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Evaluation of The PeerTalk Charitable Foundation

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2021

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Executive Summary

This report represents an amalgam of work undertaken by two Sheffield Hallam University mental health nursing master's students. It combines a review of the literature with a focus group study to provide an evaluation of PeerTalk.

PeerTalk is a nation-wide independent charitable organisation which provides peer support groups for individuals with depression and other related mental health issues. Established in 2014, its first peer support meeting was held in Bradford in 2016. PeerTalk's groups are founded on the belief that peer relationships, based on shared experiences, offer a unique recovery environment and provide a formidable way to promote optimism and hope.

A comprehensive review of the literature outlined the nature of depression and approaches to treatment. Based on a multidimensional model, it is considered that psychological disorders result from the interaction of genetic, biological, psychological, and environmental components.

The review noted that peer support can improve social support, social function, quality of life, service satisfaction, and self-efficacy of patients (Williford et al., 2012). Peer education can improve the compliance of patients with depression based on an 8-week, weekly programme (Van Mol et al. 2015). Furthermore, peer support can help patients establish new social relationships, not as patient and healer, but friends who are equal and help each other (Lloyd-Evans et al., 2014).

Ethical approval for an evaluation study was applied for and obtained from Sheffield Hallam University and PeerTalk Charitable Foundation's management. The evaluation study maintaining credibility and trustworthiness through a robust focus group methodology and adherence to Spencer, Ritchie, Lewis, and Dillon's (2004) guiding principles to advance knowledge or understanding, providing a research strategy that can address the evaluative questions posed, rigorous in the systematic and transparent collection, analysis, and interpretation of data, leading to credible claims based on evidence analysed.

A focus group of n=8 participants was undertaken, and useful data gained for analysis. The focus group was facilitated by a familiar member of PeerTalk to help participants

feel at ease and one for the masters students. Data was analysed using an accepted thematic analysis.

This evaluation suggests that peer support groups can enable mutually beneficial relationships to develop, that are built on empathy and understanding. Peer support can enable people to feel free to talk about their situation/s and to be a listening ear for others. The groups can also have the potential to enhance social connectedness, leading to improved quality of life and overall wellbeing (e.g. Repper & Carter, 2011; Pfeiffer et al., 2011). PeerTalk was commented on as a safe and supportive place to relieve the pressure of depression.

Four themes emerged from the data:

Reciprocity - Participants valued the way the groups reduced their loneliness, increased their self-efficiency by listening to others coping strategies, and enabled them to be part of something non-judgmental and supportive that '*by helping other people, you kind of also help yourself as well'.*

Relieving the pressure - As if the sessions enabled the participants to relieve some of their pressure, take action, and through a shared experience manage their mood better.

Confidence – Being a part of a group, contributing through listening and offering support enabled participants to expand their dialogue, reaching out of their family units…*'with people who are going through similar things to you, it brings so much more confidence'.*

Facilitation – Respondents valued the trained facilitation of the groups but felt that the groups could be more self-managing and that facilitators could take a less active role once the groups were established.

Although this is a small-scale pilot evaluation of a wider network of PeerTalk, it confirms many of the conclusions drawn by Walker and Bryant's (2013) qualitative meta-synthesis of 27 similar studies. They found, as did this evaluation, that peer support groups can enhance hope, improve confidence, increase social connectedness, and improve subjective wellness and symptom management.

Self-help and organisations such as PeerTalk provide cost-effective services as overheads and staff costs are minimal. In general, the positive contribution made by voluntary organisations may therefore reduce the burden on and demand of statutory services.

However, a commonly cited challenge for organisations such as PeerTalk, expressed by the focus group participants, was not only how to maintain the availability of such services but how to improve their accessibility so that distressed individuals across UK communities can be supported.

Given the impact that the COVID-19 pandemic is having, and the reported increase in mental health problems, policy makers and commissioners should recognise the merits of peer support and ensure voluntary organisations like PeerTalk are made available and accessible.

Introduction

PeerTalk is an independent charitable organisation that provides weekly volunteer-facilitated peer support for groups of individuals living with depression and related disorders. The charity's trustees have requested an evaluation of the current provision to help inform the organisation's future trajectory. Additionally, moving forward, the charity envisages securing a proportion of its funding through competitive tendering processes.

Due to Peertalk's charitable status, Sheffield Hallam University have produced this report on a pro bono basis by supporting (supervising) two MSc mental health nursing students to separately deliver different parts as their final year dissertations. Their supervisors have then combined and edited their outputs to create this composite report which outlines the current literature regarding peer support groups in general, as well as evaluating the impact of PeerTalk specifically. In doing so it provides a summary of the published evidence-base for peer support groups (for use in any future tender bids) as well as the necessary assurances to the trustees about PeerTalk itself.

Background

Presentation of depression

Depression is a state of mind characterised by irritability, feelings of sadness, disenchantment, misery, dysphoria, or despair (Bengtsson, 2016). Typically, it is a transient state, experienced by most people at various points in their lives, and is not in itself pathological. However, when the sadness is intense, it persists, and occurs in combination with the full range of depressive symptoms, it is considered clinically significant. The other symptoms that comprise the depressive syndrome are loss of appetite, sleep disorder, low energy, anhedonia, low self-esteem, guilt, difficulty concentrating, suicidal ideation, and psychomotor changes (Dale, Williams, and Bowyer, 2012).

