No Longer Fledglings but Struggling to Fly: Peer Support Workers' Experiences of Forming an Occupational Identity within an Urban NHS Trust.

An Interpretative Phenomenological Analysis.

A thesis submitted in partial fulfilment of the Doctorate in
Counselling Psychology at London Metropolitan University
By

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Declaration

I hereby declare that the work submitted in this dissertation is fully the result of my own investigation, except where otherwise stated.

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Acknowledgements

As I end my formal training, I recognise that this transformational journey will most definitely continue. I remain deeply grateful to the many people who have shared the experience with me.

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Abbreviations

APA	American Psychological Association
BPS	British Psychological Society
COP	Counselling Psychology
HEE	Health Education England
IPA	Interpretative Phenomenological Analysis
IPS	Intentional Peer Support
MH	Mental Health
MHS	Mental Health Services
MDT	Multi-disciplinary Team
NHS	National Health Service
NICE	National Institute for Clinical Excellence
OI	Occupational Identity
PS	Peer Support
PSM	Peer Support Movement
PSWs	Peer Support Workers
QOL	Quality of Life
RBP	Recovery-based Practice
SP	Service Provider
SUs	Service Users

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Abstract

Background: Mental health policy promoting the notion of self-management and the patient as the expert welcomed the advent of peer support (Watson, 2017; Gillard, 2019), which is now regarded as the fastest growing profession within mental health services (Rebeiro Gruhl et al., 2016). Research has noted the benefits of using peer support workers (PSWs) to encourage service user (SU) involvement by using their shared identity to improve mental health, well-being and confidence (Gillard et al., 2013; Simpson et al., 2018; Davidson et al., 2012). **Rationale:** With increased numbers of PSWs employed within the NHS, it is essential to understand how PSWs develop/construct their occupational identity (OI). Employment has been shown to positively affect individuals well-being by affording them a sense of identity and purpose. How OI is experienced during development and then maintained will be the focus of this research. **Methodology and main findings:** An Interpretative Phenomenological Analysis (IPA) was adopted for this research. Three superordinate themes were generated from the semi-structured interviews and analysis: 1) Symbiotic Green Shoots of Identity; 2) The Occupied Self; 3) A Limited and Limiting Role. The findings provide a timeline of how participants developed their OI, highlighting the life-changing events that led to a greater sense of self and a more meaningful life. By feeling accomplished at work, being future-orientated and having a solid OI provided participants with the motivation to spread their metaphorical wings and explore the transferability of their skills. However, despite participants significant experience of performing the role, they were met with a series of organisational hurdles that appeared to invalidate their OI outside of the originating organisation.

Introduction

Overview

This thesis will explore how experienced PSWs form their occupational identity when working in an urban NHS Trust. The following chapter provides an overview of the structure of the study. It concludes with a reflexive statement on how I have positioned myself within the research and discusses the relevance of the findings and how they relate to Counselling Psychology (CoP).

Structure of the Thesis

Chapter two presents a review of existing literature and sets out the rationale for this study. The review highlights the projected growth of PS and its potential impact across mental health services (MHS) within the UK. The current government mandates promoting PS are assessed against the relevant literature. Chapter three explores the methodological approach used and provides an insight into my epistemological position as a critical realist. It offers an explanation of how I may have influenced the gathering and analysis of data, along with the ethical procedures followed throughout the project. The findings that emerged from the data analysis are then present along with the themes that emerged. Finally, the relevance of the results are considered in relation to CoP, its professional practice and ongoing commitment to promoting ethnic and cultural diversity.

The Concept of Peer Support

In the context of mental health, peers use their lived experience to offer emotional and practical support to people going through similar experiences. They develop non-judgemental, respectful and safe relationships to help create personal and social change (Repper, 2013; Watson & Meddings, 2019). Together with extensive bodies of research, many progressive mental health professionals point to the benefits of PS, which has resulted in the role being increasingly adopted within statutory health services and the voluntary sectors (NICE, 2016; Mind, 2019; Mental Health Organisation, 2019). PS is well regarded as a means of improving recovery outcomes by developing good interpersonal relationships and focusing on person-centred treatment (Hall et al., 2016: Milton et al., 2015; Humm & Simpson, 2014). Studies highlight that PS vary widely in their roles, settings, and theoretical orientations. However, there is also universal agreement that defining the content and structure of the PS role is challenging (Watson, 2017; Gillard et al., 2014; Faulkner et al., 2013; Simpson, 2017).

Research exploring the role of Peer Support Worker[1] has been substantial over the past three decades. Peer support is grounded in a philosophy of recovery, where the emphasis is on promoting positive and active personal recovery (Watson, 2017). It is perhaps best known for its non-hierarchical mode, which offers an alternative to traditional MHS and psychiatric interventions (Gillard et al., 2017). However, having searched the literature, I confirm no one clearly defined theoretical framework exists for peer support. Conceivably, this could constitute an area open to exploration from a CoP perspective and where future research could help inform knowledge and therapeutic practice.

The literature suggests that those labelled with psychiatric disabilities have become victims of social and cultural exclusion, leading to a reduced sense of self and identity of "patient" (Gumley et al., 2010, Corringan, 2016). Peer support enables service users to increase their involvement and control over which MHS they engage with by sharing personal experiences and modelling core recovery competencies such as self-expression and hope. Further, they challenge prognoses and traditional mental health services built on the acceptance of mental health as a disease with little hope of wellness. According to Rose (2014), the 'medical model' has defined and shaped the pathologising language that has led to

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[1] There is no one universally used term in the published literature to describe individuals who use their ‘lived experience’ of mental distress to help others facing similar trials: peers, peer specialist, peer worker, consumer provider, peer provider, peer mentors and experts by experience are used interchangeably. For ease and clarity, I will use the term PSWs throughout this thesis.

the labelling, discrimination, and stigma directed towards those dealing with mental health problems.

Reflexive Statement

In order to contextualise this thesis, the following reflexive statement acknowledges my assumptions and biases for their inevitable influence on the process of data collection and analysis (Kasket & Gil-Rodrigues, 2011). It is intended to add credibility and allow the reader to scrutinise the power imbalances inherent in research encounters (Kasket, 2012). As part of the decision to choose a qualitative method for this study, I recognised the need to explore my connection and interest in mental health peer support to highlight the personal motivations that may have influenced this decision (Finlay, 2002).

Reflecting on the past six decades, I have come to understand that despite the evolution of my thoughts and feelings, they remained coloured by earlier experiences. Members of my family faced challenging psychological problems, and collectively as Irish immigrants, we were subjected to resultant societal stigma. Research has helped me understand that although Irish people are predominantly white and English speaking, those “living in the UK have much higher hospital admission rates for mental health problems than other ethnic groups. They have higher rates of depression and alcohol problems and are at greater risk of suicide” (Fitzpatrick & Newton, 2005, pp. 739-740).

These early experiences stimulated my initial interest in studying psychology. I was further attracted to counselling psychology because of its concern with the individual's subjective/intersubjective experience. I felt the training would allow me to better "understand issues of power, discrimination and oppression, and the psychological impact of these" (BPS, 2017, p. 7).

My earlier career began in the 1970s in a business environment that was typically male-dominated. Women were frequently subjected to a range of inequalities that extended beyond the workplace. Reflecting on this time, I recognise that although the notion of ontology and epistemology were far from my awareness, I had navigated my reality to a point where my views, opinions and principles best aligned with a feminist stance. By acknowledging how individual values were often violated, I found myself battling for gender equality and social justice. With hindsight, I understand that these early experiences had a pivotal role in my decision to change career. Reflection allowed me to see how my values have increasingly aligned with those of counselling psychology.

The millennium was a significant time of change for me, as I retired from the city and retrained as a compassionate coach/counsellor. It was also an informative period as I re-started my academic education by studying clinical and community psychology. I became more aware of the dominant biomedical paradigm within mental health services and adopted a critical view of its adverse effects on those it seeks to help. The community psychology element of the course allowed me to engage in local projects focusing on socioeconomic inequalities. I felt particularly drawn towards assisting others to deal with mental health challenges.

Initially, I worked in a Child and Adult Mental Health Service, which was a steep learning curve on mental health service provision. For example, I witnessed the use of physical restraint, which at times seemed to be disproportionate and aggressive. The experience further impacted my thinking and determination to fight for broader service user rights. Next, I joined a collaborative research project conducted by the university and an NHS Trust, in which peer support workers joined students for extra curriculum lectures in research methods. The end goal of this participatory project was to evaluate a recently formed peer support training programme.

This period was highly informative, and I gained a first-hand account of the expressed psychological and emotional challenges faced by PSWs. I remember feeling humbled by their courage and, at times their fragility, by sharing their lived experiences of fear, isolation, and the profound sense of difference and inferiority. Reflecting on their accounts of feeling marginalised and stigmatised by MHS, I recalled my own experiences of feeling different and alone. I relived painful memories of growing up in London during the 1960s as a child of Irish immigrants. Reflection allowed me to contextualise my inherent motivation, drive for equality and to explore my subjective experiences. Consequently, I was able to develop a deeper understanding of my personal beliefs and values. By training to be a counselling psychologist, I realised that, through research and practice, I could promote diversity and inclusion and help to provide a voice for marginalised groups.

Undoubtedly, the emergence of PSWs within the National Health Service (NHS) inspired me to understand more about their changing identities and motivation to return to the psychiatric settings where they were once patients. As I started to formulate my thoughts for this project, I recognised that I could add new knowledge to the existing literature and promote the values of counselling psychology by focusing on the power imbalances inherent in both practice and research encounters involving PSWs (Cutts, 2013).

When reviewing the literature surrounding PS, I was conscious of providing an unbiased PS account. I recognised the need to suspend my preconceived ideas and judgement of the biomedical model, which, left unchecked, could have affected how I critiqued journal articles and constructed interview questions for the study. Keeping a reflective journal throughout this project was an essential element of the research process and allowed me to reflect on the assumptions made that could have affected the interpretation of participant views and their reporting.

Although I have acted congruently throughout this project, I am aware that biases and assumptions are never far from my consciousness. Finlay (2008) describes this process as a dance between reduction and reflexivity where "the researcher slides between striving for reductive focus and reflexive self-awareness; between bracketing pre-understandings and exploiting them as a source of insight". I hope these reflections will promote a better understanding of how earlier experiences may have influenced this research.

Finally, in a parallel process, as I continue to grow and construct my own occupational identity as a counselling psychologist, I feel akin to PSWs also making a construction journey.

Relevance to Counselling Psychology

Counselling psychology has an explicit focus on humanistic values. It is concerned with developing an understanding of people as 'relational beings' by emphasising their subjective and inter-subjective experiences (Cooper, 2008). Central to CoPs philosophy is 'respect for the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment' (Lane & Corrie, 2006, p. 17). From a CoP perspective, this research can provide a non-hierarchical voice for PSWs and generate more awareness of this evolving role by better understanding their subjective experiences. Many of the philosophies and values underpinning the peer support movement correspond well with CoP, striving for social justice, equality, and a paradigm shift away from the diagnostic labelling that fails to acknowledge individuals holistically (Jones Nielsen, & Nicholas, 2016). Identity is also a significant factor that both CoPs and PS strive to develop in line with their core values.

Since the discipline emerged nearly 40 years ago, counselling psychology has embraced service users and acknowledge the importance of listening to the nature of their issues. They help reduce psychological distress by applying a person-centred approach informed by research, theory, and practice (James, 2019). CoP remains at the forefront of developments concerning minority groups by enabling difference, diversity, and social justice.

This project aligns well with the strategic plans outlined by the British Psychological Society’s (BPS), Division of counselling psychology and particularly with the stated objective of supporting change by using "the expertise of CoP profession to explore the lived experience of people with mental distress from a diverse demographic" (DCoP, 2018, p. 8).

Although the current study does not adopt a participatory methodology in a classical sense, it does put the service users' voice into the research agenda by interpreting how the peer support role impacts their quality of life. Conceivably, this research can be a first step towards a collaborative research project by understanding how PSWs form their occupational identity. It is further hoped that this study will generate greater awareness of how PSWs are experiencing the professionalisation of their rapidly expanding role. In turn, this could allow further discussion on how this knowledge could be disseminated and delivered by PSWs wishing to contribute to CoP training programmes. This approach would align with the BPS’s current directive to involve service users and experts by experience in the design and delivery of psychologist training courses (BPS, 2018).

As CoPs numbers are increasing within NHS clinics/wards and MDTs, they are more likely to encounter PSWs who are also being recruited in line with the government directive, Stepping Forward into 2020/21, which details England's mental health workforce plan promoting the recruitment of PSWs to support the delivery of MHS (HEE, 2017).

This research aims to provide CoPs with a better understanding of how to support PSWs within the NHS.

Literature Review

This section provides a review of the literature relevant to this study. The concept of PS will be explored along with its current place in mental health services. It will contextualise the use of peer support within MHS and discuss its evolution from the deinstitutionalisation of mental asylums in the 1970s to its development as a new social movement. Research shows PS and the recovery model are fundamentally aligned. Although research is wide-ranging, with many studies developing a theory to guide clinical practice and support PS growth, how PSWs experience and make sense of their occupational identity has yet to be explored in detail.

Defining Peer Support

Across the literature involving mental health, there are definitional issues surrounding "peer support" where despite the current growth of this role, the definition remains elusive, complex and nuanced (Doughty & Tse, 2011; Gillard et al., 2014; Faulkner et al., 2013; Simpson, 2017, Penney & Stastny, 2019). This, in turn, complicates the task of providing a meaningful review of the literature. A significant difficulty in defining PS comes from the numerous terms used to identify the role. The current literature offers terms such as "peer support worker", "peer support specialist", "consumer-provider", "peer workers," "peer-delivered services," "self-help," "consumer services," and "peer mentors" (Gillard et al., 2013, Repper & Carter, 2011; Hamilton et al., 2015; Humm & Simpson, 2014; Penney, 2018). Furthermore, individual NHS Trusts name, define and train for the role differently.

However, authors concur that the philosophical foundations of PS are grounded in social constructionism, focusing on how individuals make sense of their challenges. This was described as "meaning is made in a context and can only be challenged in trusting connections where both people are allowed to be vulnerable" (Mead, 2016). Therefore, as a strategy for providing help, the approach is considered an extension of the natural human tendency to respond compassionately to shared difficulty (Penney, 2018).

Broadly defined, "peer support" is a concept relating to the help and support that people with lived experience of mental health challenges can give to one another by empathically understanding and sharing psychological and emotional experiences. "It focuses on an individual's strengths, not weaknesses, and it works towards the individual's well-being and recovery (Mental Health Foundation, 2020, p. 30). PS is well regarded as a means of improving recovery outcomes by developing good interpersonal relationships and focusing on person-centred treatment (Gates & Akabas, 2007; Hamilton et al., 2015; Humm & Simpson, 2014).

Watson (2019) comments that the definition of the PS role depends on who is describing it, which leads to significant differences in interpretation on psychiatric understanding and the language used by peers. She provides the example that peers describe the primary goal of PS as "responsibly challenging assumptions about illness". In contrast, psychiatry places more focus on service user engagement, describing PS as "a model of service which can enhance clinical recovery from mental illness" (Watson, 2019, p. 29).

The conflicting opinions on definition become more entrenched when PSWs find themselves working within highly structured environments (such as NHS), which lack peer supervision (Watson, 2019). Peer leaders responsible for developing and delivering peer support are encouraged to maintain the integrity of the role; however, this is often a local NHS Trust initiative. The recently published ‘Competence Framework for Mental Health Peer Support workers’ and the supporting documents reflects the wide diversity of opinion about the nature of the role (HEE/NHS, 2020).

Service User Groups

Foucault's text Madness and Civilisation (1967) theorises how power and knowledge are inextricably linked and affect how mental health is constructed both by and within society. Foucault argues the concept of 'madness' is not a naturally occurring phenomenon; instead, a categorisation of individuals who fall outside of the social 'norms' that govern behaviour within societies. Thus, those who fail to meet the categories defined by psychiatry and psychology have traditionally been classified as requiring "treatment and a cure". Foucault placed his attention on societal 'discourse' and called for a change to the robust, social structures that created the classifications system relating to madness, arguing it was designed as a means of power to control the 'insane' and thus make "mad" as 'the other' within society. According to Heidegger (1962), words can generate concepts that have previously not existed, often leaving individuals struggling to live an authentic life as a unique entity.

Early service user groups (SUGs) were formed through civil and human rights movements to rebel against psychiatry's treatment of those suffering from mental health problems. They perceived the restraint and overmedication of individuals as a violation of rights and claimed that traditional research methodologies made an exploration of the underlying psychosocial processes difficult (Stewart et al., 2008).

SUG objectives were firmly fixed on defining different theories to those based on existing psychopathological perspectives and to challenge the narrative and labels used within the dominant medical model that denies individuals a personal identity. They believe that individuals can develop understanding and confidence to move beyond the limiting self-concepts of diagnosis and disability by using education and peer support training courses.

SUGs continue to fight for the right to challenge the scientific knowledge used in clinical settings by understanding the lived experience evidenced by SUs (Roberts & Bannigan, 2018).

Mental Health Peer Support

"The best way to cheer yourself up is to cheer someone else up" Mark Twain

The literature surrounding the growth of peer support within mental health services in the United Kingdom (UK) is diverse, including research from peer support workers themselves (Watson & Meddings, 2019). PS is acknowledged as the fastest-growing profession within mental health (Rebeiro Gruhl et al., 2016) and recognised for its alignment with recovery-orientated care (Goldstrom et al., 2016).

Much attention has been given to the importance of implementing peer support programmes into MHS, along with the need to create sufficient posts to enable the PS service to be effective (Repper, 2016). However, despite various methodological and implementation issues, the UK is now beyond the ‘tipping point’ as PS is now accepted as a fixture within mental health services (Gillard, 2019). Indeed recent statistics from Health Education England (2020) show that most NHS Mental Health Trusts in the UK now employ peer support workers in various service delivery areas. However, despite this proliferation of PS, organisations frequently have difficulties integrating the role (Mancini, 2018). The continued success of these programmes will depend on how well they integrate and support people from all ethnicities, genders, socioeconomic classes and keep their focus on promoting equality and diversity as part of the implementation approach. Indeed UCL Partners, an organisation that collaborates with the NHS, industry and clinical research centres, supports a current project exploring the training and employment of PS workers. Their research to date notes, “the role use is sometimes limited, role specification is variable, training is inconsistent, and the structures required for the sustainable adoption and development of the role are sometimes missing” (UCL Partners, 2020).

The Evolution and Growth of Peer Support

By way of background, it is helpful to provide an account of PS development in the UK, which remains sparsely documented (Rose, 2016). Advocacy Groups established by former psychiatric patients and their families have protested the cruelty, confinement and indecorous treatment of mental health patients spanning two hundred years (Corrigan, 2016). For example, John Percival (a previous mental health patient who founded the Alleged Lunatics' Friend Society in 1845) lobbied parliament on the abuse carried out in asylums (Van Tosh et al., 2011).

In the 1960s, the perceived disparity between mental and physical health provision coupled with growing discontent with the reductionist stance adopted by psychiatry fuelled PS activist groups (Scull, 2011). As a result, grassroots political and advocacy groups of MHS SUs, psychiatric survivors, and human rights activists, contested psychiatrists' expertise and their treatment of those suffering from mental distress. Activists for civil rights, social inclusion and recovery (Campbell, 2005), campaigned to change the political and social structures concerned with mental health. They fought for a paradigm shift in traditional programmes, which they considered shrouded in stigma, medication and pessimism (Mosher & Burti, 1994). As a result, the transformational process of deinstitutionalisation occurred in the 1970s, moving responsibility for mental health patients from psychiatric institutions back into the community.

Regardless of contemporary criticism, the notion of recovery is recognised in over thirty-five countries and underpins much of their respective mental health policies. PS is also a central concept for healthcare providers worldwide (Davidson et al., 2010). It is acknowledged for its person-centred approach and promoting health rather than treating disease (Watson, 2017). The United Kingdom is now recognised for providing innovative PS solutions (Gillard, 2019). Before 2010, there was no evidence of PSWs within NHS England; however, by 2013, over seventy PSWs had been employed (Repper, 2013). Current records show the NHS now employs over 500 peer workers across the United Kingdom (ImROC, 2018). More recently, Health Education England published their plans for developing the role of PS within the NHS, proposing the creation of 8,000 new jobs over five years (HEE, 2017). The proposal was received with a degree of scepticism by Puschner (2018), who suggested the popularity of the PS role was due to the uptake of an untapped resource to help close the treatment gap within the field of mental health.

The resultant literature is diverse (Williams et al., 2012; Gillard, 2017; Matthias et al., 2012; Moran et al., 2018) but originates from four broad categories including:

a) Professionals commissioned by the Government to develop policies
b) NHS Trusts evaluating existing projects or developing policy for grassroots initiatives
c) Service providers, including community mental health professionals
d) Private enterprises that provide and evaluate peer support training courses.

