmatising views about mental illness.

It is unclear why no potential mentees took up the opportunity for individual mentoring. Leaving aside the issue of delays due to employment checks, mentors were clear that they believed M.A.S.H services to be non-stigmatising whereas statutory services were. This would suggest that M.A.S.H would be more attractive and people would engage with it, but the reality is that mentees did not. Did this indicate that the mentees did not trust the mentors? Or that the mentees were happy with the social aspects of M.A.S.H but did not want to discuss their health issues wanting social engagement but preferring to seal over deeper issues they live with? Was such an attitude born of years of distrust of services (see Keating et al., 2002 & SCMH, 1998)? To address these issues a further study would be required with both mentors and mentees to investigate, in the context of enjoying the social aspects of M.A.S.H, why the individual mentoring services were not utilised.

Although the role of a mentor is difficult to define (Mind, 2013) the five participants forged their own role as mentors, viewing their participation and value in various manners. Interestingly those who had experienced mental health issues themselves did not highlight that becoming a mentor may be viewed as a measure of their personal recovery. Furthermore, this finding suggests that if mentors had more training from experts on peer support and mentoring they may value the process more themselves. Additionally, and crucially, with further training it may enable individual peer support for people they are targeting.

Equally M.A.S.H's inclination to engage with individuals with and without a history of mental health would corroborate Reberio Gruhl et al., (2016) who suggested that, "employers did not draw on the lived experiences" of support workers. The practice of engaging with individuals who have personal experiences of mental ill health, as well as engaging with those without, would indicate the experiences are considered indistinguishable.

Of particular interpretative interest was why mentors chose to take on the role. There is paucity of literature about why individuals choose to become mental health peer mentors; Devon (2016) wrote that she became a peer mentor so that she could help others on the road to recovery from their mental health problems. Indeed, there is a paucity of reflective literature about why people become mentors across the spectrum. As noted by the World Health Organization (WHO) (2012) mental illness is the result of complex social, psychological, cultural and political causes. So therefore, it is fitting that the participants volunteered to be mentors did so for reasons that stretched beyond mental health alone.

MHS have closed down day services because of decisions about how funding for MHS should be spent. However, there is a subsequent gap in provision which M.A.S.H. tried to fill, but it folded due to lack of financial support indicating a need for inclusive, non-judgemental, peer led mental health day services. Mentors were angry with MHS for providing poor services and potentially nurses should be angry too. The level of provision is demonstrably not good enough and there should be a concerted effort from service users, the community and mental health nurses to petition commissioners to reconsider current service provision. Low participation and financial restraints contribute to the limitations of this study.

Conclusion

Due to the funding being withdrawn from M.A.S.H. there was no way of measuring the long-term impact of the program or whether the participant's experiences would have developed over time. M.A.S.H. was set up to offer one-to-one peer mentoring; however, this never came to pass, though they did successfully offer group-based support. If mentoring is understood as a formalised process of support for people with mental health problems then group mentoring by robustly trained mentors is a viable model for future practice. Participants became mentors for a variety of political and social reasons, as opposed to solely mental health ones, enjoying the experience of being involved with M.A.S.H. They viewed it as a non-judgemental, non-stigmatising organization fulfilling much needed social functions, thus addressing some of their motivations to become involved. Before M.A.S.H's untimely demise the mental health peer mentoring offered by M.A.S.H. highlights that there is a need for a multitude of services that people want to use and will help disengaged and disfranchised people engage with MHS in a style which suits them.

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