Prevalence of depression

Major depression is common, affecting more than 300 million people worldwide ("UN News", 2020). It is a leading cause of disability globally, therefore, studies to determine

effective and cost-effective treatments for depression can help improve the health and lives of millions of people worldwide (Davidson et al., 2012). Although depression is a major cause of disability for all, the burden of depression is 50% higher for women than for men (World Health Organization, 2020). Studies in developing countries have shown that maternal depression can be a risk factor for slower child growth (Rahman et al., 2008). Effective methods of preventing depression include interventions such as education, problem-solving, reminiscence *et cetera* to reduce risk factors (Dale, Williams, and Bowyer, 2012; Lloyd-Evans et al., 2014). These issues mean that the mental health of people in low-income countries can affect national growth, and the effects of depression may impact multiple generations (Lockhart et al*.,* 2014). Antidepressants are effective in treating depression, but two-thirds of the individuals prescribed antidepressants do not achieve full remission and over half of the individuals who do, will relapse within a year (Rush et al., 2008). Therefore, alternative treatments for depression are necessary.

Explanations of Depression

Different explanatory models of depression have been postulated by advocates of each aspect of the biopsychosocial model, with each able to offer at least some supporting empirical evidence.

Some neurochemicals have been implicated in depression. Neurobiological findings describe neurochemical abnormalities and neurotransmitters such as serotonin, noradrenaline, and dopamine (Kaltenboeck & Harmer, 2018). Noradrenalin and potentiate serotonin are the two neurotransmitters thought to trigger depression. Biological research into depression was guided by the amine theory for over 30 years and changes in the hypothalamic-pituitary-adrenal gland, the thyroid axes, growth hormones, and prolactin secretion have been reported in depression for many years (Joyce, 1985). Studying the relationship between neurochemicals and neuroendocrine abnormalities can potentially provide an understanding of the pathophysiology of depression because neurotransmitters regulate neuroendocrine secretions. Furthermore, cortisol which helps to regulate blood glucose levels can also help to control blood pressure and the functioning of the immune system. It has been reported that persons who suffer from depression have abnormal hypothalamic-pituitary-adrenal glands and decreased levels of cortisol in their blood (Lee & Rhee, 2017).

The concept of depression can also be explained by the Evolutionary System Theory (EST). According to this theory, depression is an adaptive response by humans to the risks of unresponsive and unsympathetic personal and social consequences by showing insecurities in the social world (Chekroud, 2015). The EST also describes depression as a devastating state characterised by various neurocognitive and behavioural shortfalls. Furthermore, the EST describes depression as occurring through several unsuccessful attempts to alleviate complicated interpersonal relations or adverse neurobiological reactions to social anxieties. In people with depression, these neurobiological reactions are characteristically decreased as a result of fear which makes the patients believe that their social insecurities cannot be resolved (Nettle & Bateson, 2012). Evolutionary theory studies suggest that depression is a reaction to the fears and threats of damaging societal consequences which can reduce the likelihood of interpersonal relations (Badcock, 2012).

According to Andrews et al. (2010), depressive symptoms can affect several aspects of people's personalities which, in turn, can cause many serious consequences. This is particularly evident in adolescence, a crucial period in an individual's developmental process, marking the transition from childhood to adulthood. According to the WHO, mental and behavioural disorders are common in young people (Crabtree et al*.,* 2010), however, the attention given to the mental health of this population has been insufficient given that around 20% of children and adolescents suffer from some psychological disorder (Dale, Williams, and Bowyer, 2012). It is in adolescence that the entire maturation process of an individual culminates, ending the development of their personality (Bengtsson, 2016). During an adolescent's development, there are tortuous paths to take in the resolution of crucial questions and the resolution of tasks specific to that moment. In adolescence, the individual loses the security of unconditional positive regard that was guaranteed as a child and at the same time does not have the recognition as an adult (Bengtsson, 2016). Faced with this phase of role acquisition and transition, young people seek an independent personal identity and form new habits, behaviours and models of socialisation. Bengtsson (2016) found that adolescents go through this period of life with great suffering as a result of the successive and extensive losses that occur in their bodies, minds and social networks. This moment of great vulnerability for adolescents can contribute to the appearance of psychological disorders.

Based on a multidimensional model, it is considered that psychological disorders result from the interaction of genetic, biological, psychological, and environmental components (Crabtree et al., 2010). This interaction occurs in the relationship of individuals with their social environment and the interaction between their micro and macro systems (Dale, Williams, & Bowyer, 2012). Davidson et al*.,* (2012) corroborate this discussion by articulating contributions to the literature regarding attachment, depression, and social aspects. These authors propose a tripartite model to understand depression, which integrates individual factors, family relationships, and socio-cultural factors. Thus, concluding that mental health disorders result from complex relationships between innumerable biological, psychological, and social factors. According to Davidson et al., (2012), several studies have indicated that social ties influence the maintenance of health, functioning as a protective factor in stressful situations, and may reduce its impact on psychological well-being. Therefore, having a social support network, and receiving help from individuals who belong to that network, benefits health and well-being. On the other hand, a lack of social relationships is a risk factor for ill health. In a study by Dennis and Dowswell (2013), it was found that social support enabled individuals to deal with stressful events and conditions, functioning as a protective agent against common mental disorders such as depression and anxiety.