Rebeiro-Gruhl et al. (2016) acknowledge that despite being poorly understood and frequently under-valued due to inadequate integration strategies, PS is considered the most significant contributor to recovery-orientated services. Pilgrim and McCranie (2013) warned that without the infrastructure to support the PS role, the standard evidence-based practice could leave the recovery process vulnerable. It remains unclear from current literature if MHS are developing strategic plans and practice to support this growth rate.

The Recovery Model

As recovery and PS are intrinsically linked, it is imperative to explore how the two concepts interact (Watson. 2017). Driven by a social movement concerned with influencing MHS, the recovery model refers to subjective experiences of empowerment and optimism and focuses on promoting collaborative approaches to treating mental health problems by utilising the PS role to help reduce stigma (Warner, 2010). However, recovery is not merely a rejection of the biomedical model but also a complex subjective phenomenon whose definition remains elusive (Bentall, 2010). Although recovery has evolved from service user/survivor's groups, professionals have predominantly interpreted and implemented it. Such interpretation is contrary to the methodology suggested by Shepherd et al. (2010), who advocate co-productions involving commissioners, local providers, SUs and carers, working together to transform services by setting agreed priorities and goals.

In response to criticism, Leamy et al. developed a conceptual framework of personal recovery by synthesising individual recovery experiences. They defined PS as “a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and or roles …a way of living a satisfying, hopeful and contributing life, even with the limitation caused by illness” (2011, p. 445).

Other studies have responded positively, believing Leamy's research created an empirical base for recovery-orientated practice that encouraged service transformation (Simpson et al., 2014). It is pertinent to note that although the framework is a synthesis of participant opinions, the sample did not include ethnic minority groups. Diversity is a significant factor, as individual recovery is not built purely on a medical understanding of the problem but relies on other constructs such as cultural and political factors valued by each person. For example, people from minority groups will have different cultural and political values to those of the general UK population. Further, promoting peer support within minority communities is essential as research shows these communities are frequently exposed to individual and societal challenges that can have a negative impact on their mental health (Williams, 2018).

It is not sufficient to purely recognise cultural and political differences between groups; we need to be mindful of how we work with ethnic minorities and the assumptions made. Ade-Serrano and Nkansa-Dwamena recently highlighted this matter by urging close attention to the individual identity of ethnic minorities rather than assuming an accepted homogeneity of experience, which for instance, tends to occur when referring to individuals under the BAME (Black, Asian and minority ethnic) banner. They respectfully reminded us, “historically, the inclusion of cultures and ethnicities under the one umbrella facilitated a unified voice in tackling racial discrimination quite rightly however it failed to nurture the validity and variety of ingroup differences. Furthermore, we miss the subtle levels of discrimination that can also occur within minority ethnic groups.” (2020, p. vii). With this in mind, future recovery frameworks should include the views and experiences of those from the broader community (Bhui et al., 2018).

Identifying The Self in Peer Support

Given the preceding origins of PS, it is relevant to note that identity theorists in sociology and psychology concur that identities are multifaceted and dependent on individual/interpersonal factors and are highly influenced by the social processes embedded within society (Davis et al., 2019).

Most relevant to this study is the concept of 'self' as defined by Mead (1935), who theorised how the mind and self-arise from social interaction and experiences. Central to his argument are the concepts of I and Me, which he posits to be the dynamic relationship that forms ‘the self’ (Hogg & Williams, 2000). According to Mead, the ‘Me’ internalises how we perceive how others view us. For example, it is the opinion we form of ourselves due to how others treat us. It then follows that the ‘I’ is the dynamic part of us that reacts to such internalisations. Mead considered the internal perspectives of ‘I’ and ‘Me’ might at times fuse. Still, in essence, Mead concludes that what we call our 'sense of self' comes from observing ourselves as objects of experience and an emergent product of social experience (Dunn, 1997).

A more recent theory of 'self' is provided by Baumeister (1998) when working to provide a framework for discussing 'the self', who concluded that there is no single core phenomenon to explain the concept of 'self'. Instead, he reluctantly posited at least three significant phenomena that constitute the fundamental roots of selfhood. Firstly, he acknowledges selfhood as a consciousness that turns towards itself, often referred to as ‘reflexive consciousness’ wherein the individual is aware of who they are and can recognise the self. Secondly, the self is experienced through interpersonal relationships, and thirdly, with this awareness of self, the individual can make choices and exert control over themselves.

Benefits of Peer Support

The purpose and benefits are multifaceted, affecting the SU, PSW, and healthcare system (Watson & Meddings, 2019). Social determinants, such as ethnicity and poverty, also affect the level of benefit achieved (Corrigan, 2016). Studies have identified benefits for PSWs such as shared identity, increased confidence, receiving salaries, and social contact. According to Repper (2013), having the opportunity to share their lived experience and provide psychosocial and practical support to SUs can also benefit the PSW. Overall, most of the reporting above indicates there is benefit in involving PSWs in MHS (Crisanti, 2016; Bailie & Tickle, 2015; Collins et al., 2016, Gillard, 2017).

However, there is little research exploring the direct benefits to PSWs or how their OI develops, as most studies focus on the benefits accruing to the organisation involved. The general well-being of peer workers once in the role is an area that would benefit from more qualitative research (Penny, 2017; Harrington, 2011).

Challenges to Peer Support

There is universal agreement that defining the content and structure of the PS role is challenging (Doughty & Tse, 2011; Gillard et al., 2014; Faulkner et al., 2013; Hutchinson et al., 2006; Simpson, 2017). Much of the current commentary around PS highlights the inadequate appreciation of the peer role by non-peer staff, which may be due to a lack of training and supervision for both PSWs and non-peer staff (Repper, 2013). This clarity issue makes it difficult to identify role commonalities across different services. Moran et al. (2013) explored the challenges experienced by paid PSWs and revealed three areas of conflict; work environment, occupational path and personal mental health. The discourse surrounding the first two work areas were extensively documented, but less than a hundred words were used to explore the PSWs personal mental health experience. There is a need to generate greater holistic awareness of the PS role.

Inhibiting Factors

Watson eloquently referred to PS as a concept that 'has grown beyond infancy' and is 'spilling out in all directions' (2017, p. 346). Her analogy paints a picture of how PS is being drawn into mainstream health systems without clearly defined frameworks and warns of the struggle still faced by PSWs who report a lack of appreciation and respect from traditional MHS. Unfortunately, Watson's research does not offer a way forward but does emphasise the need for greater understanding and awareness of non-peer staff attitudes and how they may affect PSW identity and well-being.

The current problems between PSWs and staff in MHS suggest a need to protect the PS role from being co-opted within the NHS and other large organisations. Since the 1990's the NHS has been working towards a system that empowers and encourages the involvement of SUs. However, this is still evolving, as a recent report from the Care Quality Commission alluded to some MHS being 'outdated' and providing care that leaves people' helpless and powerless' (2017, p. 1). More specific research could elucidate the benefits and cost of this trend.

Moving Beyond the Conflict

For the past twenty years, the Government has been driving for a person-centred coordinated care approach within the NHS (National Voices, 2017), in which service user-led organisations (ULO) provide one route towards that goal.

Rose et al. (2016) used an ethnographic approach to observe five ULO's within NHS Trusts. The data collected over twelve months consisted of observations and interactions with management and in-depth interviews with key informants. The lead investigator was a service user who added knowledge to the study as an expert by experience. They concluded that SUs have an immense and diverse opportunity to intervene across different areas of the Trust. Still, they were not always permitted to do so, which resulted in the Trust being perceived as 'tokenistic'. These findings are consistent with other research that found that NHS Trusts failed to provide recovery-based practice environments and did not promote the spirit of joint enterprise studies (Carlson et al., 2010).

Both studies above failed to acknowledge how the perception of tokenism could affect PSWs and the development of their role. The impact of this tokenism will be diverse and differ according to culture, sexual orientations or ethnicities. As counselling psychologists undertake various roles within MHS, they are well-positioned to promote equality and diversity. CoPs are mindful of "the importance of cultural and ethnic backgrounds and an awareness of difference, including visible, less visible, and mixed backgrounds" (BPS, 2019).

CoPs can mentor the need for change within the NHS by promoting alternative models to the prevailing biomedical model. Concepts such as the biopsychosocial model created by Engel (1977) to address the biological, psychological and social elements of the individuals being can help address the ‘less visible’ challenges faced by PSWs. Through sharing and fostering an open approach and remaining true to the humanistic values that underpin CoP, formulations can be developed to create greater awareness of individual distress.

Given the multicultural composition of UK society, Nkansa-Dwamena encourages counselling psychologists to approach their work "from an intersectional positioning, understanding how race and ethnicity, or sexuality and social class, or age and gender, or any combination of such variables will intersect and have an impact on the clients narratives and experiences" (2017, p. 29). Her approach is current and highly relevant as new MHS services and roles continue to be developed.

Intersectionality offers a framework and language to examine interconnections between social categories and systems by providing theoretical explanations of how individuals may experience the workplace differently, based on their ethnicity and other social locations. Intersectionality further emphasises the significance of validating and accepting every aspect of an individual's identity and their intersections (Atewologun, 2018). Adopting this approach can undoubtedly help CoPs empower PSWs by acknowledging the intersectional positioning of their subjective experiences.

CoPs are well-positioned to observe how these variables impact vulnerable individuals accessing services. An intersectionality approach can support CoPs working in accordance with BPS practice guidelines to better "develop services, policies and guidelines in collaboration with the people who use their services" (2017, p. 29).

Without intersectional positioning or awareness of other frameworks that consider these dimensions of experience, we may simply continue to create inequitable systems and intersections that potentially promote oppression, domination and discrimination (Thompson, 2017). Therefore, a cultural shift is required to enable minority groups to benefit from PS and the recovery model. Such a shift could commence by ensuring all communities are actively included in the planning of service provision.

Acknowledging and Respecting PS Values

Much has been written about the values that underpin PS. For example, Gillard et al. (2017) developed a principles framework to evaluate and develop PS in MHS. The authors considered PS to be an established role within the NHS but raise concern for the sustainability of the distinctiveness of PS. They called for further research to explore how best to protect their values.

Gillard's research is indicative of the challenge facing PSWs as they state that without reflective practice and attention to values-based services, the conventional ways of conducting research will constrain proper evaluation of the effectiveness of PSWs "lived experience". However, as with most research surrounding PS, there was a secondary aim. In this case, the study was to develop a handbook and fidelity index to help guide randomised controlled trials (RCTs). As the NHS value RCT for developing strategies and implementing change, this advancement may help to extend the PS pathway.

Historical Challenges in the Workplace

Moran et al. (2012) studied the challenges experienced by PSWs in the work environment using a grounded theory approach to interview thirty-two experienced PSWs. The study identified many issues such as dissatisfaction with payment, supervision, and conflicts arising from role description or the lack of it. PSWs reported expressions of prejudice from members of multi-disciplinary teams (MDT), particularly in organisations operated by non-peer groups.

Such issues were addressed ten years before by Carlson et al. (2001). They recommended that conflict resolution methodologies need to be in place to enable PSWs to grow in line with the demands of the organisations.

Moran's results provided critical insight into inconsistencies across organisations and emphasised the need for more research on the effect of work on PSW personal development.

Early Effects of Employment and Self-Identity

Bailie and Tickle (2015) systematically synthesised qualitative research exploring how employment affects PSWs perceptions of personal recovery. The study focused on peers providing Intentional Peer Support (IPS). Mead describes IPS as "using relationships to see things from new angles, to develop greater awareness of personal and relational patterns and to support and challenge each other in trying new things" (2016, p. 31).

Using a grading criterion to appraise the quality of research across ten studies, they reported significant differences. They consistently found a sense of self-identity to be a key influencer in personal recovery. Most of the studies detailed self-esteem and self-confidence as by-products of personal growth and found that performing the role can potentially be "both facilitative of and detrimental to personal recovery" (2015, p. 57). These studies reported negative comments from peers working in professional teams who considered themselves as undervalued. The causation was not reported. Interestingly, the studies that the authors considered to be of acceptable quality came from samples that predominately involved PSWs, whereas the remaining studies used a mixture of peer workers and professionals.

They concluded that while PS potentially aids recovery, it is not always the case. The research found that working in a non-supportive environment where guidelines are ill-defined can impede recovery for SUs and PSWs. It is interesting to note that the authors were both clinical psychologists and did not involve PSWs in the reporting process. Using peer workers may well have enriched their study by colouring opinions on how recovery is interpreted and what facilitates or hinders the process from a PS perspective.

Similar conclusions have been drawn by Gillard et al. (2014), who emphasised the importance of using PSWs to help co-produce research, considering them to be a vital element of engagement and authenticity.

Economic Factors

From a different perspective, PS also aligns with economic agendas by generating cost benefit through re-employment. Further, according to some authors, PS helps to reduce hospital re-admission rates and length of stay for inpatients (Repper & Carter, 2011, 2013; Faulkner & Basset, 2012; Kemp & Henderson, 2012).

When attempting to review the cost-effectiveness of PS, Trachtenberg et al. (2013) reported that financial benefits to services outweighed the cost. However, gaining a clear picture of economic benefit is complicated as many studies indicate methodological problems due to the infancy of the peer role and a lack of defined terms.

Current policymakers and budget holders grapple with the disparity between the cost of physical and mental health provision. However, the Chief Medical Officer has reported that mental health problems "constitute the largest category of NHS' disease' expenditure in the UK (Department of Health, 2016, p. 5). Despite these statistics, the Nuffield Trust (2015) has posited a significant treatment gap in mental healthcare, where more than 75% of people with mental health problems receive no treatment at all.

The Cost of Poor Mental Health

It is understood that a fair society is composed of people who make their contribution via the voluntary or paid work they do (Wilkinson & Pickett, 2010), which is also a well-known factor in fostering recovery (Pilgrim, 2005). Current statistics suggest that 57% of people who use MHS are unemployed (DOH, 2016), creating room for dialogue between service decision-makers and those advocating equality and increased employability.

In the UK, poor mental health is estimated to cost the Government £24-27 billion per annum and employers £33-42 billion per annum. A further calculation reports that poor mental health costs the economy between £74 and 94 billion (Stevenson & Farmer, 2017).

These numbers have considerably more significance for lower socioeconomic classes, as Picket et al. (2006) reported a positive correlation between socioeconomic inequality and poor mental health. As PSWs continue to build their social support systems by working on self-discovery and enhancing their recovery, it is hoped they will become significant agents in reducing the burden of mental health (Corrigan, 2016). In a similar vein, the discipline of CoP is motivated to help change social inequalities by spreading awareness of deprivation in society.

Inconsistencies in Research

The exact mechanisms attributed to the success of PS have been problematic to identify, as the literature reports the benefits inconsistently, making results difficult to interpret and compare (Mahike et al., 2014).

This variance can be demonstrated by discussing the results of two studies carried out by Bracke et al. (2008) sociologists and Gillard et al. (2014), a self-acclaimed standpoint epistemologist. The sociologists gathered data using structured questionnaires that were not well-established psychometric scales for this purpose. However, they were recognised for providing good quality reliability and predictive validity in measuring support inequity. They reported the positive effects of PS to be overestimated and suggested that the main benefits were felt by the PSWs rather than SUs receiving the support.

In contrast, Gillard et al. (2015) used Grounded Theory to analyse data from fifty-one qualitative interviews with service users. They argued that participants narratives suggest that PSWs significantly reduce psychiatric inpatient admission and helped increase empowerment for service users.

The variation in opinion between the two studies may be due to different research methodologies and where the epistemological position adopted may have influenced the quality of the data collected. Still, in the absence of clearly defined standards for PS, qualitative methods may serve best to critique and strengthen the richness of future data.

Differing Values and Psychiatrists

The views and opinions of healthcare professionals have significantly impacted the implementation and emergence of PS (Bailie & Tickle, 2015). Psychiatrists have substantial influence within the NHS. However, notwithstanding Gordon (2005), little can be found in the literature that voices their opinions on the employment of PSWs.

A qualitative study by Collins et al. aimed to address this gap. They interviewed psychiatrists in the East of England and found their views to be broadly positive towards the PS role, despite classifying their comments as "Rationalist or Sceptic" (2016, p. 57). Although the research did not identify explicit resistance towards future PS development, they did find psychiatrists questioned how PSWs might handle their emotions and boundaries when in situ. Their attitudes seemed to contradict an earlier paper where those psychiatrists interviewed had no awareness of the process or mechanisms used to introduce PSWs into the service or the details that the role entailed.

A more cynical comment was voiced by Davidson et al. (2012), who claimed their fellow psychiatrists pay lip service to PSWs to conform with policy. Although he is known for his outspoken views, he questions whether psychiatry sees PS as a transformative role for MHS or one to be exploited by them.

Similarly, Bentall noted that "psychiatry’s greatest sin has been to crush hope in those it claims to care for and without hope, the struggle for survival seems pointless. With hope, almost anything seems possible” (2010, p. 288).

Peer Support Proliferation

NHS Trusts countrywide are developing individual PS interventions without consensus on the best implementation approach for these projects (Gillard et al., 2017). Despite this, the teams that had the most success adopted strict adherence to recovery-based practice. It is reasonable to assume that a significant shift from the current biomedical model, subscribing to a rigid positivist epistemology, will be necessary to accommodate this evolving role more effectively. It will rely on management facilitating a change of perception across the organisation by directing staff towards open and transformative relationships. Research exploring how PSWs are experiencing and identifying with the role would help identify additional signage to achieve this goal.

Challenges To Peer Support

In the main, the literature exploring the challenges to PS has not altered significantly over the past two decades. Mowbray et al. (1998) and Davidson et al. (1999) gave an account of the benefits and limitations experienced by PSWs. Both studies acknowledged the recruitment of peer mentors as a positive addition to formally trained mental health teams.

However, they posit that although professionals undergo significant training, they are still unable to meet all the needs of SUs and stressed the importance of having functional support systems in place to allow the growth and professional development of PS. The need for support arose from comments made by PSWs, who perceived that professionals lacked an understanding of their role and were apathetic in supporting them (Davidson et al., 1999). How such attitudes affect PSWs occupational identity remains unknown.

More Recent Developments

In 2011, Repper and Carter reviewed the literature focusing on PS in professionally led services. Their motivation was driven by the intention to employ PSWs in a local MHS. They acknowledged that the literature on experimental trials was limited. Those scrutinised reported little evidence of positive results from PS involvement, which could be due to a lack of clearly defined PS roles within the evidence-based practices. By taking a broader view of the literature, they were able to identify that peers are better at promoting belief in recovery than non-peer staff.

Implementing Recovery through Organisational Change

Repper and Carter (2012) established the ImROC Programme (Implementing recovery through organisational change), which is a collaboration between the NHS Confederation's Mental Health Network and the Centre for Mental Health. The organisational goals address the culture of MHS by “developing systems, services and cultures, that support recovery and well-being for all” (ImROC, 2018).

Slade et al. (2014) saw this programme as aiming to transform services away from a treat-and-recover approach by emphasising an equal partnership between professionals and people with lived experience. Jacob (2015) further suggests that focusing on a shared vision of recovery is a worthy goal that would benefit all mental health professionals. The research had international support, with each study adding to the analysis of what constitutes good practice for peer support (Slade et al., 2014; Bracke et al., 2008; Faulkner & Basset, 2012).

Recovery Colleges

ImROC was also responsible for introducing Recovery Colleges across the UK, classified as formal learning institutions, open to those with lived experience of mental distress, and where many of the trainers are peer workers. Recovery Colleges have grown exponentially. In 2011, there were less than eight colleges, but by 2017 the number had risen to over 70 (Anfossi, 2017). Although the initiative is another avenue for PSW involvement beyond staff training, the literature suggests that colleges are typically operated by non-peer staff. Only one college is currently under the management of an experienced peer worker. A better balance between non-peer and PSWs staff numbers/experience will be essential to promote equality within workgroups and help foster better PSW experience and a resultant positive OI.

Summary of the Current Literature

The ethos and values that underpin PS have attracted extensive commentary on the workers' identity and how the ‘role’ of PS is defined, executed and developed within the NHS and other large organisations. These reviews have detailed how PS is optimised in a process sense by exploring how the role fits and contributes to organisational aspirations.

More in-depth studies have developed conceptual frameworks to guide RBP and the outcome measures necessary for evidence-based practice. Workforce and finance-related challenges have been documented, and the underpinning processes reviewed. Other research highlights the inconsistencies of PSW job specification and salary across different NHS Trusts, where each generates an interpretation of the job roles.

Exploring studies from the southern hemisphere and North America suggests that these countries have also overlooked other holistic effects of the role and how PSWs experience their OI.

Although understanding the PS role and its perceived efficacy within the NHS is improving, the authors do not acknowledge how PSWs understand their OI. The studies fail to explore the subjective expertise of PSWs and how they develop and maintain their OI over time.

Conceptualising Occupational Identity

Before reviewing the concept of OI, it is relevant to briefly explore the concepts of self and identity as both have received significant attention in the behavioural and social sciences (Hogg & Vaughan, 2005) and are terms used throughout this research. Furthermore, identity is a significant cornerstone within sociological thought. The initial concept of 'self' was introduced by Mead (1935), who declared the self to be multi-layered and arising through social interaction with others. According to Mead, "the individual possesses a self only in relation to the selves of the other members of his social group" (Dunn, 1997, p. 29).