Peer Support

Social support refers to the resources made available by other people in situations of need. It is a focus of study for several disciplines including Medicine, Sociology, and Psychology. According to Embuldeniya et al., (2013), it was only after the 1970s that the relationship between social ties and health was verified. Several groups of people can offer social or peer support to the individual, such as family, friends, neighbours. This support may take the form of affection, company, assistance, and information; everything that makes the individual feel loved, esteemed, cared for, valued, and safe (Embuldeniya et al*.,* 2013). People need each other, therefore, when social support decreases, the individual’s defence system is compromised. The feeling of not being able to control one's life, together with the feeling of isolation, can be related to the

health-disease process, increasing an individual susceptibility to illnesses (Embuldeniya et al*.,* 2013). Lloyd-Evans *et al.,* (2014) defined a social network as a system composed of several individuals, functions, and situations, which offer instrumental and emotional support to a person, for their different needs. Instrumental support can be in the form of financial aid while emotional support, in turn, refers to affection, approval, sympathy, and concern for others.

Peer support services therefore vary according to the needs of the individual. The duration of the service can be long or short, and the service location can be in the community or the hospital. The service content differs, usually including disease-health education, social and life skills learning, and skills acquisition. Peers participate voluntarily or are selected by professionals (Pfeiffer et al., 2011). They usually need to have good communication skills, have a certain understanding of the disease, and have a sense of responsibility and compassion (Reynolds and Helgeson, 2011).

Studies have shown that peer support can improve social support, social function, quality of life, service satisfaction, and self-efficacy of patients with severe mental illness (Williford et al., 2012). According to a study by Van Mol et al. (2015), peer education can improve the compliance of patients with depression and provide inpatients with peer education once a week for 8 consecutive weeks. The results show that the peer education group had better nursing compliance and self-awareness than the routine care group. It is also found that peer education played a positive role in patients' social ability, social interests, personal hygiene, agitation control, withdrawal, and improvement of depression (Shilling et al., 2013). Furthermore, studies have shown that peer support services are more effective than some conventional treatment methods in reducing hospitalisation rates, reducing lengths of hospital stays, and increasing discharge rates (Shorey and Ng, 2019). Dukhovny et al., (2013) showed that recurrence rates of depression for outpatients who received peer support services was reduced by 50%, and only 15% of outpatients were re-hospitalised in the first year post discharge. Shilling et al’s., (2013) follow up study also showed that among patients living in the community, the relapse rate of patients receiving peer services was lower than that of other patients (62% vs. 73%). Studies have also reported no significant difference in outcomes between peer support services and the support services provided by medical staff or volunteers (non-peer) (Niela-Vilén et al., 2014). The impact of peer support on patients is passed on to other patients through

compassion and acceptance. Peers understand patients better than traditional medical workers, and patients also prefer to receive support services from peers. According to Mahlke et al*.,* (2017), the longer the patient accesses peer support services, the more obvious the effect.

Peer support services can help patients establish new social relationships, not as patient and healer, but friends who are equal and help each other (Lloyd-Evans et al*.,* 2014). Chinman et al*.,* (2014) pointed out that the functional recovery of patients receiving peer services was better than that of patients receiving services provided by traditional mental health institutions. One of the possible reasons is that peer support services give patients more opportunities to communicate while exposing them to a wider range of perspectives. Peer support also enables patients to learn from other people's successful solutions to problems, helping them improve their own social functioning (Wu, Lee, and Huang, 2017).

Loneliness is one of the most common causes of depression. Peer support, in addition to other benefits, can disrupt loneliness (Williford et al., 2012; Van Mol et al*.,* 2015). Peer support programs enable patients to participate more actively in self-care and self-realisation and offer a higher level of productivity and empowerment (Sowislo and Orth, 2013; Dale, Williams and Bowyer, 2012). Similar to depression itself, several conceptual models exist that each suggest how peer support can benefit people with depression. Pfeiffer et al*.,* (2011) identified overlapping mechanisms that can have beneficial effects. According to their analysis, mutually supportive interventions can reduce isolation (direct effects), reduce the effects of stress (buffer effects), increase health information sharing and self-control (direct effects), and provide positive models (mediating effects). Pfeiffer et al. (2011) also identified many similarities between the benefits arising from groups of supportive peers and group psychotherapy i.e. altruism, harmony, universality, imitation behaviour, stimulation of hope, and catharsis.

Whilst peer support services have many advantages, they are not without barriers, most notably access and integration however, the lack of systematic evidence of the effectiveness of peer support is perhaps the biggest cause of under-utilisation of this potentially useful intervention (Lloyd-Evans et al., 2014).

PeerTalk Charitable Foundation

PeerTalk is a nation-wide independent charitable organisation which provides peer support groups for individuals with depression and other related mental health issues. Modelled on the Irish Charity Aware, PeerTalk was established in 2014, with the first support group meetings held in Bradford and Preston in 2016. PeerTalk groups are founded on the belief that peer relationships based on shared experiences offer a unique recovery environment and provide a formidable way of promoting optimism and hope.

The organisational aim is to establish a sustainable network of peer support groups across England, to directly impact attendees' wellbeing and to indirectly reduce the stigma associated with mental illnesses. The support groups typically meet once weekly and are facilitated by two volunteers, whose roles are not to provide any counselling or to offer any advice but to ensure the attendees are safe and feel able to share their experiences between themselves for mutual benefit.