Therefore, in the context of this thesis, the self will be considered a bridging mechanism between social structures where the individual's attitude and behaviour are said to provide the motivating force for wellness (Baumeister, 1987). Together they are viewed as social identity and a significant element of one's self-concept, further defined as the sum of an individual's belief and knowledge concerning personal attributes and individual qualities.

The link between occupation and identity was made by Christiansen (1999), who coined the phrase "occupational identity" by exploring the concept of personal identity as a psychological concept and suggesting that identity is expressed through occupation. OI theorists emphasise the individual self as having control over its identity and refer to OI as a dynamic identity achievement (Skorikov & Vondracek, 2011). However, as an emerging construct within the field of occupational sciences, the assumptions that underpin OI are the focus of much research and debate (Phelan & Kinsella, 2009).

The dominant elements of discussion on what factors contribute to OI are; self-efficacy, self-confidence and self-esteem, and personal attributes such as success/motivators/goals/achievements, and personality traits. There appears to be little reference to broader social or collective notions of identity, except to link the impact of social worlds on the developing "self" (Christiansen, 1999, 2004; Kielhofner, 2008a, 2008b; Unruh, 2004; Unruh et al., 2002).

Having a conscious awareness of who we are as workers is said to be the essence of OI and the channel through which we communicate our identity (Schwartz & Vondracek, 2011). Christiansen (1999) posited that building a positive identity through occupation is essential to "creating meaningful lives, and life meaning helps us to be well" (p. 547). Likewise, Kroger (2007) conceptualised OI as a significant component of one's overall sense of identity, which often develops within the individual's dominant cultural narratives. Others make individualistic choices or are forced into constructing an OI through life circumstances, and where both serve to provide a vision that moves the individual forward with their life. (Rudman & Dennhardt, 2008).

Although there is not the scope to cover the numerous concepts of identity linked to OI, scholars most commonly make connections between self-identity, work, and occupation. However, there remains a paucity of literature exploring how work affects identity, which was succinctly addressed by Smith "while the problem of self-identity is one of the central philosophical issues of our times, philosophers have paid scant attention to the self-formative role of work, even though work (the search for it) occupies the bulk of most adult peoples waking life, shaping the sense of self in a myriad of conscious and unconscious ways" (2016, p. 24).

Whalley-Hammell (2013) asserts that occupation is a critical enabler for people in recovery as it can lead to an enhanced quality of life (QOL) by creating meaning, belonging and doing. A balance of all three elements is said to be a central part of living well. The literature shows this process to be a complex, subjective experience, where individuals shape their identity as their life story unfolds and is further influenced by a myriad of factors that include but are not limited to age, gender, socioeconomic-class, (dis)ability, education, religion along with their expectations of the role in question. It remains, therefore, that forming an OI can be a complicated and stressful process.

Literature specifically relating to occupation and recovery posits that by participating in a meaningful and valued occupation, individuals can foster a positive identity through feeling empowered and hopeful (Wilcox, 2009). It is also acknowledged that the relationship between occupation, identity and an individual’s environment are essential elements of OI. Phelan and Kinsella (2009) postulate that further debate within identity theory and occupational science is necessary to understand the implications and influences of social, cultural, and relational concepts of the self and their impact on OI. Scholars in the field of identity theory state that OI is an essential contributor to psychological well-being, and it is the well-being of PSWs that is of interest to the author (Skorikov and Vondracek, 2011).

Exploring the Way Forward Through Occupational Identity

There is limited research on how PSW performance at work impacts their recovery and the SUs they support (Repper & Carter, 2013). A valued identity is a critical factor in establishing recovery (Leamy et al., 2011) and is a primary focus for PSWs. It is further relevant to note that relationships are a key influencer in shaping identity, providing coherence, promoting well-being and providing a social structure for change (Gewurtz & Kirsh, 2007).

Thoits (2013) acknowledged the loss of identity as a significant marker for those suffering from mental health problems, which are often manifested and compounded by stigma (Corrigan et al., 2011). Stereotyping and social ostracism directed towards those labelled with mental health issues can lead to feeling disenfranchised, engulfed by helplessness and a loss of any sense of self (Mead et al., 2002).

According to Hilton & Curtis (2001), the recovery process, also known as the empowerment process, is the enabler that helps undo the identity of ‘patient’. Empowerment is seen to promote social, personal and relational change, which can assist individuals in exploring the self. Given the substantial national initiatives aimed at removing the societal stigma that affects the lives of people in recovery from mental health problems, it is considered significant to understand how PSW OI is reconstructed and developed in parallel with recovery (Department of Health, 2005: 2009: 2015).

Occupation is acknowledged as a central element of identity (Schwartz, 2011), which is often manifested in lower levels of depression and higher levels of life satisfaction (Skorikov 2008). Therefore, having a positive OI can be a predictor of good health and well-being.

For clarity, identity is defined on three levels: individual, relational and collective (Sedikides & Brewer, 2001), with OI often referred to as the vehicle through which individuals can express their identity (Christiansen, 2004).

Proposal for the Research Question

Occupational identity is described as a separate dimension of the identity status models, relevant to the proposed research. According to Skorikov and Vondracek (2011), OI contributes to psychological wellness and social adaptation and is conceptualised as “a major component of one’s overall sense of self” (p. 694). In turn, this influences meaning and structure for an individual. They further posit more research is needed to better understand how OI structure and content are engineered.

Over the past fifty years, social sciences have contributed to the concept of identity, positing it to be a multifaceted construct referred to across different theoretical and metatheoretical perspectives (McCall & Simmons, 1978: Heise & MacKinnon, 2010: Hogg, 2006). Within social psychology, the identity theory framework includes substantive issues such as the role emotion plays in processing identity and the multiple identities that form part of the identity process (Stets & Serpe, 2013).

Dyble et al. (2014) explored the transition of service users becoming service providers. The research demonstrated the process to be complicated, individualistic and a changeable experience where SUs were seen to have fluctuating identities at each stage of development. Their journey involved moving from the more rigid boundaries of a patient to a range of blurred boundaries when enacting the role of a service provider. PS is considered a bridge between SUs and professionals, helping to create increased self-efficacy and a more definitive identity.

Similarly, Simpson et al. (2018) referenced the formation of PSWs OI by exploring the use of their lived experience, professional training and how they might engage within services as they begin to redefine a sense of self and reconstruct their identity. The study found the process involved an interplay between three elements of self-identity, e.g. self at work, self as trainee peer worker and self as sharing lived experience. They concluded that newly recruited PSWs develop a liminal identity which, according to Beech, is “a position of ambiguity and uncertainty” (2011, p. 287). They cautiously recommend formalising and professionalising the PSWs role to negate the undesirable effects of a peer’s liminal identity. A limitation of Simpson's research was the length of time the PSWs had been employed in the role, with the maximum period being six months. This lack of experience could imply that identity development was still in its embryonic stage.

The current *modus operandi* has not produced research that fully embraces the lived experience of PSWs. When contemplating the future of PS, it is essential to remember that this vulnerable group are often still working on their recovery.

Therefore, this research proposes to explore the lived experience of mental health PSWs developing their OI by using the qualitative method of Interpretive Phenomenological Analysis. The intention and objectives of the research are to address the gap in the existing literature by providing:

a) an account of how PSWs develop and experience their OI while working within an urban NHS Trust

b) generate a greater understanding of how PSWs react to their work environment by reflecting critically on how the current system aids or inhibits OI growth.

It is hoped such data could ultimately help inform policies and PS implementation plans.

Methodology

Research Design and Rationale

The following chapter provides an account of the pivotal stages in selecting a qualitative phenomenological approach to explore how PSWs experience the formation of their occupational identity and my rationale in using Interpretative Phenomenological Analysis ([IPA], Smith, 2017).

Given that research methods are informed by their epistemological position, the philosophical underpinnings of IPA are presented together with reflections on my ontological/epistemological position. Further, I will demonstrate why IPA best aligns with the aims of this research, despite some limitations outlined below. This will be supported by a critique of IPA and a discussion of the process used to ensure the validity of this study

(Tuffor, 2017). Finally, the chapter concludes with a detailed explanation of the processes used during data gathering and analysis, together with an evaluation of the ethics used throughout the study.

Reflections of the Research Journey

When I started this doctorate, identifying a meaningful topic that would also make a significant contribution to counselling psychology research created some fear and uncertainty. I spent the first year researching the concept of peer support and found some peace by identifying a research question that could add to the existing literature. However, during my second year, I was informed by my supervisor that a thesis addressing the same question was about to be submitted. I remember feeling stunned as the feelings of uncertainty returned. Given reflexivity lies at the heart of CoP, I began reviewing earlier entries in my reflexive journal that traced my developing thoughts and ideas around the topic. It was evident from these notes that my interest and concern was to promote awareness and equality for PSWs, rather than identifying an area for change or defining an explicit outcome. This provided peace of mind by understanding that although the research question had to change, the topic I had already researched could remain.

I remember feeling an instant connection to a paper by Simpson et al. (2018), who defined PSWs as having a liminal identity and describing them as betwixt and between service user and service provider identities. The study resonated deeply as I was also transitioning to become a CoP. As the literature had not explored how PSWs experience their occupational identity, my research question finally came into focus. I was able to apply for ethical approval from the university. Following that process, I remained mindful that I needed a sponsor with the NHS and consent from the Health Research Authority.

Methodological Considerations and Research Design

Research relating to qualitative and quantitative research methods often offer vastly different views of the research subject (Denzin & Lincoln, 2008). I recognised that a crucial element of research is knowing when and why to use what method (Cohen and Crabtree, 2008). The decision-making process was influenced by my objective of wanting to address the gap I had identified in the current literature surrounding PSWs forming an occupational identity. Qualitative approaches differ significantly from quantitative methods, where the latter focuses on hypothesis testing, predictions, and variable manipulation rather than social reality (Willig, 2013). Given the objectives of this study were to understand PSWs subjective experiences rather than seeking to locate an empirically based truth, I felt logically justified in disregarding quantitative methods (Silverman, 2007).

Although qualitative methods are an umbrella term covering many different methodological approaches, there are re-occurring attributes across this group of methods (Lyon & Coyle, 2007). In principle, qualitative research enables the researcher to gain a holistic understanding of the phenomena in question. It draws on a philosophy of curiosity to develop greater awareness, of knowing what can be known of an individual's situation and how it is experienced (McLeod, 2013). Although embedded in a unique perspective of data analysis, each qualitative method holds the commonality of an inductive approach that is underpinned by reflexivity and subjectivity (Rafalin, 2010). It felt important to create a space for participants to freely express their lived experiences and how their occupational identity developed over time. With this in mind, a qualitative approach was deemed most appropriate to allow multiple interpretations and meaning to be explored (Toloie-Eshlaghy et al., 2011).

Phenomenological Approaches and Counselling Psychology

As I had adopted an interest in phenomenological approaches within the qualitative research paradigm, my next challenge was to understand the various philosophies that underpin the process and how the phenomena in an individual's consciousness are experienced, allowing their account of time, context and social environment (Willig, 2008). This can be better understood by considering Husserl's concept of intentionality (Smith Flowers & Larkin, 2009), which suggests that an individual's consciousness is always focused on an intentional relationship between their consciousness and wherever this is placed. Individuals, therefore, are intrinsically linked to the phenomena that they experience in the world rather than being separate from it.

Within phenomenological research methods, three fundamental principles prevail epoche, phenomenological reduction, and imaginative variation (Willig, 2008). Husserl's concept of epoche also referred to as bracketing, relates to phenomena as they are and are not considered influenced by other assumptions. On the other hand, phenomenological reduction aims to uncover different layers of meaning relating to the phenomenon in consciousness by providing a detailed account of it. When the phenomenon within conscious experience requires further meaning, imaginative variation allows different perspectives to emerge (Langdridge & Hagger-Johnson, 2009). The principles briefly described here are further characterised as relating to either a descriptive or interpretative phenomenological approach.

The first to use descriptive phenomenology was Husserl, who drew on the belief that the researcher should bracket all past knowledge and assumptions about the phenomenon under investigation to keep the focus on the participant's experiences of the phenomenon. This view contrasts to those held by Heidegger, who presented an interpretative phenomenology approach by drawing on the tradition of hermeneutics. Heidegger posited that description and interpretation are inseparable and that description is another form of interpretation (Willig, 2008). This approach acknowledges that interpretation will always be influenced by the researchers fore-conceptions (Smith et al., 2009).

The above is given by way of contextualising phenomenological methods and how they fit within counselling psychology. Given CoPs core value of privileging their client's subjective experience, along with their pursuit of innovative phenomenological methods for understanding human experiences, an interpretative approach was considered appropriate to address the research question (Bury & Strauss, 2006). Therefore, the idiographic approach of IPA was selected as the most appropriate interpretative method for this research. My rationale for this decision follows below.

Rationale for Choosing IPA

IPA is considered more a framework than a method, as it remains concerned with the deeper levels of epistemology and ontology sitting within the existential-phenomenological research paradigm (Braun & Clark, 2013). This aligns with CoPs humanistic value base and its explicit use of a phenomenological and hermeneutic inquiry (BPS, 2018). IPA places its focus and exploration on the individual's unique functioning and meaning-making processes (Cooper, 2009).

Much consideration was given to the sensitive nature of this research and the need for a robust and appropriate methodology to explore the participants lived experiences and meaning-making through a non-directive lens. IPA is acknowledged for its ability to adopt an advocacy role by helping to highlight processes of marginalisation and identify areas in which people are misunderstood (Larkin, Shaw & Flowers, 2018). I felt IPA would provide sufficient analytical depth to explore the participants underlying assumptions and how their processes could be shaping their views of society and the dominant culture in which they reside (Lopez & Willis, 2004).

IPA is a popular tool when researching areas that are as yet unidentified (Morrow, 2005) and for the analysis of "identity changes associated with major life transitions" (Smith, Larkin & Flowers, 2009, p. 163). Further, IPA describes and documents rather than providing explanations (Willig, 2013). These attributes added to my confidence that IPA was appropriate to explore PSWs developing occupational identity. The approach also aligns well with the ethos and theoretical underpinning of peer support by valuing individual subjective experiences of mental health. IPA also offers a holistic approach that allows further focus on the integrated self (Dickson, Knusssen, & Flowers, 2008) and aligns this research with CoPs humanistic values and recognition that human beings are relational in nature.

Double Hermeneutic

As previously discussed, the interpretative lens applied in IPA is also noted for its alignment with the philosophy of hermeneutics. Heidegger articulated that what we experience and encounter is interpreted, so we may be examining that which could be latent or disguised (Polt, 2013). The double hermeneutic approach applied by IPA is most apparent when the researcher is trying to make sense of the participant world while the participant is attempting to make sense of their own experiences (Tuffour, 2017). IPA recognises the interpretive nature of the approach and that by bringing phenomenology and hermeneutics together, our understanding of phenomena through an interpretative lens will be enhanced (Smith et al., 2009).

During the interpretation process, I remained aware of the limitations preventing complete understanding of the participant's inner world and acknowledging my assumptions, which could have thwarted the “process of interpretative activity” (Smith, 2011, p. 264). However, by remaining conscious of how this ‘double hermeneutic’ is reported in IPA analysis, I fully engaged in a reflexive process that provided insight into how I could be shaping the research (Smith & Osborn, 2008). Thus, I consider that by using IPA for this study, I have been able to provide an authentic account of the participants' experiences, along with an honest appraisal of how I have positioned myself in this research.

Methodological Criticisms of IPA

Each qualitative method presents its underlying conceptual framework, together with ontological and epistemological viewpoints. In choosing IPA, I remained mindful that the method's limitations should not impair the quality of the study (Hollway, 2007). Bearing this in mind, the criticisms directed towards IPA have been considered in the context of Yardley's (2011) core principles for evaluating validity, which emphasise that producing a good quality study is essential and should not result in researchers using rigid checklists that restrict freedom and flexibility, as all research comes with its specific perspective (Howitt, 2010).

According to Tuffour (2017), IPA is frequently criticised for its substandard recognition of the integral role language plays. However, while accepting that meaning-making takes place in the context of discourse and individual narratives, I would argue that gaining an insight into participant experiences is always interwoven with language. There is further criticism of IPA, querying if participants and researchers have the necessary communication skills to effectively relate the nuances of the experience under investigation. I suggest this is an elitist perspective that could potentially dismiss IPA as a method for exploring sensitive issues such as mental health challenges. This criticism appears to indicate that only the most eloquent can describe their experiences. Overall much of the IPA criticism suggests that the approach is descriptive and not interpretative and that there is little standardisation, resulting in a process that is full of ambiguities. There is, however, a growing volume of publications that address the approach and infrastructure of IPA, answering much of this criticism (Tuffor, 2017). Given the small sample sizes used, generalizability is often quoted as a limitation of the method. However, findings from IPA studies contribute to and influence theory (Pringle et al., 2011). Despite the noted limitations of IPA, the method remains consistent with the aim of this study and with the philosophical underpinnings of counselling psychology and the peer support movement.

Epistemology and Ontology Reflexivity

In addition to the reflexive statements above, the intention here is to provide an account of my epistemological and reflexive positions, acknowledging how they may impact the research methodology and reporting (Willig, 2013).

While ontology and epistemology are not considered independent of each other, matters relating to what can be known about the nature of what exists in the world is more of an ontological inquiry (McQueen & McQueen, 2010). By assuming a relativist ontological position, I believe reality can be interpreted in many ways and remain focused on subjectivity rather than adopting a rigid objective way of being (Willig, 2013).

Although epistemology is often considered an off-putting concept by those new to research, it remains a crucial element. Epistemology posits views on what can be known (Willig, 2013). It is concerned with the theory of knowledge by helping to define how we study and generate knowledge and what forms of knowledge are possible and legitimate (Slevin, 2001). As the researchers' methodology depends on their epistemological position, I understand the importance of first considering my position before selecting a research method (McLeod, 2013). IPA is described as compatible with critical realism and contextualism, which both strike a midpoint on the ontological continuum between positivism and constructionism (Madhill et al., 2000).

As a critical realist, I acknowledge the concept that there are stable realities such as experiences and events existing beyond our social construction and that different perspectives will influence individual experiences of that reality (Bhaskar, 1975). I endorse the assumption that socio-cultural and historical processes are somewhat responsible for shaping how an individual will contextualise and make sense of their life (Eatough & Smith, 2008). Consistent with critical realism, I also acknowledge the inherent subjectivity between humans, such that I can never wholly understand the participants' view of the world, but only partially develop a sense of how they may have thought and felt about specific experiences (Smith et al., 2009).

Therefore, it is imperative when generating knowledge that we validate the viewpoints of others. Similarly, counselling psychology's core values are based on philosophy and practice honouring individuals' social context and meaning-making (Strawbridge, 2016). Willig (2013) encourages researchers to engage in epistemological reflexivity to congruently remain aware of assumptions that may form during the research process.

Other Qualitative Approaches Considered

Before deciding to utilise IPA for this research, I considered other qualitative approaches compatible with the research question and my epistemological position. There were a number of closely contending methods, in particular discursive approaches (DA) and Grounded Theory (GT).

Discursive Analysis

DA, which adopts a social constructionist view of language, was considered due to their commitment to the study and use of language and the central concept of individuals creating and negotiating the meaning of events (Parker, 2013). For example, Foucauldian Discourse Analysis (FDA) is based on the 1970's post-structuralist philosophy of Michel Foucault and is used to explore the relationship between subjectivity and language. Therefore, allowing the researcher to take a constructivist approach on how an individual uses language to construct versions of their world, resulting in discourse being constructed rather than reflected.

By comparison, phenomenological research such as IPA places more emphasis on the meaning given to experience. For these reasons, discursive approaches were not considered appropriate (Langdridge et al., 2009).

Grounded Theory

Developed in 1967 by Glaser & Strauss, GT is frequently considered an alternative to IPA, and both are commonly used in health psychology to explore social phenomena (Smith et al., 2009).

However, the significant difference between the two and why GT was deemed unsuitable for this project is that GT's core focus is on generating theoretical explanations for the phenomenon under investigation (Starks et al., 2007). IPA, on the other hand, remains focused on reporting how individuals experience their inner psychological world.

As the essence of this study was more aligned to elucidating and making sense of the individuals lived experience and not generating a theory, I felt the best approach would use a psychological rather than a sociological framework (Willig, 2013). Moreover, the aim of this research was not to identify factors that influenced outcomes.

Design

Participants

In line with IPA's use of relatively small purposive samples, six experienced PSWs employed within the same urban NHS Trust were recruited (Smith & Eatough, 2007). All participants were in paid employment. Five worked in a community setting, and the remaining participant was employed in a high-intensity psychiatric ward. This information is highlighted to help contextualise their experiences within the findings. Participant demographic data is provided in Table 1 below:

Table 1

Participants' Demographic Information

Pseudonym	Age	Gender & Ethnicity	Time employed in paid Peer Support
Arthur	36	Male - Asian British	Four years+
Martin	42	Male - White British	Ten months
George	38	Male – Black British	Two years, seven months
Jordan	51	Male– White British	Seven years+
Nancy	47	Female–Asian British	Two years and six months
Winifred	37	Female – Black British	Three years and eight months

Inclusion Criteria

Participants were required to meet the inclusion criteria of having completed their PS training course within the trust to help increase the homogeneity of the sample. Further, they were required to have been in paid full/part-time employment with the Trust for a minimum of six months. Six months was considered an appropriate period of employment experience that could account for training, assignment to departments, and PSWs to gain exposure to SUs and staff. It was expected that within six months, they might have experienced a shift in their sense of self and be able to talk about how their occupational identity was forming.

Recruitment

The decision to recruit a sample from one NHS Trust was considered to add to the sample homogeneity as detailed in IPA (Smith et al., 2009). The NHS sponsor for the project agreed to email details of this study to paid PSWs for their consideration (Appendix C).

Before deciding to participate in the research, those interested were asked to contact the researcher directly by phone or email to understand the study in more detail.

Coercion was not used at any point in the recruitment process. For example, I accepted an invitation to attend the trusts annual mental health games day, where I was introduced to several PSWs and discretely discussed the study with each of them. There was, however, no follow up or agreement to participate from that event. On reflection, I felt they might have had concerns about confidentiality. I, therefore, declined an offer to attend the PSWs monthly meeting, fearing this might also compromise participant confidentiality.

However, due to a lack of participant interest, and by agreement with the NHS, it was considered prudent to offer a £25 Marks and Spencer voucher, plus travel expenses, to cover the cost of participation. Consequently, the approved ethical application was amended, resubmitted and re-approved, before details were recirculated to PSWs.

Eight participants responded via email and were sent a full explanation of the aims and process of the research (Appendix D). The information explained that interviews would be conducted in person and be audio recorded. Although explicitly stated in the information provided, it was repeated before the interview that verbatim sections of the transcribed (albeit anonymised) text might appear in the final thesis. Of the eight people that registered interest in participating, two failed to meet the selection criteria. Thus, six participants were finally recruited.

Ethical Considerations

Interviews and Data Collection

Gathering data from semi-structured interviews was described by Smith and Osborn (2003) as an exemplary method, allowing the implementation of IPA's inductive epistemology. By gently guiding the participants around the area of interest and encouraging them to talk openly about their experience, this approach can account for the emergence of any unanticipated areas participants may wish to mention.

The interview schedule (Appendix E) was developed in line with the study's aims and the guidelines relating to qualitative research design and planning (Smith et al., 2009), together with informed detail from the literature surrounding PS and OI and points raised in supervision.

Using open-ended questions and a non-directive interview style, participants could share their in-depth accounts of personal experiences. This method allowed the researcher to explore the topic with greater freedom and flexibility.

The meetings were scheduled to last up to ninety minutes, providing sufficient time to discuss the research principles, obtain consent (Appendix F) before the interview and allow time to give participants a debriefing sheet outlining sources of support available on completion of the process (Appendix G).

The actual recorded interviews lasted between 50-70 minutes and ended when participants had shared all that they felt was significant to the process. A distress protocol was in place, which could be followed if necessary (Appendix H).

Data Management

Interviews were digitally recorded to facilitate the researcher's immersion in the data. All digital records and transcripts were securely stored on a password-protected personal server in line with the Data Protection Act (2018) and the BPS’s Code of Human Research Ethics (BPS, 2018).

All data was anonymised during transcription, and identifying names or places were allocated pseudonyms to ensure participants’ anonymity.

Data Analysis

The process of analysing data was conducted by following the directions outlined by Smith, Flower and Larkin, (2009). The first step involved verbatim transcription of the audio recording. An iterative and inductive cycle followed, which involved reading and rereading the transcripts while also listening to the digital recordings. This process allowed me to immerse myself in the data and to start coding a free textual style of analysis, noting initial thoughts in the righthand margin. This process permitted salient and significant ideas/topics to be highlighted, which I felt captured the participant’s accounts of their experiences. Each transcript was further annotated by making interpretative notes in the left-hand margin (Smith & Eatough, 2007). By concentrating on the participants' use of language, I was able to see interrelating patterns developing in their comments which helped provide additional content and meaning. Appendix I gives an example of a transcript with accompanying notes.

During this process, I became aware of my tendency to be influenced by a particular transcript and then look for similar thoughts/comments in other transcripts. In turn, this seemed to create a snowball effect which resulted in me getting caught up in my assumptions and expectations. I used a reflexive diary to help ‘bracket’ my assumptions/expectations and keep them separate from participants' actual experiences.

Another objective during the analysis was to remain aware of my perceived thoughts of the medical model and its incompatibility with the essence of recovery. I was, therefore, mindful of bracketing the expectation that participants would find it challenging to work in areas of the NHS that did not adhere to the principles of recovery, as this was most definitely a personal opinion.

The final stages of analysis involved creating a preliminary list of emergent themes, thus moving away from the transcripts but concisely capturing the significance of the initial noting. I used a spreadsheet to record each participant’s narrative alongside my interpretations and then to organise these in related clusters (Appendix H). After further interpretation, I was able to make cross-case comparisons which led to the creation of the initial superordinate themes (Appendix J).

Before I started writing the results section, and to enhance the rigour of the analysis, I referred to my reflective diary (Burgess, 1991). This allowed me to review my interpretations and ensure I was not using the participant's comments to represent my views/biases. This review process further reinforced the need to continue bracketing.

Ethical Considerations

Ethical approval was granted from the National Health Services (NHS), Health Research Authority (Appendix A), and London Metropolitan University's Research Ethics Review Panel (Appendix B). Both organisations concurred with the ethical standards for the study had been demonstrated. Throughout the research process, strict adherence was paid to ensure an ethical attitude in line with the BPS's Code of Ethics and Conduct (BPS, 2018).

Confidentiality

All participants were made aware verbally and in the participant consent form (Appendix D) of how confidentiality would be maintained throughout the process. The process was in accordance with the BPS Code of Human Research Ethics (2021). The limits of confidentiality were outlined, and it was explicitly stated that if a participant disclosed sensitive information in the nature of intended harm to self or others, or they spoke of someone who was under such risk, confidentiality would be mitigated.

Participants understood that interviews would be audio-recorded and that to guarantee their data remained anonymous, they would be assigned a pseudonym. Any identifying information would be altered or omitted from the transcripts. Participants were further informed that anonymised extracts from the interviews would be used verbatim in this research and shared with others involved in this research process; for example, the research supervisor, examiners and published documents

Data Protection

Particular attention was paid to data protection during each stage of the research to protect participant confidentiality and rights.

Personal information was stored separately from audio recordings and kept in a securely locked cabinet at the researcher's home. The recording/storage devices were encrypted and stored on a computer folder that was double password-protected in line with the Data Protection Act (2018) and the BPS Data Protection Guidance (2018). The above information was reiterated during the initial stages of recruitment and again during the interview process.

They were fully informed that the stored data would be kept only as long as necessary (until the Doctorate has been awarded, or up to five years after publication) and would then be destroyed. Participants were made aware that should they withdraw their consent within two months of being interviewed, all the data relating to them would be immediately destroyed. All data relating to the research was handled with respect and discretion.

Quality and Validity of the Research

McLeod (2011) draws attention to the challenge researchers face when assessing the quality of their work. Within the literature, there is no consensus on a definition covering the reliability and validity of qualitative research. Although scholars offer varying opinions and frameworks for the concept of validity, they appear to agree that there is no universal concept but that it is always contingent and grounded in the processes and intentions of the research methodology applied (Cypress, 2017).

My intention for this project was to immerse myself in the phenomenon of how PSWs develop their occupational identity and to present a transparent account of their experiences to add to the literature from a counselling psychology perspective.

Overall, I felt the quality criteria outlined in Yardley's framework (2008, p. 235-251) would cover my intentions for the project, would guide my practice as a researcher and hold me accountable to the reader. The following passage explains how I followed the four criteria stages;- sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Much attention was given to the sensitivity to context requirement, which was demonstrated through awareness of the existing literature and my characteristics and privileges (race, gender and culture) that could potentially influence the interview and data collection process (as discussed within reflexivity sections throughout this thesis). Finally, by explicitly offering verbatim extracts, the reader can audit my interpretations and analysis. By implementing a strict code of ethics during the data-gathering phase and adopting a reflexive stance throughout the analysis process, I maintained a high degree of sensitivity towards my assumptions and reactions to the data.

The commitment and rigour criteria were carefully attended to by paying attention to participant needs before and during the interview. Participants were offered the opportunity to state where they would like their interviews to take place. Once in situ, they were given time to respond to questions, allowing them to recall their experiences and express related meaning.

Being mindful of the need to demonstrate transparency and coherence across the presentation of the study and in accordance with Yin's (1989) proposal, each transcript was carefully analysed, and a clear audit trail provided to further ensure the validity of this research. The procedures used can be audited by following the process shown in the appendices of this study, which allows the reader to see the unfolding process that started with ethical approval from both the Health Research Authority and London Metropolitan University. To further improve the validity of the research, feedback relating to the emergent themes and subsequent super/subordinate themes was sought from my research supervisor and two peers. They were also using IPA for their research projects. Through a process of questioning, meaning-making and further audit, I was able to demonstrate how I had congruently produced my interpretations. The process was helpful, providing positive feedback confirming the themes were credible and coherent, although not precisely how another might present them (Willig, 2013). The final criterion attended to has been this study's impact and utility (Yardley, 2000). This study has added to the sparse literature relating to PSWs OI by reporting how participants declared that their quality of life improved considerably by developing, owning, and embracing their OI. Exploring how PSWs experience their OI helps deepen our understanding of how the role affects well-being and can potentially inform the continuing rollout of this position within mental health services.

It is hoped that counselling psychology will benefit by gaining a greater understanding of the hurdles encountered by PSW and alert CoPs to the need to promote a recovery-based environment, particularly in areas that adhere to the bio-medical model.

Analysis and Results

Overview

This chapter reports the results generated after an in-depth analysis of the six participant transcripts. Despite some divergence of participant views, there was a consensus of expression describing a shift in identity as they embodied the role of PS and moved away from their previous states of isolation.

The results are presented in developmental order, allowing the reader to follow how participants experienced the formation of their OI. The superordinate themes are independent of each other, although there are certain commonalities between them. The first superordinate theme: Symbiotic Green Shoots of Identity, describes the profound changes participants experienced by being occupied and forming relationships with the self and others. The second superordinate theme: The Occupied Self, reports how PSWs appeared to attribute purpose and meaning as significant building blocks in the formation of their OI and that by embracing the role, a greater sense of self seemed to emerge.

In the final superordinate theme: A Limited and Limiting Role, participants expressed uncertainty and described their struggle to move forward in a system they consider lacking sufficient policy and infrastructure to further develop their OI and career.

Themes

Three superordinate themes with multiple subordinate themes were generated from the analysis (see Table 2 below). The key quotes provide a broad representation and voice participants and highlight the essence of how participants described their experiences. The verbatim extracts have been subject to minor edits to improve clarity and readability, for example, by removing word repetition and expressions such as “mm” unless deemed relevant. The transcripts have also been wholly anonymised to maintain confidentiality.

Table 2

Superordinate and Subordinate Themes with Key Quotes

Themes Superordinate	Subordinate	Key Quotes
Symbiotic Green Shoots of Identity	A question of survival	"I thought let's just give it a go because if I don't move and do something, my mind will take me into some very dark places, so it was really a question of survival" (Martin: L44-45).
	Life changing integration	"Peer support work is sort of like an opportunity which comes to you without trying, where you earn, but also you learn…I don't see any role, even a professional role in this society, that will match this one. You also get better ….it's really life-changing as it is magic" (Arthur: L408- 410).
	Change of label	"I was known as a mental patient, but now I feel like I am well enough to be called a working person and now staff, I am working in the NHS" (Arthur: L141).
The Occupied Self	Finding unique meaning and purpose	"It's given me purpose, and it's one of the best jobs I've had as well because I'm working by myself, and it's how you define it yourself. It's not always they tell you what to do because a lot of people don't know what peer support is until they meet someone who's a peer support worker. They see them at work and say, okay, then I can see where they are coming from" (Winifred: L51-152).
	Embodying the role	"Since I started my peer support role, I stopped going to the doctors as much, I would go there quite often, but then I started saying, well, if I'm helping people, that won't look good. I don't know really if I wanted to look good, not that I felt ashamed or anything. But because I felt well, I'm helping people. I guess it kind of made me try to do a bit more for myself, build up my resistance and stuff like that" (George: L373-374).

Themes Superordinate	Subordinate	Key quotes
The occupied self	Beyond tokenism - embracing an occupational identity	“It had felt tokenistic because I'm just another service user coming in, with a label that means I’ve got a right and entitlement to do the job, but there’s more to the job…... I’m not here to just put that label on. Mental health helps, but it’s about the whole listening communication. You had to learn through the trial and error of peer support, and we adjusted to what the staff needed, what the service users need, then my identity was not purely tokenistic” (Nancy: L88- 110).
A limited and limiting role	Struggling to fly	"Being someone that's currently still in the system... maybe a change...in attitudes from some of the younger people that are coming into it, but is trying to turn around the ocean liner, it doesn't matter how frantically you turn the wheel, the ocean liner is going to be inching its way around" (Martin: L187) "It was a bit daunting because the first manager did not know anything about peer support. I was the first person, and I was their guinea pig" (Winifred: L155-6).
	Arrested development	"I've done two years of peer support. So, if I do another peer support role, it's like more fixed time. I don't know if I would because you don’t know where you fit in. I'm considering other options (George: L158).

Superordinate theme: Symbiotic Green Shoots of Identity

This superordinate theme captures the initial identity changes participants experienced while embracing the PS role. It interprets the importance placed on being accepted and feeling that their "being" was relevant. They reported that the work environment had led to a new level of relating to self and others. Participants experienced early gains to their confidence through the reciprocal relationships they formed, which became building blocks for new self-concepts and self-expression. The initial period of performing the role appeared to influence how successful they were at integrating into teams and feeling able to perform the PS role. More significantly, they shared how OI development required a greater understanding of oneself and the ability to identify with service users and as peers with professional members in the teams.

They referred to the most successful of these symbiotic relationships as those that were perceived as honest, non-judgemental, person-centred and authentic. Participants described these elements/qualities as crucial to regaining their sense of agency and recognising how societal and personal level stigma had impeded their ability to connect with others.

The following three subordinate themes provide an interpretation of participant narratives relating to the Superordinate theme Symbiotic Green Shoots of Identity.

Subordinate theme: "A question of survival."

Participants were deeply reflective of reconnecting with the self and others as their PSW OI developed. They spoke of a previous shattered sense of self, resigned to a life of emptiness, where accepting the identity of "mental patient" appeared to perpetuate feelings of hopelessness. There was consensus that living with the effects/symptoms of their mental health problems was seemingly also fuelled by an internalized sense of shame. Martin referred to the opportunity to train as a PSW as "*a question of survival*". This poignant phrase encapsulates the powerlessness felt by all participants and is a valuable measure of the magnitude of the decision to train as a PSW.

Participants had previously isolated themselves, rarely interacting with their families or others, so returning to work was felt to be a daunting step and perhaps a final chance to reclaim a sense of autonomy. Martin shared that he was unaware of what to expect from the PS role but spoke candidly about his earlier resignation:

> *"I thought let's just give it a go because if I don't move and do something, my mind will take me into some very dark places, so it was really a question of survival" (Martin: L44).*

His reflection on life before PS embodies the lack of hope participants experienced and provides an insight into their level of immobility during periods of isolation. Martin paints a picture of the *"dark places"* in his mind, perhaps preventing him from seeing his potential self. His reference to *"survival"* also seems to indicate he had reached "rock bottom" and that the offer to train as a PSW was a chance to regain momentum in his life.

Similarly, Arthur spoke of a metaphoric lifeline offered by engaging with PS. He was very thankful for the support and encouragement to move forward in his life. His words suggest an overall theme of gratitude:

> *"If we could not get this opportunity, our destiny was forever in a shell of unwellness, where we hid ourselves under the beds and blankets…then we had professional support co-opting the voices and giving ourselves time to acknowledge the voice, "Yea, we hear them, and we understand," instead of fighting with them, we make a timetable, a time setting with them…. it's a really excellent approach and very life-changing (Arthur: 13-17).*

Arthur’s comments allow experiential insight into his previous mental health problem. His use of the word *“fighting”* the internal voices suggests he was at war in his mind and that hiding *“under the bed”* perhaps provided a level of relief from the internal battle. He spoke about his life in terms of *"destiny"*, possibly indicating that he had accepted his situation as a fait accompli. Arthur’s use of metaphor in describing his life as a *"shell of unwellness",* suggests a dark void containing the *“voices”* that perpetuated a loss of self-esteem. He expresses immense gratitude to the professionals who helped remove the burden of his shell. Feeling lighter, Arthur appeared to recognise his ability to restart his life’s journey by recreating his identity and experiencing a different *“destiny”*.

Arthur's narrative also provides an example of nosism, which is a type of grammar also adopted by Jordan, in which they refer to themselves in the first-person plural. It could be that nosism allows greater openness and the ability to view their lives from a distance, enabling a more impersonal account of their experiences. It could also be that recounting their past from a collective perspective allowed them to avoid revisiting first-hand accounts of painful memories and the identity they had left behind.

Participants concurred that engaging with work and interacting with SUs and NHS professionals helped them change how they felt about themselves and life in general. They had gained a better QOL and no longer felt the need to isolate socially as the green shoots of their OI had started to emerge and seemingly were helping them become future-orientated.

Subordinate theme: Life-Changing Integration

Participants acknowledged PS as providing them with a “*life-changing*” opportunity to regain a sense of self. Their narratives reflect the significant changes they experienced by having the confidence to re-connect with others. They candidly shared how earlier spoilt identities had prevented them from fully engaging with life and of the significance they placed on receiving external validation from their contribution as a PSW.

> Being employed was significant in their narratives, initially describing the joy of their new collective identity of being an “NHS employee”. Their views firmly converged on the concept of PS providing a significant lifeline as they translated their perceived weakness of having mental health problems into a strength. This symbiotic sharing of their lived experience with SUs provided benefits to both parties, but most importantly, it provided a vehicle for their OI to evolve.

Winifred alludes to such symbiosis as she pragmatically shared the changes she had experienced:

> *"It gives me an excuse to get out of bed in the morning; it gives me a structure to my day, and it's aiding my recovery as well because I'm there doing something…. I'm using my experiences of going through the system" (Winifred: 19-23).*

Her statement was interpreted to mean that she perceived both internal and external factors that influenced her decision making. Her reference to *“an excuse*” seems to imply an external source of permission and a reason to re-engage with her life. Having structure seems to allow Winifred to rationalise that her experience of “*going through the system”* benefitted both her and those she supported.

A further change to their general outlook on life also occurred early in the OI formation. Participants shared a mutual vocabulary, punctuated with words such as “*battling”* and *“fighting”*, indicating the level of internal struggle experienced while trying to make sense of their changing identity and how they could relate to others.

By integrating as members of staff, they seem to relate to their developing personal identity, allowing a different perspective on life:

> *"peer support work is sort of like an opportunity which comes to you without trying, where you earn, but also you learn to improve*

> *yourself. I don't see any role even a professional role in his society which will match this one, as you also get better. You are working on improving your health, but you are working as well. It's life-changing, and it's magic" (Arthur: 408).*

Arthur emphasised the multifaceted benefits he experienced while performing the role and the significant changes in all areas of his life, which was themed across participant narratives. In coming to terms with these changes, participants frequently referred to their new realities as almost unbelievable. Arthur's reference to *"it is magic"* describes his experience of regaining the power of choice, which participants perceived as a crucial enabler for a different life. They spoke of the changes as a mysterious and magical journey that previously would have been unimaginable.

Integration into teams was considered to be a vital step in strengthening their evolving OI. Positive acknowledgement by professionals of PS contribution appears to boost their efficacy and confidence:

> *"when a peer support worker starts coming to work, the first thing they get is the feeling that they are professionals as well, as they are working with nurses and consultants who appreciate them, especially in business meetings" (Jordan: 246).*

As participants began to identify with the PS role, they spoke of the apparent bi-directional benefits on offer. They were inspired by SUs and by receiving positive approval of their work from team members:

> *"I am using my experiences of going through the system, and helping them (*services users*) to learn from their experiences …. for instance, a lot of peers are creative, and it has inspired me to go back and do some art drop-in classes (Winifred: 20-24).*

Winifred provides an example of the benefits of learning to listen to SUs and validating their experiences. Most of these relationships were reported as mutually beneficial and a source of self-motivation. Performing the role appears to help participants restructure negative internal thoughts and feelings that had previously impeded their lives.

Subordinate theme: Change of Label

Fundamental to their evolving OI was the significant gains participants perceived by no longer holding onto harmful labels but instead identifying with a job title that was meaningful to them.