PeerTalk also seeks to promote positive narratives about mental health through its support groups. The organisation raises awareness of and challenges the stigma associated with depression by enabling peers to tell their stories, learn from and support each other.

Evaluation of PeerTalk

Aim

To evaluate the impact of PeerTalk charitable organisation's support groups.

Objectives

- To gain an understanding of PeerTalk's effects on attendees' subjective wellbeing.
- To ascertain its impact on the other aspects of attendees' lives.
- To ascertain whether and (if appropriate) how it is contributing to positive narratives.
- To blend these three objectives with attendees' ideas for service improvements.

Methodology

Overview

Crotty (1998, p.3) defines methodology as the strategy, plan of action, process or design lying behind the choice and use of particular research methods which link these methods to the desired outcomes. To understand the perceptions of Peertalk's support group attendees, a qualitative methodology has been adopted. Qualitative research approaches are naturalistic in nature and enable the exploration of individuals' experiences (King, Horrocks & Brooks, 2018; Willig, 2008). They typically use words and text during data collection and analysis (Bryman, 2016).

Furthermore, given that the aim of this project was to ascertain the impact of Peertalk's support groups, a service evaluation approach (described by the World Health Organisation (WHO; 2013, p.1) as a systematic and impartial assessment, of an activity, project, programme, or service) was adopted. Service evaluations focus on the accomplishments, practices, and contextual factors of the organisation/service to truly understand its achievements or shortfalls (WHO, 2013). To achieve this, evaluations must offer evidence-based credible, reliable, and useful findings which can shed light on the experience of individuals who use the service and provide the basis for further service improvement recommendations.

When conducting a service or intervention evaluation, the design should use the research methods and data that are most suited to the aims / research question

(Health Foundation England, 2015). In this case, the data were obtained through a focus group (a commonly used method in healthcare research). Powell et al. (1996, p.499) define a focus group as a group of individuals selected and assembled by researchers to discuss and comment (from personal experience), on the research topic. Focus group interviews facilitate the collection of multiple and diverse narratives about a subject through group interaction and the sharing of insights, feelings, thoughts, ideas, and attitudes. These discussions are typically facilitated by a moderator (Morgan, 1996) as, without active moderation to ensure the discussion remains focused on the topic, group dynamics can impact on the information shared and data obtained (Kitzinger, 1995). In this instance, it was also helpful that the focus group attendees were already part of an established (support) group as there is evidence that focus groups work well with existing groups in which individuals are comfortable to converse with each other and articulate their opinions, views and experiences in a group context (e.g. NHS England, 2015; King & Horrocks, 2010).

Ethical Considerations

Ethics approval for the study was obtained from Sheffield Hallam University and PeerTalk Charitable Foundation's management confirmed (in writing) their support for the evaluation. Participant information sheets were provided electronically when the established support group attendees were invited to take part and give written consent In addition, informed consent was confirmed verbally with all the participants at the start of the focus group, after they had been comprehensively briefed about the purpose of the evaluation and offered opportunities to ask any questions about participation. All participants were informed that their involvement was wholly voluntary. They were also advised about the importance of confidentiality of their data, but also of the views expressed by others during the meeting (King & Horrocks, 2010). Finally, all participants were advised of their right to withdraw at any point during the focus group (and how to seek emotional support if needed). They were also informed of how to withdraw up to two weeks post-data collection (after which transcription and analysis would make removal of their data impractical).

The final noteworthy point relating to participant safety relates to the fact the focus group was scheduled to take place during the Covid-19 national lockdown. At the time, support groups were exempt from these restrictions, and the participants were

continuing to meet regularly in a Covid-secure setting. However, as a precautionary measure, Sheffield Hallam University stipulated that the focus group would need to be conducted on-line, using a sufficiently secure video conferencing platform.

Ongoing advances in communication technologies mean researchers are increasingly using Voice over Internet Protocols (VoIP) to collect data successfully. These VoIP include Skype, Facetime, Microsoft Teams, etc., and more recently, Zoom and Webex video conferencing (Archibald, Ambagtsheer, Casey & Lawless, 2019), which all allow two or more people in different sites to connect and interact using audio and video imaging in real-time (Nehls, Smith & Schneider, 2015). These modes of communication enable researchers to collect data from participants when meeting them in person is not feasible (Deakin & Wakefield, 2013). To avoid issues of cost relating to data usage, participants were advised of the focus group's estimated 75-minute duration and permission to video record the interview for transcription purposes was also obtained.

Recruitment and sampling

When recruiting focus group participants, NHS England (2016, p3) suggest that inviting people through trusted intermediaries', can enhance their confidence and provide a sense of security. Consequently, an invitation to participate was posted on PeerTalk's web page. This purposive sampling method enables information-rich participants to be recruited (Patton, 2014). Prospective participants were asked to email the researcher, or to inform PeerTalk admin staff when booking into their peer support groups. These individuals were then sent a plain English information sheet written in simple English and encouraged to ask any question about the study.

Participants were accepted if they were:

- Over 18
- Able to give informed consent
- An attendee of a PeerTalk support group
- Living with, or had previously experienced depression
- Able to download the WebEx app (necessary for the on-line focus group)
- Able to effectively express themselves in English

Data collection

Based on a review of relevant published literature, a loosely framed topic guide was developed to steer and maintain focus whilst allowing sufficient latitude to capture and explore unexpected issues that arose during the focus group.