Participant interaction and conversations in the workplace appear to promote a sense of competence that, in turn, increased their levels of self-esteem. Their changing identity seems to play a vital role in enabling them to embrace their achievements and move beyond the adverse effects of self-stigma. Arthur succinctly describes such a change of label:

> *"my relatives and the people who knew me would say he is a mad person. I was known as a mental patient, …but now I feel like I am well enough to be called a working person and staff" (Arthur: 141).*

Developing a sense of competence by performing the PS role seems to allow participants to "*feel well enough"* to move away from harmful negative labelling. Being *"a working person and staff"* appears to provide them with a further opportunity to explore their self-concepts and to start defining new values and goals. Consequently, both of these changes enabled participants to derive meaning from their new daily experiences and to help promote their developing OI.

Participants described the process of change occurring over time, where all participants except Martin had been employed for more than two years and were relying on earlier memories to account for how and when changes occurred:

> “*from about four to six months, it started easing because I think that people got comfortable with you and they relaxed, and you get to know the staff. So it doesn't happen overnight" (Nancy: 183).*

Nancy's reference to *"it started to ease"* seems to refer to an element of uncertainty between PSWs and staff as they began working together. Her reference to the amount of time needed to settle into performing the role was consistent with the views of other participants, who also referenced needing time. This period was interpreted as allowing them to understand both their own needs as PSWs alongside those of the service.

Participants also shared previous preconceptions they held of the staff that had cared for them as SUs. Their narratives provide insight into how a greater sense of self allowed them to view professionals differently. Their consensus suggested that as their OI started evolving, they felt better able to relate to others and reflect on how they had perhaps also engaged in labelling:

> "*I see that they have a hard job and they do the best that they can. They care, that's what I have noticed, but when I was in the hospital, I wasn't always sure that the nurse or the doctors really cared. That's how I felt" (Winifred: L147).*

Winifred’s reflection alluded to wanting mutual respect between professional staff and PSWs. It also indicates the changes participants experienced during the first six months in the role.

During this period, participants described change as a constant, reporting the process as challenging and demanding due to the uncertainty and newness of their routine. Participants unanimously reported most of the changes to be positive, motivating them to push forward. The changes reported were interpreted as participants having improved self-esteem and confidence across many areas of their lives, which, in turn, allowed them to embrace the benefits from their developing OI.

Participants commented with surprise on how their relationships with others appeared to change, even those experienced outside of the work environment. George shared an insight into how he had compartmentalised his work and his home life, describing some of the unexpected changes he experienced through employment:

> *"In my personal life as well, it made people open up to me a bit more with personal issues. I found as a side thing to work, and it was comforting" (George: 71-84).*

His comment *"as a side thing"* could indicate how his evolving OI acted as a catalyst for change across all areas of his life.

Summary of the Symbiotic Relationships

The above themes have interpreted the significant early stages of OI formation as being encouraged by being employed, re-connecting with others and building new relationships. During this period, participants became more future-orientated and better able to challenge limiting and negative self-beliefs. Collectively these initial changes were viewed as *"life-changing".*

Superordinate theme 2: The Occupied Self

This superordinate theme encapsulates the benefits participants believed they derived through experiencing their newly formed OI. Employment provided them with routine and structure and was perceived by participants as having a greater sense of "*purpose",* which in itself enables a more positive sense of identity. It became apparent that by 'embodying the role', participants described their recovery, occupation, and identity as entwined and significantly contributing to a more satisfying and future-orientated life. By feeling comfortable with 'their occupied selves', they were able to look more objectively at the PS role. This contrasts with Winifred, Nancy and Martin's earlier concerns of feeling that the position was a form of *"public sector tokenism"*.

Subordinate theme: Finding unique "Meaning and Purpose."

Overall, participants described that being back in employment provided a sense of meaning that enabled a symbolic separation from the negative labels that previously defined them. Typically, participants were returning to work after prolonged periods of unemployment and commented that feeling accepted by others promoted a sense of *"normality"*. Doing things that contributed something to others was interpreted as necessary, as it allowed them to feel useful and valuable. Their views of re-connecting with work highlight an idiosyncratic journey in which they experience a developing sense of independence and self-belief.

Being meaningfully occupied appears to leave them open to living a more fulfilled life. Participants empathized that *"meaning"* was derived from using their lived experience without fear of judgement. Being able to share an alternative perspective at work was *"liberating"* and fundamental to their improved self-esteem, optimism and hope.

They spoke with almost disbelief about the positive changes they were experiencing but remained mindful of how their lives had changed from a perpetual state of helplessness to helping change the lives of others.

Employment appears to catalyse the transformation of their identity. Participants described how purpose enabled them to convert previously held beliefs of resignation into accounts of recovery. As a result, they felt more able to begin exchanging negative self-stigma for more optimistic views of self. The essence of this theme is illustrated by Winifred, who spoke of how she was previously lost in a diagnosis of Schizoid Affective Disorder:

> "*employment has given me a good structure, and this enables me to be a better version of myself and to learn from my mistakes and move*

> *on with my life ....basically it means, I am no longer defining myself by my illness" (Winifred: L27-29).*

Winifred's excerpt provides an example of the multifaceted benefits derived from being employed. Her views are congruent with the sample and illustrate how participants perceived the initial stages of their recovery process and OI formation. Her poignant statement suggests that having purpose allowed her to move on from previously held limiting beliefs about her mental health. Winifred's reference to *"being a better version of myself"* could suggest she feels more comfortable with herself, which may be a significant change from *"the version"* dominated by limiting beliefs and the pain of identifying with internalised stigma and discrimination. Having a greater understanding of her mental health and sense of self, Winifred appears to be *"defining"* her life according to her values and OI as a PSW.

Similarly, Jordan shared that having a new sense of meaning in his life enabled him to redefine earlier self-discrimination. He appears to make sense of his experiences by connecting with himself and his peers through a more positively stated self-belief. The following excerpt encapsulates how his sense of purpose aligns with the role and provides a source of validation from others:

> *"I've now got a purpose ...it shows the peers that I know what they are going through, I've got lived experience. I've not just read books like a doctor or a nurse or a psychiatrist. They know that when I tell them my diagnosis, you are someone that's gone through the same thing, and then they open up more...they feel more comfortable talking to us....it's given me back my life, it's given me meaning and purpose" (Jordon: 363).*

Jordan's modest summary of significant life changes since becoming a PSW provides an insight into his past and perhaps his values. His words seem to echo a sense of pride in having the experiential knowledge to reach others with mental health difficulties more cohesively than other academically qualified professionals in the team. He describes how incredulous participants feel when they recognise that they have the prerequisite skills to perform the PS role. His comments illustrate the juxtaposition experienced by all participants by departing from the notion that their mental health difficulties are a limiting weakness to a position where that experience is a strength and a prerequisite for PS work.

Subordinate theme: Embodying the Role

Participant purpose appeared to be further enhanced by embodying OI. Their change of self-perception seems to provide a solid foundation for a greater sense of self, in which they recognise earlier experiences as meaningful for their current situation.

Their narrative provides insight into how recovery and OI appear to be entwined and describes how the PS role had helped their recovery process by providing a greater sense of empowerment and a structure for their lives. The following excerpt from George illustrates how combining recovery and OI had changed other behaviour:

> *"it does affect your identity* [performing the PS role]…. *since I started my peer support role, I stopped going to the doctors as much…I started saying well if I'm helping people ..that won't look good. I don't know if I wanted to look good, not that I felt ashamed or anything…but it just reduced me going to doctors because I felt well…so I guess it kind of made me try to do a bit more for myself" (George: L362-374).*

George alludes to recovery as a bi-product of performing the PS role and to which he attributes his confidence and wellness. His shared internal dialogue offers an insight into his self-evaluation process and how this may have motivated him to keep pushing forward with newly defined values.

However, by feeling more accomplished and confident at work, participants appeared to move beyond feeling overwhelmed with gratitude to the NHS and look more pragmatically at the role and team setting they were operating in. As the changes to self were significant, it could suggest that their embryonic OI was shaped by a trial and error process while trying to embrace the demands of the interrelating relationships required in the PS role.

Participants revealed how they developed their understanding of the role without a vision of how it should be performed, but by looking at the multitude of benefits they felt they had gained from it:

> *"it's given me a purpose, and it's one of the best jobs I've had…..it's how you define it yourself…. a lot of people don't know what peer support is until they meet someone who is a peer support worker. It is pressurised, and it can be emotionally draining, but you leave with a smile on your face" (Winifred: 47-51).*
>
> *"I'm not looking to go back to the other work because I feel like I have found my lane….I have had big titles in the past, and I've even had people fight over me in terms of jobs…but I didn't feel the sense of belonging to anything like I do now… I was paid a lot more before, but I get more satisfaction now" (George: L591-601).*

George no longer identified with his previous work as a well-paid professional before encountering mental health difficulties and recounted a sense of emptiness and being unfulfilled by his previous role. His metaphorical expression of *"found my lane"* suggests he has achieved a level of congruency from the PS role previously missing.

Winifred's excerpt alludes to the daily rollercoaster of emotions she experienced, but like George, she found peace by being meaningfully occupied. Both suggest that they have developed a sense of autonomy and definition from bringing their unique skills to the role.

This is consistent with other participants, who appear to create their interpretation of PS by embodying the role and congruently enacting their duties using their own values.

Although participants seemed to interpret the role differently, an underlying tone of contentment appeared to come from feeling settled at work. Arthur provides insight into how participants feel indebted to the service:

> *"It has become a passion for me to help more people because it is like I have been given a task, given an opportunity, through my condition, I can help others, and that feeling is great" (Arthur: L60).*

Arthur succinctly draws attention to how he perceives himself as never being far away from the broader implications of how he arrived here.

Similarly, Martin's sense of pride and purpose seems to relate to the absolute openness that comes from being authentic:

> *"There is very, very few if any place, where having a mental health problem is actually something that you can put on your CV with the sense of pride and honesty" (Martin: L58).*

Martin could be alluding to the fact that previously he had not been able to talk about his mental distress. By positively identifying with their mental health difficulties, participants seem to have developed a sense of gratitude for their earlier problems, which are now a prerequisite for their new occupation. Having an OI appears to have allowed participants to express themselves with more openness, and as Martin suggests, they have also developed a greater *"sense of pride and honesty".*

Subordinate theme: Beyond Tokenism

Beyond tokenism overlaps the previous theme as participants continue to reflect on their earlier experiences and how they changed after being in situ for some time and feeling more connected with the role. They valued PS as it provided a unique opportunity to use their experience of mental health difficulties in a position that enabled expertise and autonomy. As their OI formed, participant perception of their labels and the role being tokenistic also changed.

Participants ' narratives suggest a new level of liberation and freedom by gaining confidence at work and feeling more attuned to their evolving OI. Nancy's reflection is an example of this change:

> *"It had felt tokenistic because I am just another service user coming in, with a label that means I've got a right and entitlement to do the job, but there's more to the job. I'm not here to just put that label on. Mental health helps, but it's about the whole listening communication. You had to learn through the trial and error of peer support ….we adjusted to what the staff needed, what the service users need, and then my identity was not purely tokenistic" (Nancy: L88- 110).*

Nancy provides an insight into the difficulties experienced by participants during the initial period of performing the role, illuminating the discomfort participants may have experienced as their identities transitioned from SU to service provider. However, I sensed her determination to succeed as a PSW and demonstrate the value of her experience. Nancy, like other participants, did not merely want to wear the PS badge; she wanted to prove her value to the service and to the SUs and staff she worked alongside. I interpreted this stage of their development to mean that they wanted to be recognised for their value and worth by passing on their knowledge and encouraging SUs to aspire to a better quality of life in the same way as they had done. It was also essential for participants to feel that the mental health professionals were genuinely authenticating them for the value they added to the service. It was not until they believed they were fully integrated with the role and could feel accomplished within the service that they perceived their role had developed from tokenism to a position of authenticity.

Participants spoke of how they felt their OI to be a pivotal point of connection between peers, allowing them to be authentic. Winifred shared the importance of expressing herself and, in particular, of using her experiential knowledge alongside other skills developed in the workplace:

> *"peer support enables me to express myself, to be myself and to use all the skills that I have… my experiences of being in the system, and how to recover, and how even if you can't recover, how to manage your illness" (Winifred: L339).*

Her reference to "*manage your illness"* could imply that by embracing her OI, Winifred's understanding of self allowed her greater inner strength, capacity for wellness and a more optimistic view of life. Reflecting on her journey, Winifred alludes to how she has perhaps developed a greater degree of self-management and independence.

Being more critically aware of their self-appraisal and expressing themselves more freely was described by Martin as providing a voice for SUs whose words might otherwise have remained unheard:

> *"being busy on my terms and doing something that I want to do, I don't have to pretend to be normal; I can be open because I'm tired of struggling with things and not saying anything" (Martin: L50).*

Having a forum to express their views on mental health issues confidently was a substantial benefit for participants. Martin spoke of being occupied on his terms and creates the impression of no longer wanting to conform to a mainstream narrative that restricts self-expression. His poignant reference of pretending to be *"normal"* could be interpreted as acknowledging and accepting that his version of normal was valid.

Like most participants, Nancy attributed her changing self to having her values align with those of the Trust:

> *"I like the trust and their values, certain things they did, felt right, I think I'm totally different, I was literally like a different person" (Nancy: L568).*

The NHS identity card appears to provide positive changes to the participants' identities. They considered that being able to identify as a member of staff was a status symbol within the community:

> *"We should keep hope in ourselves and help each other. We can become part of the larger society again as were before.....now I feel like I am working again, that's a big thing and this card [*staff identity card]*, it has given us identity, we are the staff of the organisation" (Arthur: L126).*

Superordinate theme 3: A Limited and Limiting Role

This superordinate theme shares participants convoluted and conflicting experiences of the workplace. They spoke of the *"trial and errors"* experienced between the initial promise of employment and the reality of the role, which often resulted in confusion and misunderstanding. The inconsistencies they experience within the teams and across the organisation often left them feeling discouraged and less optimistic. A common theme mentioned by participants was the difficulty of working in an environment that was not structured to integrate and support the PS role.

They voiced concerns about establishing working relationships with colleagues who had little understanding of the recovery model. Experiencing negative interactions seemed to impact participants confidence and disrupt their sense of meaning/belonging.

Subordinate theme: Struggling to Fly

In this subordinate theme, participants shared their experiences of unmet needs, which were highlighted by working alongside staff who lacked the knowledge /awareness to supervise the PS role. Participants believed that working in this environment impeded the growth of the PS role. It was felt that a lack of clearly defined job descriptions and inexperienced management hindered integration into the position and the team. Participants shared that relationships with supervisors and other team members were critically important to them. When these relationships were experienced as inauthentic, participants felt uncertain about their future and experienced a range of emotions such as worry, anxiety and low mood.

They shared that, at times, they felt marginalised by interactions with other team members who were unaware of the PS role. Participants perceived these staff members as uninformed rather than deliberately obstructive, as demonstrated by Winifred's account of her first PS role:

> *"it was a bit daunting because, in my first job, the manager didn't know anything about peer support. I was the first person. I was their guinea pig, but within a couple of months of being there, my supervisor nominated me for an award. Isn't that ironic" (Winifred: L155).*

Starting a new role with a manager who is also new to the concept of PS seems to have been a bittersweet experience for Winifred. She reflected on her introduction to the workplace four years ago, where her natural ability to help SUs was sufficient to change her managers' initial lack of awareness into an understanding of the value of PS.

In Winifred's case, the experiment had a positive ending as her manager was willing to explore and develop the role in tandem with Winifred. Participants, in general, only saw these issues as role development teething problems and expressed that the gains from performing the role far outweighed any negative impacts experienced.

However, more philosophical concerns were expressed by Martin, who perceived PS related problems occurring not only at the team level but across the broader NHS. He illuminates issues that relate to inexperienced teams operating PS initiatives:

> *"I think because it's such a step into the unknown for the NHS, the whole peer support thing, especially in mental health, I think we should have been better prepared for some of the attitudes of the professionals" (Martin: L141).*

Martin reflects on how PS is managed and that the Trust is not reviewing implementation more broadly across the organisation. His words seem to express a sense of knowing that something fundamental is missing from the workplace. Martins comment *"some of the attitudes"* appears to refer to a sense of disappointment felt by working in a team that he perceived as being unable to relate to his needs.

In addition to Winifred and Martins views, Nancy had formed her opinion of how professionals in the NHS view PSWs:

> *"Generally, across the Trust peer support is like the lowest paid job, band three or band four ...it feels like service users can never rise up" (Nancy: L237).*

Nancy's reference to herself as a *"service user"* was surprising as earlier in the interview, she had mentioned her disdain for the label. Nancy indicated that stigma accompanied the title; her words were interpreted to mean she was maybe engaging in an element of self-stigma. Nancy's statement *"could never rise up"* appears to express a level of frustration towards the role, which by definition indicates a history of mental health difficulties. Nancy words seem inconsistent with her desire, values and commitment to the position she had already expressed. I felt she could be referring to the lack of structure and pathway that prevent PSWs from rising above the label, as she had previously alluded to professionals seeing "*PSWs firstly as SUs and secondly as peers"*. However, despite Nancy's conflicted views, she remained committed to being a part of the changes the role requires:

> *"Things change slowly, but I really have to be part of it to kind of change it" (Nancy: L314).*

Despite her sometimes negative experiences, I detected a sense of determination in Nancy's narrative. She acknowledges that changes are necessary and that by feeling competent in her OI and ability to perform the role, she wanted to be part of the solution going forward.

Subordinate theme: Arrested Development

This subordinate theme provides an account of challenges participants felt may threaten their OI, which relates to inconsistencies they observed during their employment with the Trust. They recognised potential roadblocks for their personal development and careers, which arise through inconsistencies in training standards, job descriptions and staff bandings.

These difficulties were highlighted by participants trying to move between NHS Trusts. All but one of the participants described the initial training course as highly informative, despite not being externally accredited.

Course accreditation was not identified as a problem until participants wanted to explore moving to a similar role outside of the Trust. Jordan had worked for the Trust for more than seven years and made the following observation:

> *"It was accredited back then, but now they can't get the funding" (Jordan: L144).*

This accreditation issue restricts movement between NHS Trusts, which was clearly articulated by Winifred, who had worked within the Trust for more than three years and had gained the confidence to look at positions with other organisations:

> *"I saw a job advertised in a hospital not too far….but within my area, and they asked for accreditation for peer support" (Winifred: L450).*

Despite having the relevant experience, Winifred did not meet the recruitment selection criteria. She appeared to be saddened by the realisation that her experience alone was insufficient to transfer to other Trusts. Not having an accredited qualification was felt to be disempowering by participants, who questioned the validity of their OI and how well the PSW role was embedded within the NHS.

However, despite the lack of structure, participants remain committed to performing the role:

> *"I want to stay helping in NHS, and hopefully, they will start having a career path where it can go from A to B you know and feel like you are making some kind of progress" (Winifred: L480).*

By reflecting on how her current role is structured, Winifred seemed to express concern and perhaps an element of disappointment. Despite her best efforts, she is currently not moving forward with her career. However, her reference to a career path within the NHS seems to imply her commitment to her occupation. She remains hopeful the NHS will eventually consider the greater needs of PSWs by providing a more strategically outlined pathway that could allow seamless transfers within and between Trusts.

Aside from training, participants identified discrepancies in standards across departments. Participants were predominately employed on fixed-term contracts, which mostly left them unclear about the Trust's policy regarding contract extensions. Initially, participants were satisfied with the conditions of employment; however, once they felt competent in performing the role, they voiced concerns about the non-permanence of the position despite the amount of time they had invested. A sentiment explicitly stated by George:

> *“I don't like the way that it's fixed-term all the time, because it does make you worry what you're going to do after this and I didn't really like the way they handled it really in terms of extending it, they didn't tell me until last month that it wasn't going to be extended…. I think the length of the contracts could be looked at” (George: L446).*

George shared that he had previously had his contract extended on many occasions and was given no indication that the process would change. His disappointment was evident; not having the security of employment was considered stressful by participants.

Discussion

Overview

This chapter discusses the findings from the IPA analysis, outlining the developmental journey experienced by participants during the formation of their OI. The discussion highlights the practical implications of the results and reflects on the broader field of literature concerning OI, PS, and the recovery model. It will map the significant identity changes participants experienced through occupation/work.

Participant narratives concur that OI was shaped through a complex interplay of processes involving regaining a sense of purpose, meaning, embracing the concept of recovery, reconnecting with self and others, and developing a greater sense of autonomy. Having a sense of autonomy is referred to as the "sine qua non" of recovery orientated practice (Mancini, 2008, p358) and is often the basis for self-motivated behaviour.

As well as exploring the positive and successful experiences of developing solid OI’s, the discussion also covers some of the issues and limitations stifling further OI development.

OI changes are further related and viewed against the Salutogenesis model of Antonovsky (1979), who models wellness by considering some of the elements contributing to resilience.

Relationships are vital influencers in shaping participant identity as they provide the social structure needed to enable change (Gewurtz & Kirsh, 2007). However, being occupied was a pivotal developmental point and a critical element of survival (Wilcock, 2001). Re-engaging with work and developing resilience allowed participants to gain a greater sense of mutuality and reciprocity, building the necessary social capital to establish their OI further and attain a greater quality of life.

Green Shoots of identity - Re-learning to relate

This superordinate theme discusses how the participant's OI was shaped by embracing the concept of recovery, reconnecting with themselves, and developing a greater sense of autonomy through positive bidirectional relationships. Further, there is a plethora of literature espousing relationships as a key influencer in shaping identity by providing the social structure needed to enable change (Gewurtz & Kirsh, 2007).

The first three subordinate themes demonstrate the depth of change experienced by participants as they transition from the identity of patient to service provider during their initial period of employment. This initial stage in their journey aligns with the literature where developing self-expression and hope are seen as critical enablers and green shoots of a reconstructing identity (Davidson et al., 2010).

"A question of survival" a pivotal developmental point

All participants felt that returning to the workplace was pivotal to their recovery and the first step towards a significant shift in their thinking and well-being. The changes experienced correlate with the literature, emphasizing that occupation plays a central role in maintaining health and well-being. Wilcock, an expert in the field, theorises that occupation "is the biological mechanism for human health and survival and therefore all people have inbuilt needs to engage in occupation" (2001, p. 413). The results of this study concurred with her concept and were exemplified by Martin, who shared that accepting the offer to work within the NHS was a "*question of survival*".

Each participant recounted what it meant to return to the workplace. Their views strongly converged on the concept of PS being a lifeline to a future that was previously considered out of reach. Arthur's metaphorical statement: "*without this opportunity …. our destiny was forever in a shell of unwellness*", seemed to echo the thoughts of PS pioneers (Deegan, 1988; O'Hagan, 1996), who expressed her experience of mental health problems as feeling reduced "from being a person to being an illness" (p. 72). The participant's views further concur with Deegan's (2001) on recovery, in which she posits the process to be a unique journey, allowing the individual to develop a new sense of self and purpose through connectedness.

Perkins and Farmer (2009) explored the importance of providing support for those in the workplace, who despite having a mental health condition, continue to pursue successful careers. Their research identified "people with a mental health problem have the highest 'want to work' rate of all disabled groups (p. 8). This appeared to be accurate for the participants in this study, who declared that re-engaging with work and becoming more resilient allowed them to gain a greater sense of mutuality and reciprocity, which helped build the necessary social capital to maintain their well-being (McKenzie, 2016).

Life-Changing Integration – Green Shoots of Identity

Forming mutually beneficial relationships were expressed as *"life-changing"*, allowing participants the space to step away from previously held self-perceptions. These changes are referenced in the literature as the start of the recovery process (Loumpa, 2012). Participants felt validated by others in the workplace, which was considered a crucial element of their developing OI. Being acknowledged without judgement and beginning to relate to others from a more compassionate/positive perspective were reported as enabling participants to change their limiting beliefs and self-concepts.

The gains experienced by participants are consistent with the literature from two perspectives. Firstly, PS is considered a central element of recovery by helping to promote a more positive sense of self by fostering connections with others (Loumpa, 2012). Secondly, occupational science has connected occupation to identity by theorizing the context in which changes are likely to occur. Transitioning back into the workplace is considered a central element of identity, where occupation and recovery are intrinsically linked to the maintenance of well-being (Christiansen & Townsend, 2010: Dunn et al., 2008, Schwartz, 2001).

Participants spoke of how their QOL life changed through being employed and that having a meaningful activity influenced their recovery process. Winifred spoke eloquently of how she felt "*doing something*" to help others was a key enabler for her sense of empowerment. Participants described the significance of reconnecting with the community and that having a sense of *"belonging"* promoted feelings of hope and general well-being. These results relate to the literature on hope and recovery, where hope is referred to as a significant human trait inscribed in human nature and a tension focused on a future that is currently beyond reach (Provencher et al., 2011).

Participants reference to a felt sense of hope is not unfounded or unrecorded, as, in earlier years, the prospect of recovery from mental health was considered impossible. Credit goes to individuals such as Deegan (1988) for her account of overcoming mental illness and regaining her position in society, which helped to promote the paradigm of recovery.

Becoming a PSW was described as providing varying dimensions of personal meaning which helped participants contextualise their mental health problems. This process is consistent with the literature speculating that being occupied empowers individuals to develop a conscious awareness of oneself (Schwartz, 2011).

The changes participants experienced in their daily routine were expressed as profound and tied to external validation of their role. Highlighting the importance of acknowledging the needs of those that live with mental health problems. The most common change experienced by participants was that they no longer felt caught in the dark corners of their minds where mental health problems were perceived as a fait accompli. This interpretation came as participants reflected on how their life stories had changed due to engaging with the PS role.

Change of Label – Developing a positive outlook

> "*Although the walls of the old asylums may have been broken down, there are many who have been 'institutionalised' in segregated communities and have lost all roles and identities other than that of mental patient*". (Perkins & Farmer, 2009, p. 11).

Before PSW employment, Arthur, Winifred and Jordan described feeling helpless, perpetuated by identifying as a "*mental patient*". This form of negative self-labelling is recognised in the literature related to psychopathology and the "medical model". Despite pushing for a recovery orientated approach to practice, the medical model, which perceives professionals as experts and patients as passive recipients of care, is still said to prevail within the NHS (Gumley et al., 2010).

Arthur commentated on being negatively labelled by his family: "*they used to call me a mad person and mental patient",* which seemed to reinforce his negative beliefs. His narrative alludes to a spoiled identity, echoing a concept created by Goffman (1963), which occurs when an individual's identity causes them to experience stigma. All participants experienced stigma in varying forms before engaging with PS work and, in part, can account for their sense of helplessness.

The participant narratives around negative labels resonate with the finding of Levy et al. (2014), who contextualise societal beliefs as a catalyst inflaming negatively held assumptions towards those living with mental health problems. They further posited that as a society, we are unaware of the extent to which stigma and discrimination hamper recovery from mental health issues. These views are shared by Gumley et al., 2010 and Corrigan, 2016, who also claimed labelling as demoralising by promoting social and cultural exclusion.

George attributed his improved self-esteem to being positively labelled and having a shared identity: "*I am using my experience to turn somebody else's experiences into a more positive situation.".* Similar fundamental changes were experienced by other participants, where their shift in perception could be attributed to a reduction in self-stigma and a greater sense of self. This concept has been explored by many researchers (Solomon, 2004; Bracke et al. 2008). Self-stigma was posited to be positively correlated with a decreased sense of self-esteem and hope (Corrigan, 2011). Developing a greater understanding of self concurs with the literature, suggesting relationships with others are tied to OI and well-being (Waterman, 1999).

Participants reported increased self-confidence and self-esteem as a beneficial effect of feeling accepted and unjudged by others. By joining a team of professionals, participants felt able to acknowledge a more positively biased identity. Their change of perception is congruent with the findings of Salzer and Shear (2002), who made the connection between social approval and positive changes in identity for those employed as PSWs.

The Occupied Self

"*The purpose of life is a life of purpose*" Robert Bryne

This superordinate theme discusses the meaning participants placed on being employed, occupied, and developing new skills. Their views resonate with Fidler and Fidler's (1983), who theorised that humans are essentially occupational beings who derive meaning from their occupation.

Participants' gratitude was directed towards the restorative powers of; being occupied, acquiring new skills, and engaging with the community. These changes are congruent with the conclusions of Leamy et al. (2011), who posit that these factors are necessary to build a valued identity and are critical in establishing recovery.

The following three subordinate themes interpret how participants link a developing OI with their initial stages of recovery. The themes also go some way to addressing the research question by exploring their experiences in the workplace. Their narratives were interpreted to align with the views of Skorikov and Vondracek (2011). They claim that OI contributes to psychological wellness, social adaptation and is conceptualised as "a major component of one's overall sense of self" (p. 694). This adaptive behaviour can be seen to further strengthening participants sense of self and OI development.

Renewed Sense of Meaning

> *"Life is not primarily a quest for pleasure, as Freud believed, or a quest for power, as Alfred Adler taught, but a quest for meaning. The greatest task for any person is to find meaning in his or her life."* **(**Frankl, 1985)

Jordon's words, "*it has given me back my life, it has given me meaning and purpose,"* are highly indicative of how participants felt towards the PS role. This transitional period was acknowledged by Davidson et al. (2012), who describes the process as promoting feelings of empowerment and an increased sense of confidence.

Participants reported that becoming "an expert by experience" and using their past experience to help SUs, enabled them to better express themselves. Their narratives concur with the ethos of occupational therapy and the belief that people can create a new version of themselves through what they do (Kielhofner, 2009).

Although each participant described a unique way of self-identifying, they unanimously agreed that being employed and having an increased level of social engagement provided a sense of purpose. By moving away from habituated states of negativity, their narratives allude to discovering "*a better version*" of themselves. Their views resonate with the literature that acknowledges the critical role PS plays in modelling purpose and encouraging individuals to move beyond limiting beliefs. These qualities help promote a more empowered sense of purpose and meaning (Austin et al., 2014).

Winifred's statement: *"I am no longer defining myself by my illness"*, suggests how having an OI allows her a more positive form of self-identification. Her words resonate in all participant narratives and align with the concept of occupation being able to make a significant contribution to how individuals develop and express their identity (Christiansen, 2004).

Leider (2015) speculates that purpose is the essence of who we are and how we structure our lives and gather meaning. Martin and Jordan spoke of finding purpose in their work and talking openly about their mental health problems. The fact that previous experience of mental health was a pre-requite for the role was perceived as empowering and promoted the development of their OI. Christiansen (2004) espouses that positive personal identity remains a crucial element of OI and a phenomenon that people aspire to achieve.

Participants early experiences with the role varied, often depending on the team they were assigned to work within. They spoke reflectively about the stages of their development and how progress depended on interactions with peers and professionals in their teams. Learning to relate to others from a different perspective is covered in the literature, which identified that PS relationships require individuals to recognise relational patterns and to challenge self and others (Mead, 2003). Except for one participant, the amount of experience in performing the role exceeded two years, and their narratives suggest that the benefits of an evolving OI increased with role experience. Earlier studies highlighted the challenges PSWs faced when working in teams that were not recovery-focused, which ultimately resulted in problems with their recovery (Walker and Bryant 2013; Moran et al. 2013: Mancini & Lawson 2009). Contrary to this, although participants in this study initially reported work-related stress, they felt that by having developed a solid OI, they could adapt to the role and move forward with their recovery.

Participants shared that earlier that they perceived PS to be a politically correct form of tokenism. A concept said to arise in situations where there is minimal empirical basis for the PS intervention and particularly in environments where NHS clinicians abide by evidence-based practice (Gordan, 2005). However, although participants initially felt more like “patients” than “colleagues”, they reflected that a process of trial and error enabled them to understand and value the views and needs of the team and SUs alike, which was considered an early and significant identity milestone and provided an insight into the challenges experienced by PSWs developing their OI.

Despite the rise in numbers of PSWs employed across the UK, it is still being implemented without the necessary structure for clinical staff to fully understand the importance/consequences of non-adherence to recovery-based practice. Several studies have suggested that non-peer staff would be better informed if they received more education on RBP and the benefits of having PSWs within their teams (Ahmed et al., 2015; Crane et al., 2016; Otte et al., 2020).

It is not possible to empirically measure how poor infrastructure impacts the developing OI of PSWs, but in all probability, it would not be helpful.

Embracing Occupational Identity Through Self-reflection

Over time and by building competence through the acquisition of skills, all participants reported a more meaningful way of relating to self and others. Equally, their lived experience linked their newly found self-identification to being occupied/employed. This enhanced well-being is consistent with the literature that proposes occupation as a medium that helps engender a sense of self (Mead et al., 2004).

The participant's experiences concur with the study by Dyble et al. (2014), who found that PS correlates with identity transformation. However, the participants in that study had limited experience and appeared not to have moved beyond the tenuous early stages of re-constructing a new sense of self.

However, the participants of this study described their OI development in terms of building blocks from which they continued to grow and develop the confidence to exert a greater sense of authenticity within themselves. Feeling competent in the role allowed participants to work autonomously, with several participants helping less experienced PSWs start their transition process.

More research exploring the significance of PS intervention for SUs and PSWs could help define the elements of the role that provide the most benefit to the parties involved. Hutchinson et al. (2006) posit the importance of transitioning away from the identity of ‘patient’ to a more positive identity. However, to date, little research has explored the significance of OI for people in recovery from mental health problems. Although in 2008, Dunn et al. conferred that PSWs who considered their role to be valuable were able to develop a more positive sense of self.

Participants took great credence from having the NHS identity badge. It was seen as a status symbol, promoting an enhanced sense of health and well-being. These results are consistent with existing literature where significant shifts occur when an individual can identify with occupation and not a diagnostic label (Lloyd-Evans et al., 2014). However, this study has shown that having an OI means more than merely changing labels and that having an opinion valued by self and others was also important.

A meta-synthesis of the literature focusing on individual accounts of what occupation concluded that a personal sense of fulfilment, restoration, and social elements, play a significant role in shaping individual identities (Roberts & Bannigan, 2018). Although the study was not directly related to PSWs, the results align with participants' views in this study who have shared their experiences of re-learning to connect with others and working their way through the challenges initially presented by being meaningfully occupied.

Arthur's claim "*we can become part of the larger society again*" was interpreted as providing insight into the importance of being employed and socially accepted. It portrays the significance he placed on relating to others within social norms in which he had previously felt an outcast. Research by occupational scientists cites the importance of social and cultural perspectives as part of an individuals OI (Malfitano et al., 2019; Hammell, 2009).

Occupation and identity are shown to be the lens through which participants in this study found new ways of expressing themselves. Forming an OI provided a framework through which they could begin to reclaim their identity. This research has shown that participants attribute increased well-being, social engagement and a greater sense of self by being employed. It could be that OI and recovery are intrinsically linked and that PSWs experiences of both the self and their social/cultural factors influence their way of being in the world.

Linking OI and Sense of Coherence

In wanting to add to the holistic view of their inherently multifaceted OI development, the author proposes that participants may have gained a greater sense of coherence (SOC) by feeling more competent with a developing OI. SOC is a core construct of the Salutogenic Model proposed by Antonovsky (1979).

The opposite of pathogenesis, Salutogenesis, focuses on the origins of health and well-being, positing that life experiences help to shape an individual’s SOC. Described as the ability to use personal resources when under stress, a SOC proposes individuals hold a set of beliefs that life is meaningful, manageable and comprehensible (Mittelmark & Bauer, 2016). Antonovsky intended to explore “the illness consequences of psychosocial factors howsoever these consequences might be expressed” (Antonovsky, 1990, p. 75).

Salutogenesis suggest that those with a strong SOC can cope with life stressors without substantial consequences to their mental health. The salutogenic model is said to work in harmony with the social sciences that focus on understanding the human experience from a positive aspect (Eriksson, 2017). Antonovsky described the model as a process that could promote the development of an alternative paradigm but did not consider this to be opposed to the medical model. He was clear: “I have no illusions. A salutogenic orientation is not likely to take over. Pathogenesis is too deeply entrenched in our thinking” (Antonovsky, 1996, p. 171).

However, Mittelmark and Bauer (2016) consider the literature relating to the salutogenic model to be sparse, mainly due to its recent origins. Therefore, they concludes that mainstream health professions and disciplines have yet to be strongly touched by salutogenesis as it is still in infancy.

Participant narratives expressed high levels of gratitude by embracing change which is one of the positive determinants of SOC (Lambert, 2009). Therefore, it could be that expressing gratitude for their OI is an indicator of participants increased ability to manage their lives in a more meaningful and understandable manner. According to salutogenesis, gratitude is a significant factor, as a strong SOC indicates that individuals may be better equipped to deal with challenges. Christiansen (1999) hypothesised that identity and SOC are related. Although there is no current literature to link SOC with OI development, participants in this study described improvement in areas that unpin SOC traits.

The participant's descriptive comments were interpreted to be clustered around markers for OI development; therefore, the parallel between a developing OI and an increasing SOC could suggest a relationship between the two.

A Limited and Limiting role

This final superordinate theme discusses how participants experienced developing OI within a team setting and their perception of the necessary changes needed across the NHS to better support the role. Despite the individuality of their development, participants felt they were part of a broader PS movement and were determined to use their collective identity to initiate change to the PS role.

They spoke of various hurdles faced while performing the role and of the challenges identified beyond their current work environment. Their narrative allows insight into the confidence they gained from performing the role and the motivation necessary to overcome some of the hurdles encountered.

The final two subordinate themes highlight specific areas participants described as challenging their OI, well-being, and PS role development. The issues became more apparent as their ability to perform the PS role grew and as they considered leaving the developmental nest to further their PS careers.

Struggling to Fly

Participants spoke of the discrepancies between the initial promise of the PS role and their experience of undertaking it. The issues they described while performing the PS role and how it has been integrated across the organisation often left them feeling less secure about progressing the position. A common theme was the difficulty of working in an environment that was not structured to support the PS role. They voiced concerns around establishing working relationships and attempting to integrate into teams with little understanding of RBP.

Non-adherence to Recovery-based Practice

Their experiences represent a common challenge for PSWs and could be symptomatic of the large number of formulations offered to intercept changes in RBP. This is primarily due to the number of PS initiatives that permeate much of the international policies surrounding mental health and continue to grow within MHS (Slade et al., 2014). Notwithstanding, recovery is a complex, multifaceted concept in need of more research on the specific characteristics that constitute good recovery-oriented practice and environment (Mancini, 2008) and how it is can be optimised within MHS (Bird et al., 2011; Le Boutillier et al., 2011). Staff training to help promote awareness of the PS role has been recognised as fundamental (Gillard, 2017). The literature also calls for more empirical research to discover the contribution MHS make to recovery and what implications there may be for policy and procedures (Andresen et al., 2011). Despite the divergence of opinion among theorists and the PSM, there is an agreement that the external environment plays a significant role in facilitating the internal conditions for PSWs recovery (Bedregal et al., 2006). Participants verified that negative interactions with team members disrupted their confidence and sense of meaning/belonging. During their first year of performing the role, such experiences seemed to leave them perceiving the role as tokenistic and that they were less than equal to other team members.

Their views are further supported by the literature, which calls for the PS role to be implemented with viable integration plans if it is to be genuinely sustainable across different types of organisations (Bluebird, 2008). Consistent with earlier research is that leadership and commitment from management are critical requirements for successful implementation. The literature reports that a lack of awareness of RBP creates misunderstanding for PSWs and the teams they are assigned to (Faulkner & Basset, 2010). Where integration of the role is weak, there appear to be far-reaching problems for PSWs that, in some cases, can discredit the position itself (Perkins et al., 2009). These roadblocks for PS in the work environment were further identified by Moran et al. (2012).

Participants questioned their identity and reported feeling marginalised by staff who seemed unaware of how to direct their PS duties. Typically, this happened in environments where PS work was new, and there was little or no job description. Their experiences are confirmed by Myrick and del Vecchio (2016), who identified that inconsistent policy, documentation of core competencies and a lack of formal structure, undermines the integrity of PS. A more structured integration of the role would perhaps allow PSW a smoother and less troublesome start, all of which impact the rate and quality of their OI development.

Martin summarised the generic problems he encountered when he referred to the NHS as taking "*a step into the unknown*". His comments were considered to mean Martin was acknowledging that problems exist for both the NHS and the PS role. However, there has been a national initiative driven in part by the NHS and Health Education England (HEE) to promote the employment of PSWs. Details were incorporated into "Stepping Forward to 2021", a collaboratively developed five-year plan for MHS. The paper outlines improvement targets for 2021 (HEE, 2017). Although the directive to grow the number of PSWs employed is an integral part of the plan, it remains to be reported whether the integration of the PS role and supporting policy have also be actioned.

Overall, participants shared that the reported issues occurred early in employment when they required more rigidity and formal guidance to help perform their work. Typically, this is when participants were transitioning from an identity of SU to PSW and when they encountered most obstacles in the workplace. Their views align with those expressed by

Simpson et al. (2018), who concluded that PSW's develop a "liminal identity" during the initial stages (first six months) of performing the role, which leaves them "betwixt and between" the identities of SU and service provider. However, despite highlighting the importance of recognising this 'liminal' identity, their study was limited by PSWs only have six months of experience in situ. They were, therefore, only able to comment on the faltering early stages of the transition process.

It is essential to remain mindful of the transitions experienced by PSWs, particularly in the case of professionals working alongside PSW, as they have a duty of care to ensure that authentic empathic relationships are developed and in place to eradicate the discrimination noted by participants. The effect of infrastructure or lack of it on the PSWs and the consequences of introducing PS into a non-recovery-based environment have been well documented (Dixon et al., 1994; Mowbray et al., 1997; Gillard et al., 2014, Repper & Carter 2011, Faulkner, 2013). The results from the current research highlight that despite a plethora of literature reporting how far MHS has come in using service users as "experts by experience", the problems remain.