Participants were sent easy to read instructions to download the WebEx video conferencing app and encouraged to do this in advance of the focus group. They were also advised to logon before the agreed time for the focus group to avoid delays.

Participants were welcomed to the focus group by two familiar PeerTalk admin staff members (the CEO and Director of Operations) who then introduced the researcher and made sure everyone could use the in-meeting controls, thus ensuring everyone felt ready and comfortable to participate. Once the admin staff left, the virtual room was 'locked', and the recording commenced. Using the topic guide, the researcher then elicited the group's views, ensuring each participant had the opportunity to comment at each stage.

Data analysis

The transcript of the focus group interview was thematically analysed using Braun and Clarke's (2006) six steps:

1) The researcher familiarising themselves with the focus group data
2) Generating initial codes by going through the transcript line by line
3) Searching for themes from the codes
4) Reviewing the themes in keeping with the aims of the service evaluation
5) Defining and naming the themes
6) Writing the evaluation report

To enhance credibility (the extent to which a piece of research is believable and appropriate), particularly regarding the way conclusions were reached (Polit & Beck, 2004), verbatim quotes were included to show the derivation of each theme (Morse, 2015; King & Horrocks, 2010).

Summary

In summary, this service evaluation has sought to maintain credibility and trustworthiness through adherence to the four guiding principles proposed by Spencer, Ritchie, Lewis, and Dillon (2004) i.e.:

- Contributory in advancing more comprehensive knowledge or understanding about policy, practice, theory, or a particular substantive field
- Defensible in design by providing a research strategy that can address the evaluative questions posed
- Rigorous in conduct through the systematic and transparent collection, analysis, and interpretation of qualitative data
- Credible claim through offering well-founded and plausible arguments about the significance of the evidence generated

(Spencer, Ritchie, Lewis & Dillon, 2004, p.20)

Findings

Participants

Nine participants initially expressed a desire to participate in the service evaluation; however, one participant struggled to log on to WebEx and subsequently withdrew at the introductory phase of the focus group leaving eight participants (six male and two female). These eight people were regular support group attendees and met all the criteria for inclusion.

Themes

After immersion in the transcribed data, and following Braun and Clarke's method, four themes emerged:

1: Reciprocity of peer support: *Understanding one another and building relationships.*

This theme describes the reciprocal nature of peer support in supporting others and being supported. The participants described how peers share lived experience of depression or anxiety in their support group sessions, which they described as a non-judgemental, empathic, and embracing environment. For many, this shared experience was crucial in helping them to feel understood and, in turn empowered. Attending the group sessions resulted in the creation of a culture of openness, companionship, and a sense of belonging:

> *Yes, I guess I would echo pretty much what the other people have said in that by helping other people, you kind of also help yourself as well as it helps you tease things out and think about things from their perspective, which might apply to you, or it might not, or at least it gives you a different angle on things and similarly, by giving your angle on things you are kind of helping them out as well* (Participant 2)

For most participants, attending PeerTalk support sessions enabled them to exchange experiences of coping with depression in a supportive environment and to learn from each other's shared lived experiences:

> *What I find is that it's just nice to get other people's points of view and their coping strategies with depression. Sometimes you can go away and potentially put some of those ideas into practice and then the week after, or even two weeks after, you can feed it back to people and actually, it might not work, not everything works for everyone, but you tend to find some of the ideas do. The simple ideas are the most effective ones as well* (Participant 8)

There was a strong emphasis on how support sessions can facilitate freedom of expression, with most participants referring to their support group as a platform from which to support and be supported without fear of judgement:

> *So, you are in a safe space, and you have not got anybody there that is going to judge what you are saying, and nobody is going to laugh because*

you felt a particular way in a particular situation or you watched Yogi Bear and cried because it made you think of something else. (Participant 2)

Being heard and listening to others was highly valued. Indeed, listening to people who can relate to one's difficulties was perceived as an essential aspect of peer support:

> *Sometimes people just need to be listened to*. (Participant 2)
>
> *So, if you can listen actively, as everybody does seem to in the group that we are in, then you are contributing even if you say nothing* (Participant 5)
>
> *…it's a team effort, and we all listen to each other, and we all give our views freely* (Participant 4)

Attending support groups helped alleviate loneliness, social isolation, and develop the realisation that others were facing the same situation. Most participants viewed the mutuality and reciprocity of peer support as a means of learning about their condition, their strengths and aiding their recovery:

> *I find going to the group just helps me feel not alone, that I am not in this on my own, that there are other people going through what I am going through. I would echo what Participant 2 said about people sharing things that you can pick up on and use for yourself, and people sometimes use what you say* (Participant 4)

The exchange of lived experiences of depression, even if there are some differences, was critical in enabling a sense of connectedness between peers:

> *It is that interaction, really, that I find helping other people and telling them about yourself and they help you in turn. It gives you a real feeling of being joined up with other people that are going through similar situations. Not the same, but similar* (Participant 2)

There was clear consensus that support sessions were enriching, fulfilling and meaningful experiences. Some spoke about how sharing their experience could help others whilst others found sessions facilitated self-reflection. Sometimes, attending

support groups afforded the opportunity to speak openly about their circumstances for the first time:

> *I spoke for the first time, we got a chance to sit down and talk openly and honestly about the condition, how it affected you, how it affected other people without prejudice or anything else. So, in that case, it just gives you an open platform to talk about how you feel, what impacts there are, and also to listen to other people going through the same thing.* (Participants 3)

The importance of mutual relationships permeated the focus group discussion. For many participants, peer support groups felt like a small family. The connection between peers was not just knowing each other, but looking out for each other:

> *It feels like a small family, you know when people do not go for a couple of weeks, and you are there you are wondering are they okay, you know, you are always checking up on other people and stuff. It's a benefit for everybody, you know, it's a win-win for everybody.* (Participant 7)

Peer support sessions simply helped individuals get to know others and build supportive relationships:

> *...and giving you something to kind of focus on and a real bond with the other people in the group. A real encounter for me.* (Participant 4)

To break out of their own world and become more socially connected:

> *Yes, I think for me it helped. I think one of the things about anxiety and depression is you do get stuck in a bit of a bubble, and you do not go outside a lot, and I think the one thing that the PeerTalk did is make me kind of go out and you are in a bad structure.* (Participant 3)

And alleviate their loneliness:

> *I find going to the group just helps me feel not alone, that I am not in this on my own, that there are other people going through what I am going through.* (Participant 4)

Overall, attending group sessions was universally valued, and typically seen as a mutually beneficial symbiotic process:

> *It becomes almost a symbiotic thing that is going on; there is not a side; you do not have sort of one side or the other side; it's very much a team effort.* (Participant 2)

2: The right place to 'lance the boil': *Relieving the pressure.*

This metaphorical title encapsulates the way PeerTalk's sessions enable attendees to ventilate and relieve the pressures associated with their depression. For many, PeerTalk offers a stable and familiar environment in which to release their bottled-up feelings. One participant described PeerTalk sessions as a place where one can 'lance the boil' – a place where one can squeeze the hidden emotional challenges of depression out like pus from a boil:

> *Everybody has some sort of common experience in that we feel as if we are not understood. So, being able to go there and lance that boil and squeeze it and get rid of some of the infection every week, I feel it is a quite useful thing to do. It works for me, anyway. So, that is me.* (Participant 2)

Attendance was a source of positivity, allowing group members not only to divulge their own problems and experiences of mental health but to see things differently by learning about their mental illness from others:

> *Well, I think sometimes people need-- me included-- we all need help to be able to look at things in a different way. So, being depressed sometimes can feel as if you have almost got emotional tunnel vision and you cannot see outside of that, but to know that there are different ways of approaching problems and different ways of thinking things by sharing that with other people and some cases-- it does not happen for everybody-- but in some*

cases, you share things which other people find useful, and other people share things with you which you also find useful. (Participant 7)

In addition to learning from others and developing an understanding of their own situation, most PeerTalk attendees found groups helped them to develop coping strategies for their depression:

What I find is that it's just nice to get other people's point of views and their coping strategies with depression. Sometimes you can go away and potentially put some of those ideas into practice and then the week after, or even two weeks after, you can feed it back to people and actually, it might not work, not everything works for everyone, but you tend to find some of the ideas do. (Participant 8)

Another key point that permeated the focus group discussion was that PeerTalk's sessions not only 'opened their eyes' but also offered breathing space to reflect and realise that other people were also confronting the challenges of depression:

I think just going back to what Participant 7 was saying, there are so many times when you hear new people coming to a group who have said, "I thought it was only me,' and that is the most common statement you hear. To say, "Oh, thank God for that. I thought it was only me who felt this way," and that is the biggest thing. (Participant 3)

As in the previous theme, most participants strongly believed PeerTalk groups relieved loneliness, but they also explained that the groups enhanced their understanding that others faced the same challenges:

It's nice to know you are not alone. Depression can be the loneliest illness that you can have because you just think you are on your own, you are isolated, but when you go to PeerTalk you realize you are not, you realize there somebody who might be living down the road, you know, somebody who might be doing really well who is struggling, you know what I mean? Everybody is the same. (Participant 7)

Some participants, rued not knowing about PeerTalk earlier:

> *I think all I would say is that I have suffered from depression now since 2010, on and off, I have those three major bouts of depression, and I wish I had this sort of group a long time before November last year.* (Participant 5)

Delays in accessing PeerTalk could be several years and clearly delayed recovery:

> *I have been going to the doctor for donkey's years talking about depression, and for the first time, just after Christmas, I was asked if I wanted to see the social prescriber, and I had heard of that person before, so, I said yes, please, and it was the social prescriber who pointed me to PeerTalk.* (Participants 1)

> *I have done that, managed to pay the mortgage off, stick with my wife, sort my life out a little bit. It's not easy but at least talking about it means that the pressure-- I liken it to lancing a boil or squeezing a spot, you get that pressure squeezed off and then it enables you to go back into whatever normal society is and you can go back into that and go back in without that pressure because you have managed to just let it out just once a week. That means I still have a wife*. (Participant 2)

3: Re-building of confidence: Enhanced sense of worth, purpose and meaning.

This theme encapsulates participants strong belief that meeting a group of people facing the same situation rebuilt their confidence generally, as well as to talk about their situation:

> *It has helped me to communicate with people again. I lost confidence in having a conversation with people outside my family group. I seem to have lost the ability to actually engage in conversation, and that has come back, you know, I feel much more confident to have a chat with somebody, like, maybe when I go to church..* (Participant 1)

> *I found once I went to my first meeting and sat around with people who are going through similar things to you, it brings so much more confidence, and it makes you-- like other people have said-- you do not feel alone.* (Participant, 7).