Arrested Development – No flight path between organisations

Participants described that feeling accomplished in their employment had generated the confidence to be more curious and outward-looking about how they could continue to develop their OI beyond their current environment. They identified problem areas such as the length of employment contracts and the quality/authenticity of the training courses as the main impediments to continued personal growth.

For most participants, the training was sufficient to move between departments but lacked the necessary certification to qualify for similar roles beyond the Trust. Winifred shared her disappointment when she realised that her initial training course was not accredited. Despite having more than three years of peer support experience, she was not eligible for a PS role advertised within another Trust.

Another concern raised by all participants was the length of the employment contract and the uncertainty surrounding contract renewal. George had several contracts throughout his 30 months of employment and shared his distress at being notified that his contract would not be renewed at the last minute. Although not strictly relating to PSW's, the literature exploring employment and contracts suggests that short-term contracts are likely to provoke psychological concern through uncertainty, particularly in those who wish to work full time (Moscone et al., 2016).

This research highlights that the contracts process would benefit from closer attention by human resources and recruitment management so they can focus on procedures that promote the well-being of those who perform the role.

A recent paper argues that the UK has moved beyond the "tenuous early stages" (Gillard et al., 2017, p. 134) of development and that PS is now an accepted fixture within organisations.

Whilst this study has found PS is indeed a 'fixture' within the NHS. The results further align a statement by Watson, who refers to PS as a concept that '*has grown beyond infancy'* and is now *'spilling out in all directions'* (2017, p. 346). Watson's research paints a picture of PS being chaotically drawn into mainstream health systems without clearly defined boundaries. Watson, herself a PSW, warns of the potential pitfalls associated with the rapid introduction of PS. Her caution resonates with participant views which illustrate the consequences of a poorly defined process and framework.

It is relevant to note that PSWs are often developing their OI under the negative influences of the medical model, notably the vocabulary used to describe illness and dysfunction within the field of mental health. Wilcox (2005) explicitly stated that “a medical science view masks the powerful relationship that exists between occupation and health”.

These findings highlight the complexity of SUs, forming the OI of a PSW within an environment that is struggling to provide the necessary structure to develop the PS role. Despite the lack of infrastructure, participant well-being was significantly improved through both social and work-related activities. Having developed a strong sense of purpose and being meaningfully occupied were considered core assets in developing participants OI.

Conclusion

This final chapter identifies the strengths and limitations of this research and highlights areas for future research, together with the implications for practice and the developing PS pathway.

Adding to Existing Knowledge

This study has added to the sparse literature relating to PSWs OI by reporting how participants declared their quality of life improved considerably by developing, owning, and embracing their OI.

Their development occurred by being meaningfully employed, allowing participants a renewed sense of self-identity, which served to keep them well, psychologically robust, and future-orientated. By feeling empowered, they reported being able to deal with everyday life stressors. Although a definitive structure or universal method for developing an OI was not found, the ensuing OI appears to evolve through a symbiotic process involving social inclusion, recovery and autonomy. These elements were considered as individualistic, complex and dynamic.

The foundations of their occupational competence appeared to grow in parallel with their embryonic OI, which led to feelings of empowerment and where they no longer felt encumbered by previously held labels. For example, early gains came from believing that a change from their previous identity of “mental patient” to a professional identity was possible. Their OI seemed to be intrinsically linked to the title of PSW, the perceived prestige of identifying as an NHS employee and a radical change of life circumstances.

As participants engaged in their new occupation, their identity changed, and the recovery journey began. In summary, the narratives show OI and recovery are intrinsically linked. Developing an OI is similar to the process of recovery, where neither matures linearly, but both promote the growth of self-empowerment and self-efficacy. The changes reported were accompanied by enhanced feelings of self-motivation as participants often worked in areas where support for the role was limited. Through sheer determination, they used their recovery and a more positive sense of self to promote feelings of authenticity and purpose.

This research has shown the PS role to be successful but limited and limiting within this NHS Trust. Despite the promise of a new pathway, the PS role appears to be periphery within individual departments. Developing the PS role further will require more emphasis on policy structures and improved staff training/awareness.

Participants in this study were not considered fledgelings looking to spread their metaphorical wings but were experienced PSWs, with substantial experience of the role. They had helped shape the role in areas where PS was nothing but a notion and developed it to such an extent that they no longer considered the position to be tokenistic. Participants created value by feeling confident in their ability to support SUs and to understand other team members. There is an element of irony in this accomplishment as most research calls for professional staff and team members to become more aware of the PS role and provide them with a greater level of support.

There is no clearly defined career pathway for participants and, in some cases, no contract to continue PSW employment. These results show that participants struggle to move forward in the workplace despite gaining significant experience in the role. A generic career pathway across NHS Trusts could better promote the developing PS role and the well-being of those performing it. The analysis also suggests that participants were better able to progress when the relevant recovery-focused support was in place. Equally, the analysis documents that insufficient information relating to role specification and lack of awareness by the professional staff of what constitutes “recovery” can impede PS success and impact the developing OIs of those performing the role. The NHS needs to consider how they are implementing the PS role and ensure that systems are in place to promote sustainable development and support for both OI and recovery.

The requirements identified resonate with the words of Kinderman (2019), who calls for a revolution in mental health care that will help change the dominant evidence-based practice within the NHS. From the literature, it appears PS is here to stay and, as such, should be afforded the same support and professional development as other professions within the NHS.

Evaluation and Limitations of the Current Study

The strength in using IPA for this research is that it enables good quality data to be captured during interviews and provides a nuanced understanding of how a group of PSWs form their occupation identity. As with all qualitative research, I remained mindful of the weakness that can be caused by the subjective nature of the approach and reiterate that the conclusions result from my interpretation of the data gathered. The sample size was small and not considered a definitive representation of the PS community. As a result, it did not allow substantive conclusions or generalisations to be drawn from the data. In addition, other urban NHS Trusts may differ in their approach to PS by using alternative policy and procedures, staff training and different job descriptions.

Homogeneity of the sample was achieved by recruiting from one NHS Trust, with a diverse mix of personal variables (i.e. gender, race, age). While the diversity of personal attributes is acknowledged, on reflection, I felt there was an absence of narrative informing how ethnicity may have interacted with the other identity intersections during the formation of their OI. For example, how ethnic minority groups with lived experience of mental health problems may have experienced more stigma and discrimination than their white peers. Research suggests that in comparison to white people, ethnic minority groups have less satisfactory experiences with the mental health system (Carter et al., 2017; Rethink, 2021). I further considered the possible impact of my demographic as a white female counselling psychologist in training and being an outsider to their group. Perhaps if a researcher from within the organisation and possibly from a more diverse background had conducted the interviews, the participants might have felt more comfortable talking about ethnicity and discrimination.

In response to a letter of invitation sent to all PSWs employed within the Trust, participants then self-selected to join the study. With one exception, all participants had more than two years post-training experience, so it is possible that these responders may have been further advanced in their recovery and better able to engage in the participation process than those with less experience. Therefore, larger sample sizes may produce different results.

Four years before the current study, I was part of a research project with the Trust (as discussed in an earlier reflective statement). Although I did not have any in/formal relationship with members of the Trust, participants may have been aware that I was a psychologist known to the Trust. Reflection on this point led me to question whether participants had accentuated the positive elements of the role rather than being more candid about their experiences. This factor could also have been influenced by the fact that all interviews were conducted at Trust headquarters. Despite efforts to ensure confidentiality and anonymity, participants may have been affected by their surroundings and unable to be completely open about their experiences.

For absolute clarity, the Trust agreed to sponsor this project and my ethics application with the Health Research Authority. They felt the research question could add knowledge to the progression of the peer support role. The intention was not to focus on a need for change but rather to generate data on the subjective experiences of PSWs forming their occupational identities. There were clearly defined boundaries between the Trust and myself and a strict code of ethics that governed the conduct of this project. The sponsors allowed me to advertise the research within the Trust and agreed to email details of the study to all existing peer support employees. During early discussions, I ascertained that the Trust no longer employed the PSWs involved in the previous research project, ensuring no potential conflict of interest with or prior knowledge of the participants recruited. Although there was no explicit discussion on the Trusts expectation of the research, I wondered if there might be an implicit expectation of a favourable report by virtue of having access to staff and using Trust facilities. I remained mindful of an earlier reflection during the data analysis stage of this project that I should stay close to participant narratives and present an accurate interpretation of their data.

Methodological Limitations

The data was gathered using semi-structured interviews, where the researcher held the agenda, directed the flow of questions, and thereby potentially influenced participant responses (Low, 2013). Alternative methods such as participatory research are frequently applied to offset this power imbalance in qualitative research. The Department of Health (DOH, 2017) and BPS (2019) actively encourage ‘experts by experience’ involvement in research endeavours to ensure shared principles and values. There is evidence that more successful outcomes are generated by actively including participants in defining the research question, selecting research methodology, and seeking support in interpreting research findings (Bergold & Thomas, 2012).

This research is limited by not adopting a participatory approach, although most co-productions and variations of participatory research aim to promote change. The current study did not seek a defined outcome, and neither did it set out to explore areas that required change. However, on reflection, involvement from participants may have produced a different data set. For example, soliciting PSWs opinions on the nature of the questions used in data gathering or their ideas on the super/subordinate themes as they developed may have provided greater clarity by enriching the researcher's conclusions. The participatory research approaches also align well with counselling psychology's respect for client identity. It remains important to include participants and acknowledge their voices early in the research process.

One final point of concern was that participants predominantly relied on their memory to account for events that happened years earlier. It is possible that the participants had not reflected on past events accurately.

Future Research

Research into the experience of forming the occupational identity of a peer support worker is limited in the UK. This project has contributed to the literature by providing a voice for experienced PSWs. It has also identified several areas that would benefit from further investigation, which could be considered starting points for further research.

The present study was firmly focused on reporting the participants' subjective experiences and not wanting to affect change. The results reported inconsistencies across the Trust relating to role definition, professional awareness of managing the PS role, and how best to contract it. All of these factors appeared to have impeded the progression of their career. Future research aiming to build on these findings would benefit from adopting an action-orientated approach focused on these areas needing change. A practical suggestion would be to use participatory action research (PAR), which is an equitable method in which the traditional roles of researcher and participant are changed, ensuring the research is democratic and inclusive (Reason & Bradbury, 2006). Like all variations of action research, the purpose of PAR is to create social change through specific goals and actions, typically achieved by engaging with the people most affected (McNiff & Whitehead, 2006).

The result of this study also resonates with the newly published competency framework for PSWs, which has been developed to support the growth of peer support within mental health services (HEE, 2020). The framework was designed to protect PSWs from being subjected to inappropriate ways of working or practices that do not make good use of their skills. It could be that using the framework as guidance, collaborative research projects involving PSWs and their managers/supervisors could improve current working conditions within the Trust and help to facilitate greater job satisfaction for all involved. These projects could benefit further by inviting counterparts from different Trusts to share best practice and their experience of OI development.

An exploration of how different management styles impact the well-being of PSWs could also provide greater insight into the challenges highlighted in this research and ensure staff are suitably trained in the management and supervision of PSWs.

Further research projects could also benefit from focusing on intersectionality theory to explore how PSWs multiple social identities intersect (Atewologun, 2018), including considering that PSWs stress at work may be additive when compounded with the effects of other intersections. As previously mentioned, those from ethnic minority groups and with lived experience of mental health problems may suffer increased stigma and discrimination compared to their white peers. Therefore, explicitly exploring the intersection between PSWs

OI and race, ethnicity, religion, and gender could generate further knowledge and empower those concerned.

Dissemination of this Research

All participants of this research have requested a copy of the thesis, which will initially be disseminated to them. I will be available to answer any queries they may have and to discuss any ideas on content or how to share the results further.

With sponsor approval, I will offer to distil the report and support participant distribution through internal PSW networks. The results will initially be presented to the Trust sponsor and stakeholders, with a view of establishing a list of projects for change. It is hoped this will then be further disseminated within the organisation to reach those interested but unable to participate initially.

It is thought, PSWs in collaboration with relevant stakeholders may want to initiate research within their communities as part of the projects for change. These projects could develop a more in-depth understanding of the intersections of identity faced by PSW and how systems could efficiently change.

An interim report relating to the Health and Care Workforce Strategy for England to 2027 (HEE, 2019) has provided evidence that the NHS can better promote the mental well-being of its staff. Similarly, the current study has highlighted several areas that require changes to promote the well-being of PSWs. Consideration could be given to aligning the results from this research with the national policy goals mentioned above to help drive projects for change.

Implications for Counselling Psychology and the Greater Community

Important implications for mental health professionals have been raised in this research, including training for managers and staff involved in the introduction and growth of PS. The NHS has a duty of care to ensure that the relevant infrastructure is in place to prepare the work environment and teams to accommodate the emerging PS role and to accommodate the performance/outcomes of the role. Clearer guidelines covering the necessary support to promote PSW recovery and career pathways could prevent PSWs from developing an inhibited or diluted OI. Without such changes, we risk the mental health of those performing the role and of losing a valuable resource from an already stressed MHS within the NHS. Further, the positive outcomes from PS would be enhanced by a shift from a ‘medical model’ mode of practice to RBP. It seems that despite the plethora of literature reporting MHS progress in using PSWs, there is still some way to go before the potential of the approach is fully realised (Bailie & Tickle, 2015, Bird et al., 2011, Gillard et al., 2018).

My intention for this research was to raise awareness within the CoP community of the plight of this demographic group. Particularly for CoPs working in the NHS who would have an opportunity to challenge how PSWs may be viewed by others and help promote a greater understanding of their needs. As CoP favour a social justice framework that views individuals through a humanistic lens, we are well placed to encourage the development of the PS community.

As previously mentioned, there are commonalities in CoP and the PSM ethos, along with parallels between the evolving identities. However, given that the NHS increasingly employs both professions, PSWs and CoPs must not be co-opted into the prevailing medical model focusing on aetiology and pathology. Instead, they should both consider their core premise of promoting a person-centred recovery-based practice, honouring diversity and respecting clients' subjective experience.

This research further highlights the value and importance of using service users and experts by experience to inform and deliver CoP training courses (BPS, 2019) which can help trainees stay at the forefront of the social and political demands of the profession and those they serve.

As counselling psychologists, we are encouraged to look beyond labels and diagnosis to better understand individuals and their subjective experiences. I anticipate this research may inform practice for those working with PSWs and emphasise the importance of holding an appropriate and supportive space for the PSWs involved. By helping to empower the individuals performing the PS role, it is considered that RBP would also benefit.

I hope this research may further encourage clinicians who have experienced mental health difficulties and feel able to share their experiences. The BPS knowledge that professionals with "lived experience is an asset to the profession and make a significant contribution to it" (BPS, 2020). They are well placed to champion the cause of PS.

The information shared by participants in this study could contribute to the PS role's future development and better inform working environment strategies, policy and procedures. Further, it could be used to develop knowledge and awareness of areas that potentially demotivate or distract PSWs.

Further, from a clinical perspective, CoPs are well placed to promote the growth of the PS role by recognising the strength of PSW ‘story-telling and use their support to help provide narrative group therapy (NGT) to SUs within MHS. As the PS role commonly draws on past experience to encourage the reconstruction of new identities, PSWs are well placed to help deliver NGT, which aims to promote the same (Angus & McLeod, 2004). In turn, this could open a valid pathway fulfilling the needs of both MHS and PSWs. Counselling psychologists must be mindful of the challenges faced by PSWs and better promote a more holistic integration of the PS role in practice.

References

Ade-Serrano, Y., & Nkansa-Dwamena, O. (Eds.), (2020). Foreword. In *Applied Psychology and Allied Professions Working with Ethnic Minorities*. The British Psychological Society.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)*. Arlington.

Andresen, R., Oades, L. G., & Caputi, P. (2011). *Psychological Recovery: Beyond Mental Illness*. John Wiley & Sons.

Ahmed, A. O., Hunter, K. M., Mabe, A. P., Tucker, S. J., & Buckley, P. F. (2015). The Professional Experiences of Peer Specialists in the Georgia Mental Health Consumer Network. *Community Mental Health Journal*, *51*(4), 424-436. https://doi.org/10.1007/s10597-015-9854-8

Anfossi, A. (2017). The Current State of Recovery Colleges in the UK. https://imroc.org/resources/anfossi-a-2017-the-current-state-of-recovery-colleges-in-the-uk-final-report-nottingham-imroc

Angus, L. E., & McLeod, J. (Eds.). (2004). *The Handbook of Narrative and Psychotherapy: Practice, Theory and Research*. Sage. https://www.doi.org/10.4135/9781412973496

Antonovsky, A. (1996a) The Salutogenic Model as a theory to guide health promotion. *Health Promotion International 4*(11), 102. https://ademic.oup.com/ heapro/article-abstract

Antonovsky, A. (1996b). The Sense of Coherence: An Historical and Future Perspective. *Journal of Medical Sciences, 32*(3), 170–178. https://doi.org/10.1177/01939459922043820

Antonovsky, A. (1990). A Somewhat Personal Odyssey in Studying the Stress Process. *Stress Medicine, 6*(2), 71–80. https://doi.org/10.1002/smi.2460060203

Ashforth, B. (2000). *Role Transitions in the Organizational Life: An Identity-based Perspective*. Routledge.

Atewologun, D. (2018). Intersectionality Theory and Practice. *Oxford Research Encyclopedia of Business and Management, 8*(4),113-168. https://doi.org/10.1093/acrefore/9780190224851.013.48

Austin, E., Ramakrishnan, A., & Hopper, K. (2014). Embodying recovery: A Qualitative Study of Peer Work in a Consumer-run Service Setting. *Community Mental Health Journal, 50*(8), 879-885. https://doi.org/10.1007/s10597-014-9693-z

Bailie, A. M. & Tickle, A. (2015). Effects of employment as a peer support worker on personal recovery: a review of qualitative evidence. *Mental Health Journal 20*(1),48-64. https://doi.org/10.1108/MHRJ-04-2014-0014

Bandura, A. (1977). *Social Learning Theory*. Prentice-Hall.

Basset, T., Faulkner, A., Repper, J., & Stamou, E. (2010). Lived experience leading the way: Peer support in mental health. *Together UK*. https://www.together-uk.org/wp-content/uploads/downloads/2011/11/livedexperiencereport.pdf

Baumeister, R. F. (1997). Identity, Self-concept and Self-esteem. In Hogan, R., Johnson, J. & Briggs, S. (Eds.), *Handbook of Personality Psychology* (pp. 681–711). Academic Press.

Bedregal, L. E., O’Connell, M., Davidson, L., (2006) The Recovery Knowledge Inventory: Assessment of mental health staff knowledge and attitudes about recovery. *Psychiatric Rehabilitation Journal, 4*(30), 96–103. https://doi.org/10.2975/30.2006.96.103

Bentall, R. P. (2010). *Doctoring the Mind: Why Psychiatric Treatments Fail*. Penguin.

Bergold, J., & Thomas, S. (2012). Participatory Research Methods: A Methodological Approach in Motion. *Historical Social Research, 37*(4), 191-222. https://www.jstor.org/stable/41756482

Bhaskar, R. (2008). *A Realist Theory of Science*. Routledge.

Bird, V., Leamy, M., Le Boutillier, C., Williams, J., & Slade, M. (2011). REFOCUS: Promoting recovery in community mental health services. https://www.researchintorecovery.com/refocus-promoting-recovery-in-community-mental-health-services

Blair, L. (2010). A Critical Review of the Scientist-practitioner Model for Counselling Psychology. *Counselling Psychology Review*, *25*(4), 19-30. https://www.researchgate.net/publication/272021892_A_critical_review_of_the_scientist_practitioner_model_for_counselling_psychology

Bluebird, G. (2008). Paving New Ground: Peers Working in Inpatient Settings. https://www.nasmhpd.org/content/paving-new-ground-peers-working-patient-settings

Bourdieu, P. (2003). Participant objectivation. *Journal of the Royal Anthropological Institute*, *9*(2), 281-294. https://rai.onlinelibrary.wiley.com/doi/full/10.1111/1467-9655.00150

Bracke, P., Christiaens, W., & Verhaeghe M. (2008). Self-esteem, self-efficacy, and the balance of peer support among persons with chronic mental health problems. *Journal Of Applied Social Psychology 38*(2),436-459. https://doi.org/10.1111/j.1559-1816.2008.00312.x

British Psychological Society (2020). Supporting and valuing lived experience of mental health difficulties in clinical psychology training. The British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/MemberNetworks/Divisions/DCP/Livedexperienceofmentalhealthdifficulties/inclinicalpsychologytraining.pdf

British Psychological Society (2019). Standards for the Accreditation of Doctoral programmes in counselling psychology. https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%202019.pdf

British Psychological Society (2018). Code of Human Research Ethics. https://www.bps.org.uk/sites/Policy/BPSCodeofHumanResearchEthics.pdf

British Psychology Society (2017). Practice Guidelines (Third Edition). www.bps.org.uk/Policy/PracticeGuidelinesThird Edition.pdf

Bhui K., Nazroo J., Francis J. (2018). The Impact of Racism on Mental Health. https://synergicollaborativecentre.co.uk/wp-content/uploads/2017/11

Burgess, RG. (1991). *Field Research: A Sourcebook and Field Manual.* Routledge.