Overcoming their fear to attend their first group session seemed particularly challenging:

> *I think the only problematic thing, is getting that confidence in yourself to go to the meeting……I think getting over the initial fear of going is really hard, but sometimes you have got to push yourself to want to get better.* (Participant 7)

In part this was due to uncertainty about what the group sessions offered and doubts about being judged. However, once this was overcome, confidence levels were quickly improved by the openness and non-judgmental nature of PeerTalk's meetings:

> *Quite frankly, you are crapping yourself because you do not know what is going to happen and people are going to be saying, whether people will be judgmental to you, and you soon realize over a couple of sessions at first, that actually people can just be open and honest and there is no retribution, or there is no feedback, or there is no laughing at you or people kind of judging you at the start.* (Participant 3)

> *It has given me a lot of confidence. I would not normally go into a group, so, now I go by choice.* (Participant 5)

Other attendees went further than talking about confidence, saying attending group sessions had helped them to start believing in themselves as well as relieving the pressures caused by depression:

> *I think as other people have been saying, the main impact to myself, I suppose it's the (…) it actually gives you the belief to actually make that next step forward, and what that enables you to do is actually unlock the fear and the tightness in your chest (…) it allows you to sleep.* (Participant 6)

Some described this as cultivating a sense of self-worth:

> *…I would absolutely concur with is that it gives everybody actually a sense of worth because even you are sitting there and saying nothing you are still contributing because you are listening.* (Participant 2)

Others talked of an improved sense of purpose:

> *I think it just gives you a sense of purpose, it gives you a sense of doing things in a different way. It's so good to hear stories from people that might give you a little bit of insight to the way you think, you can change the way you think, just you can view things from a different angle.* (Participant 7)

> *And that gives you a sense of worth and a sense of value, which sometimes when you are depressed, you wonder what the heck it's all about.* (Participant 2)

> *That valuing each other means you will value yourself as well, so, it gives you a sense of purpose in a lot of ways because you have got that value. After all, you feel that you are valued.* (Participant 3)

The mutual exchange of experiences created a real sense of achievement and, perhaps most pleasingly, was often reciprocal in that one's own confidence grew through seeing other people's confidence improve:

> *We know that we are actually valued by other people, but we do not always feel it, so, to go and share with people and hear them share gives you that real-- yes, it's that high five together, all for one, one for all kind of thing, musketeers.* (Participant 4)

> *I know with the [name of place] group we have had people who have come, not maybe spoke for a couple of weeks, then you see them open up and start talking, you work as a group to try and help them, and when you see them growing confidence, it helps your confidence grow as well*. (Participant 7)

4: Service Improvement with Peers as facilitators: Improving the availability and accessibility of peer support group sessions

This theme relates to the service improvement suggestions expressed by participants. The issue of group sessions being facilitated by people with a shared experience was regarded as a fundamental characteristic of PeerTalk support groups. For Participant 2, it was a principle that like-minded people lead the sessions – peers themselves:

> *I think the fundamental bit of professionalising the group is that it does not work, so, do not mess it up by changing it because as a principle of getting like-minded people together to talk about common issues, and just talking as peers, literally, it works. If it's not broken, do not fix it.* (Participant 2)

As a result, most participants felt that PeerTalk should limit the 'professionalisation' of the support groups. They explained that, even though trained facilitators were essential at times, PeerTalk sessions should be about those with a lived experience:

> *I would agree with what Participant 2 said. I think in the beginning the facilitators were more needed than they are now. Not that they are not needed, but it's PeerTalk, and it's about the members of the group.* (Participant 4)

And that facilitators needed to take a more passive role in the groups but still be there to step in to stimulate the group whenever necessary:

> *I do not think they need to be very proactive really, they need to be able to sit back when they need to sit back and if it goes very quiet, perhaps just to throw bits and pieces out there to try and tease people's thoughts out a little bit. But less is more facilitating.* (Participant 6)

Participants also made several suggestions about improving the availability and accessibility of support groups. For example, participants favoured the use of video conferencing to overcome the impact caused by the current COVID-19 lockdown:

> *I believe that having, particularly in the current situation, the option to be able to join a Zoom meeting is a good thing. It may also be nice, I say nice, it may also be desirable, shall we say, that when we have meetings in*

whatever location it is, whether it's a church hall or a youth club, or wherever you have the meeting, if we could open that up to known members on Zoom as well. (Participant 2)

Or even just bad weather:

So, for instance, I know sometimes Participant 5, particularly in the cold weather, struggles to get to meeting because of health issues and ice on the paths and all the rest of it where those young ones at a mere 58 like myself manage to get there okay. But we could have the webcam in the group, invite Participant 5 to join our meeting in a virtual way, so she joins the real meeting, then that would give us the best of both worlds, would it not? Because people in Participant 5's position would not have to miss out and err (…) cannot get yourself off the bed, out of the house, whatever, you might find it within yourself to join the big meeting. (Participant 8)

Combined virtual (Zoom) and face to face sessions/meetings were advocated by some, allowing everyone to be part of the group. However, while this was welcomed by many participants, others made it clear that virtual sessions should not be regarded as a substitute the face to face meetings:

So, yes, combine the Zoom type technology with the live meetings as well. I would not want to see the live meetings disappear because as an old salesman or sales manager once said to me to try and get me out on the road, he said, "You can't beat press in the flesh, and you really cannot beat face to face meetings. (Participant 5)

Discussion

It is important to note that previous studies have principally been quantitative in nature, mainly focussing on the efficacy of groups, rather than the experiences of group attendees. In this regard, Pfeiffer et al.'s (2011) meta-analysis showed that peer support could assist in reducing the symptoms of depression. However, this study adopted a qualitative approach to evaluate the impact of PeerTalk's support groups on attendees' subjective wellbeing. Rich data encompassing diverse PeerTalk

attendees' experiences were gathered through an on-line (WebEx) focus group. From this it seems that being in a non-judgemental, understanding, and empathetic environment where people with a shared experience listen to each other's stories relating to an array of everyday challenges, feelings of loss, anguish, and grief caused by depression, has a positive impact on people's lives.

Various explanations as to how peer support groups benefit individuals with depression have been postulated. Dennis (2003) reported three closely related mechanisms including: lessening social isolation; decreasing the intensity of everyday life stressors; and enhancing information. PeerTalk attendees in this service evaluation mentioned all three but added the importance of having peers with whom to offload some of their challenges to improve self-management of depression.

As in Austin, Ramakrishan and Hopper (2014), and Repper et al. (2013), the nurturing nature of PeerTalk groups was described as an appropriate place for attendees to develop the confidence to talk freely about their experiences without fear of judgment. This also creates positive narratives about depression and helps reduce the stigma attached to the mental illness (Corrigan et al., 2013).

Being listened to and understood was vital to PeerTalk attendees' subjective wellbeing as it enabled them to ventilate whilst learning from other people's ways of coping with depression. These findings echo Shorey and Ng's (2019) qualitative evaluation of a technology-based peer support intervention in which mothers with postnatal depression reported that their engagement with the programme enabled them to develop enhanced coping abilities due to a mutual exchange of experiences. PeerTalk group attendees reportedly developed richer and deepened personal insights from the process of peer support. This service evaluation therefore supports previously reported benefits of peer support groups for people with depression, such as the alleviation of social isolation, empowerment, improved self-efficacy and openness (Bracke, Christiaens & Verhaeghe, 2008).

Most participants in this evaluation emphasised how PeerTalk groups triggered a sense of self-worth, purpose and meaning which they associated with an increased understanding of their condition and circumstances, self-efficacy, and coping skills enhancement. Similar findings were documented in a recent systematic review of ten RCTs where Huang et al (2020) concluded that peer support groups could reduce the

symptoms of depression. Given such evidence, peer support services should be recognised for the impact they have on the wellbeing of patients with depression that, for some, can be as important as medication (Filson and Mead, 2016).

This evaluation contributes to current evidence base and supports a claim made by Lyass and Chen (2007) that peer support groups can provide opportunities for openness about mental health, thus promoting an open dialogue about experiences that may not be easily shared in other contexts (Shalaby & Agyapong, 2020; Repper et al., 2013; Walker & Bryant, 2013; Seebohm et al., 2013). Yalom (1995) and Pfeiffer et al (2011) have described peer support groups as having comparable features to that of group psychotherapy, including altruism, cohesiveness, universality, imitative behaviour, instillation of hope, and catharsis. Lyass and Chen (2007) reported that peer support programs might also be a source of empowerment for individuals with depression to be actively involved in their self-care, potentially reducing admissions to hospital (Sledge et al., 2011). Given the current pressure on mental health services in the UK, organisations like PeerTalk could alleviate the increasing demand for services, especially post the COVID-19 pandemic.

As widely articulated in other studies, this evaluation suggests that peer support groups can enable mutually beneficial relationships to develop, that are built on empathy and understanding. These relationships provide the basis by which the individuals with depression feel free to talk about their situation/s and to be a listening ear for others. It also reinforces the current view that peer-support groups have the potential to enhance social connectedness, leading to improved quality of life and overall wellbeing (e.g. Repper & Carter, 2011; Pfeiffer et al., 2011). Finally, the fact that PeerTalk was deemed a safe and supportive place to 'lance the boil' adds to the positive outcomes reported by the likes of Dyble et al. (2014), Repper & Carter (2011) and Repper et al. (2013).

Conclusion

In summary, this qualitative evaluation of PeerTalk's support groups confirms many of the conclusions drawn by the likes of Walker and Bryant (2013). Their qualitative meta-synthesis of 27 studies examined the experiences of the recipients of peer support services and found that peer support groups enhanced hope, confidence, social connectedness, and subjective wellness as well as reducing the symptoms of mental illness.

There is growing recognition of the positive impact and cost-effectiveness of services provided by organisations such as PeerTalk. There is also evidence to believe that the positive contribution made by voluntary organisations could reduce the burden on and demand of statutory services. However, a commonly cited challenge for PeerTalk expressed by the focus group participants was not only how to maintain the availability of such services but how to improve their accessibility so that distressed individuals across UK communities can be supported.

Given the impact that the COVID-19 pandemic is having, and the anticipated upsurge in mental health problems, policy makers and commissioners should recognise the merits of peer support and ensure voluntary organisations like PeerTalk are made available and accessible.

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