Campbell, J. (2005). The Historical and Philosophical Development of Peer-Run Support Programs. In S. Clay, B. Schell, P. W. Corrigan, & R. O. Ralph (Eds.), *On our own, together: Peer programs for people with mental illness* (pp. 17–64). Vanderbilt University Press.

Care Quality Commission (2017). Press release: CQC Warns Mental Health Sector is at a Crossroads. www.cqc.org.uk/news/releases

Carlson, L. S., Rapp, C. A. & McDiarmid, D. (2001). Hiring consumer-providers: Barriers and alternative solutions. *Community Mental Health Journal, 37*(3), 199-213. doi: 10.1023/a:1017569913118

Carter, R. T., Lau, M. Y., Johnson, V., & Kirkinis, K. (2017). Racial discrimination and health outcomes among racial/ethnic minorities: A meta-analytic review. *Journal of Multicultural Counseling and Development*, *45*(4), 232-259. https://doi.org/10.1002/jmcd.12076

Centre for Mental Health. (2021). Response to the Mental Health Act White Paper. https://www.centreformentalhealth.org.uk/sites mentalhealthsummaryresponsemhawhitepaper21042021.pdf.

Christiansen, C. H. (1999). Defining lives: Occupation as identity: An essay on competence, coherence, and the creation of meaning. *American Journal of Occupational Therapy*, *53*(6), 547-558. https://doi.org/10.5014/ajot.53.6.547

Christiansen, C. (2004). *Introduction to Occupation. The Art and Science of Living.* Pearson.

Cooper, M. (2008). *Essential Research Findings in Counselling and Psychotherapy: The Facts are Friendly*. Sage.

Corrie, S., & Callahan, M. M. (2000). A Review of the Scientist-practitioner Model: Reflections on its potential contribution to counselling psychology within the context of current health care trends. *The British Journal of Medical Psychology, 73*(3), 413-73. https://doi:10.1348/000711200160507

Corrigan, P. W., Rafacz, J., & Rüsch, N. (2011). Examining a Progressive Model of Self-Stigma and its Impact on People with Serious Mental Illness. *Psychiatry Research*, *189*(3), 339-343. https://doi.org/10.1016/j.psychres.2011.05.024

Corrigan, P.W. (2016). *Principles and Practice of Psychiatric Rehabilitation*, Guildford Press.

Corrigan, P. W. (2016). Lessons learned from unintended consequences about erasing the stigma of mental illness. *World Psychiatry*, *15*(1), 67-73. https://doi.org/10.1002/wps.20295

Crane, D. A., Lepicki, T., & Knudsen, K. (2016). Unique and common elements of the role of peer support in the context of traditional mental health services. *Psychiatric Rehabilitation Journal*, *39*(3), 282–288. https://doi.org/10.1037/prj0000186

Crisanti, A. S., Murray-Krezan, C., Karlin, L. S., Sutherland-Bruaw, K., Najavits, L. M. & Walla, P. (2016) Evaluation of an evidence-based practice training for peer support workers in behavioural health care. *Cogent Psychology Journal, 3*(1), 1212453. Doi:10.1080/23311908.2016.1212453

Cutts, L. A. (2013). Considering a social justice agenda for counselling psychology in the UK. *Counselling Psychology Review, 28*(2), 8-16. https://www.researchgate.net/publication/261056065_Considering_a_social_justice_agenda_for_counselling_psychology_in_the_UK

Cypress, B. S. (2017). Rigor or reliability and validity in qualitative research: Perspectives, strategies, reconceptualization, and recommendations. *Dimensions of Critical Care Nursing, 36*(4), 253-263. doi:10.1097/DCC.000253

Davidson, L., Bellamy, C., Guy, K. & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry, 11*(2), 123-128. https://doi.org/10.1016/j.wpsyc.2012.05.009

Davidson, L., Chinman, M. J., Kloos, B., Weingarten, R., Stayner, D. A., & Tebes, J. K. (2005). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice, 6*(2), 165–187. https://doi.org/10.1093/clipsy.6.2.165

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: a report from the field. *Schizophrenia Bulletin*, *32*(3), 443-450. https://doi.org/10.1093/clipsy.6.2.165

Davidson, L., Rakfeldt, J., & Strauss, J. S. (2010). *The Roots of the Recovery Movement in Psychiatry: Lessons Learned*. Wiley-Blackwell.

Davis, J. L., Love, T. P., & Fares, P. (2019). Collective Social Identity: Synthesizing identity theory and social identity theory using digital data. *Social Psychology Quarterly, 82*(3), 254-273. https://doi.org/10.1177/0190272519851025

Deegan, P. E. (1988). Recovery: The Lived Experience of Rehabilitation. *Psychosocial Rehabilitation Journal*, *11*(4), 11-19. doi:10.1037/h0099565

Deegan, P. E. (2001). Recovery as a self-directed process of healing and transformation. In C. Brown (Ed.) *Recovery and wellness: Models of hope and empowerment for people with mental illness.* Haworth Press.

Dennis, C.L. (2003). Peer support within a health care context: a concept analysis. *Journal of International Nursing Studies*, *40*0(3), 321–332. https://doi.org/10.1016/S0020-7489(02)00092-5

Department of Health. (2009). New Horizons: Towards a shared vision for mental health. https://www.dh.gov.uk/en.consultations 103144

Department of Health. (2016). Annual Report of the Chief Medical Officer, Public Mental Health Priorities. https://www.gov.uk/government/publications /chief medical-officer-cmo-annual-report-public-mental-health

Dixon, L., Krauss, N., & Lehman, A. (1994). Consumers as service providers: The Promise and Challenge. *Community Mental Health Journal*, *30*(6), 615-625. doi:10.1007/BF02188599

Doughty, C., & Tse, S. (2011). Can Consumer-Led Mental Health Services be Equally Effective? An Integrative Review of CLMH Services in High-Income Countries. *Community Mental Health Journal, 47*(3), 252-266 15p. doi:10.1007/s10597-010-9321-5

Dunn, E. C., Wewiorski, N. J., & Rogers, E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study. *Psychiatric Rehabilitation Journal*, *32*(1), 59–62. doi:10.2975/32.1.2008.59.62

Dunn, R. G. (1997). Self, identity, and difference: Mead and the poststructuralists. *The Sociological Quarterly*, *38*(4), 687-705. https://doi.org/10.1111/j.1533-8525.1997.tb00760.x

Dyble, G., Tickle, A., & Collinson, C. (2014). From end-user to provider: making sense of becoming a peer support worker using interpretative phenomenological analysis. *Journal of Public Mental Health, 2*(13), 1746-5729. doi/10.1108/JPMH-03-2013-0016

Engel, G. L. (1988). The need for a new medical model: a challenge for biomedicine. *Science, 196*(4286), 129-136. http://doi.org/10.1126/science.847460

Eriksson M. (2017) The Sense of Coherence in the Salutogenic Model of Health. In: Mittelmark M. (Eds) *The Handbook of Salutogenesis*. Springer. https://doi.org/10.1007/978-3-319-04600-6_11

Faulkner, A. & Basset, T. (2012). A helping hand: taking peer support into the 21st century. *Mental Health and Social Inclusion, (16)*, 41-47. DOI:10.1108/20428301211205892

Faulkner, A., & Basset, T. (2010). A Helping Hand: Consultations with Service Users about Peer Support. *Together For Mental Wellbeing.* https://www.together-uk.org/wp-content/uploads/downloads/2011/11/helpinghand.pdf

Faulkner, A., & Kalathil, K. (2012). The Freedom to be, the chance to dream: Preserving user-led peer support in mental health. http://www.together-uk.org/wp-content/uploads/2012/09/The-Freedom-to-be-The-Chance-to-dream-Full-Report1

Festinger, L. (1954). A Theory of Social Comparison Processes. *Human Relations*, doi.org/10.1177/001872675400700202

Finlay, L. (2002). “Outing” the researcher: The Provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531-545. https://doi.org/10.1177/104973202129120052

Finlay, L. & Gough, B. (2003). *Deconstructing Reflexivity.* Wiley Online Library. doi.org/10.1002/9780470776094.ch2

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the phenomenological psychological attitude. *Journal of Phenomenological Psychology, 39*(1), 1-32. https://doi.org/10.1163/156916208X311601

Fitzpatrick M. & Newton J. (2005) Profiling mental health needs: what about your Irish patients? *The British Journal of General Practice*, *55*(519), 739-740. PMC1562353

Foucault, M. (1967). *Madness & Civilization*. Random House.

Frankl, V. E. (1985). *Man's Search for Meaning.* Simon and Schuster.

Gray, M., Davies, K., & Butcher, L. (2017). Finding the right connections: Peer support within a community-based mental health service. *International Journal of Social Welfare*, *26*(2), 188–196. https://doi.org/10.1111/ ijsw.12222

Gates, L. B., & Akabas, S. H. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. *Administration and Policy In Mental Health and Mental Health Services Research*, *34*(3), 293-306. doi:10.1007/s10488-006-0109-4

Gewurtz, R., & Kirsh, B. (2007). How consumers of mental health services come to understand their potential for work: Doing and becoming revisited. *Canadian Journal of Occupational Therapy*, *74*(3), 195–207. https://doi.org/10.2182/cjot.06.014

Gillard S., Edwards C., Gibson S., Holley J. & Owen, K. (2014). New ways of working in mental health services: a qualitative, comparative case study assessing and informing the emergence of new peer worker roles in mental health services in England. *Health Services and Delivery Research, 2*(19). doi.org/10.3310/hsdr02190

Gillard, S., Foster, R., Gibson, S., Goldsmith, L., Marks, J. & White, S. (2017). Describing a principles-based approach to developing and evaluating peer worker roles as peer support moves in mainstream mental health services. *Mental Health and Social Inclusion, 21(*3), 133-143. https://doi.org/10.1108/MHSI-03-2017-0016

Gillard, S., Gibson, S. L., Holley, J., & Lucock, M. (2015). Developing a change model for peer worker interventions in mental health services: a qualitative research study. *Epidemiology and Psychiatric Sciences*, *24*(5), 435. http://doi./10.1017/S2045796014000407

Gillard, S. (2019). Peer support in mental health services: where is the research taking us, and do we want to go there?. *Journal of Mental Health*, *28*(4), 341-344.
https://doi10.1080/09638237.2019.1608935

Goffman, E. (1963). *Stigma: Notes on the management of a Spoiled Identity*. Prentice-Hall.

Goldstrom, I. D., Campbell, J., Rogers, J. A., Lambert D. B., Blacklow, B., & Henderson, M. J., (2006). National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(1), 92–102. DOI: 10.1007/s10488-005-0019-x

Gordon S. (2005). The Role of the Consumer in the Leadership and Management of Mental Health Services. *Australasian Psychiatry, 13*(4*)*, 362–65. https://doi.org/10.1080/j.1440-1665.2005.02215.x

Government UK. (2018). Data Protection Act. Department for Digital, Culture, Media & Sport. https://www.gov.uk/government/collections/data-protection-act-2018

Grant, J. (2010). Embracing an emerging structure in community mental health services: hope, respect and affection. *Qualitative Social Work*, 9(1), 53-72. https://doi.org/10.1177/1473325009355620

Gumley, A., Braehler, C., Laithwaite, H., MacBeth, A., & Gilbert, P. (2010). A Compassion Focused Model of Recovery after Psychosis. *International Journal of Cognitive Therapy, 3*(2), 186-201. https://doi.org/10.1521/ijct.2010.3.2.186

Hamilton, A., Chinman, M., Cohen, A., Oberman, R., & Young, A. (2015). Implementation of Consumer Providers into Mental Health Intensive Case Management Teams. *Journal Of Behavioural Health Services & Research, 42*(1), 100-108. doi:10.1007/s11414-013-9365-8

Hammell, K. W. (2009). Sacred texts: A sceptical exploration of the assumptions underpinning theories of occupation. *Canadian Journal of Occupational Therapy, 76*(1), 6-13. https://doi.org/10.1177/000841740907600105

Harper, D. & Speed, E. (2012). Uncovering recovery: The resistible rise of recovery and resilience. *Studies in Social Justice*. 6(1) 9-25. https://doi.org/10.1057/97811373046673

Harrington, S. (2011). Recovery to Practice Situational Analysis, National Association of Peer Specialists. https://www.samhsa.gov/sites/default/files/partnersforrecovery

Health Education England. (2017). Stepping forward to 2020/21: The Mental Health Workforce Plan for England. http://hdl.voced.edu.au/10707/450168

Heidegger, M. (1962). *Being and Time*. Harper.

Heise, D., MacKinnon, N., & Scholl, W. (2015). Identities, Roles, and Social Institutions: An Affect Control Account of Social Order. In E. Lawler, S. Thye, & J. Yoon (Eds.), *Order on the Edge of Chaos: Social Psychology and the Problem of Social Order* (pp. 165-188). Cambridge University Press. doi:10.1017/CBO9781139924627.010

Hogg, M. A. (2006). Social identity theory. In P. J. Burke (Ed.), *Contemporary Social Psychological Theories* (pp. 111–136). Stanford University Press.

Humm, R., & Simpson, A. (2014). Users of mental health services as peer support providers and research collaborators. *Journal Of Psychosocial Nursing And Mental Health Services, 52*(1), 3-4. doi:10.3928/02793695-20131126-01

Husserl, E. (1970). *Logical investigation.* Humanities Press.

Hutchinson, D. S., Anthony, W. A., Ashcraft, L., Johnson, E., Dunn, E. C., Lyass, A., & Rogers, E. S. (2006). The personal and vocational impact of training and employing people with psychiatric disabilities as providers. *Psychiatric Rehabilitation Journal*, *29*(3), 205-213. doi:10.2975/29.2006.205.213

Jacob, K. S. (2015). Recovery Model of Mental Illness: A Complementary Approach to Psychiatric Care. *Indian Journal of Psychological Medicine, 37*(2), 117–119. http://doi.org/10.4103/0253-7176.155605

Jones Nielsen, J. D., & Nicholas, H. (2016). Counselling psychology in the United Kingdom. *Counselling Psychology Quarterly 29*(2), 206-215. https://doi.org/10.1080/09515070.2015.1127210

Kasket, E. & Gil-Rodriguez, E. (2011). The Identity Crisis in Trainee Counselling Psychology Research and what to do about it. Counselling Psychology Review, 26(4), 20-30. https://psycnet.apa.org/record/2012-00109-003

Kasket, E. (2012). The counselling psychologist researcher. Counselling Psychology Review, 27(2), 64-73. https://psycnet.apa.org/record/2012-25166-005

Kemp, V., & Henderson, A. R. (2012). Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal*, *35*(4), 337-340. doi:10.2975/35.4.2012.337.340

Kielhofner, G. (2009). *Model of Human Occupation*. Williams & Wilkins.

Kinderman, P. (2019). *A Manifesto for Mental Health: Why We Need a Revolution in Mental Health Care.* Springer Nature.

Langdridge, D. & Hagger-Johnson, G. (2009). *Introduction to Research Methods and Data Analysis in Psychology*. Pearson Education.

Lambert, N. M., Graham, S. M., Fincham, F. D., & Stillman, T. F. (2009). A Changed Perspective: How gratitude can affect a sense of coherence through positive reframing. *The Journal of Positive Psychology*, *4*(6), 461-470. https://doi.org/10.1080/17439760903157182

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry,199*(6):445-52. doi:bjp.bp.110.083733

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric services*, *62*(12), 1470-1476. https://doi:10.1176/appi.ps.001312011

Leider, R. J. (2015). *The Power of Purpose: Creating Meaning in your Life and Work*. Berrett-Koehler Publishers.

LeVasseur, J. J. (2003). The Problem of Bracketing in Phenomenology. *Qualitative Health Research*, *13*(3), 408-420. https://doi.org/10.1177/1049732302250337

Levy, B., Celen-Demirtas, S., Surguladze, T., & Sweeney, K. K. (2014). Stigma and discrimination: A socio-cultural etiology of mental illness. *The Humanistic Psychologist, 42*(2), 199-214. https://doi.org/10.1080/08873267.2014.893513

Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., & Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry*, *14*(39). doi:10.1186/1471-244X-14-39

Loumpa, V. (2012). Promoting recovery through peer support: Possibilities for social work practice. *Social Work in Health Care*, *51*(1), 53-65. doi:10.1080/00981389.2011.622667, 53-65

Lyons. E., & Coyle, A. (2007), Analysing qualitative data in psychology. Sage.

MacNeil, C. & Mead, S. (2005). A Narrative Approach to Developing Standards for Trauma-Informed Peer Support. *American Journal of Evaluation*, *26*(2), 231-244. https:// doi:10.1177/1098214005275633

McNiff, J. & Whitehead, J. (2006). *All you Need to Know about Action Research*. Sage

Mahlke, C. I., Krämer, U. M., Becker, T., & Bocka, T. (2014). Peer support in mental health services. *Current Opinion in Psychiatry*, *27*(4), 276-278. https://doi: 10.1097/YCO.0000000000000074

Mancini, A. D. (2008). Self-determination theory: A framework for the recovery paradigm. *Advances in Psychiatric Treatment*, *14*(5), 358-365. https://doi.org/10.1192/apt.bp.107.004036

Mancini, M. A., & Lawson, H. A. (2009). Facilitating Positive Emotional Labor in Peer Providers of Mental Health Services. *Administration in Social Work*, *33*(1), 3-22. https://doi.org/10.1080/03643100802508619

Mancini, M.A. (2018). An Exploration of Factors that Effect the Implementation of Peer Support Services in Community Mental Health Settings. *Community Mental Health Journal*. *54*, 127–137. DOI: 10.1007/s10597-017-0145-4

Matthias, M. S., Salyers, M. P., Rollins, A. L., & Frankel, R. M. (2012). Decision making in recovery-oriented mental health care. *Psychiatric Rehabilitation Journal*, *35*(4), 305-314. doi:10.2975/35.4.2012.305.314

McCall, G. J., & Simmons, J. L. (1978). The Role-identity Model. Identities and interactions: An examination of human associations in everyday life. *Social Forces, 45*(3), 452. doi:10.1093/SF/45.3.452

McKenzie, K. (2006) *Social Capital and Mental Health*. Jessica Kingsley Publishers.

McLeod, J. (2013). *An Introduction to Research in Counselling and Psychotherapy*. Sage.

McQueen, P. and McQueen, H. (2010). *Key Concepts in Philosophy*. Palgrave MacMillan.

Mead S. & MacNeil C. (2006). Peer Support: What Makes It Unique? *International Journal of Psychosocial Rehabilitation*. *10*(2), 29-37.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer Support: A Theoretical Perspective. *Psychiatric Rehabilitation Journal*, *25*(2), 134-141. https://doi.org/10.1037/h0095032

Mead, G. H. (1934). *Mind, Self and Society (Vol. 111)*. University of Chicago Press.

Mental Health Foundation (2020). Mental Health Foundation Strategy 2020-2025: Making Prevention Happen. https://www.mentalhealth.org.uk

Mittelmark, M.B., & Bauer G.F. (2016). *The Handbook of Salutogenesis.* Springer. https://www.ncbi.nlm.nih.gov/books/NBK435831/doi: 10.1007/978-3-319-04600-6

Moran, G. S., Russinova, Z., Gidugu, V. & Gagne, C. (2012). Challenges Experienced by Paid Peer Providers in Mental Health Recovery: A Qualitative Study. *Community Mental Health Journal, 49*(3), 281-91. http://dx.doi.org/10.1007/s10597-012-9541-y

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250.

Mosher, L. R., & Burti, L. (1994). *Community Mental Health: A Practical Guide*. Norton.

Murphy, D. (Ed.) (2017). *Counselling Psychology: A Textbook for Study and Practice* (BPS Textbooks in Psychology). Wiley-Blackwell.

National Institute for Health and Care Excellence. (2020). Rehabilitation for Adults with Complex Psychosis. NICE guideline 181. https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#recovery-orientated-rehabilitation-services.

National Institute for Health and Care Excellence. (2016). Transition between Inpatient Mental Health Settings and Community or Care Home Settings. NICE Guideline 53. https://www.nice.org.uk/guidance/ng53

National Voices (2017). Reflections on the National Voices Annual Conference. www.pennybrohn.org.uk/2017/02/01/reflections-national-voices-2017

Nestor, P., & Galletly, C. (2008). The Employment of Consumers in Mental Health Services: Politically Correct Tokenism or Genuinely Useful? *Australasian Psychiatry*, *16*(5), 344-347. https://doi.org/10.1080/10398560802196016

Nkansa-Dwanena, O. (2017). Issues of Race and Ethnicity in Counselling Psychology. In Murphy, D. (Ed.), *Counselling Psychology: A Textbook for Study and Practice. (BPS Textbooks in Psychology*. (pp. 265-278). John Wiley and Sons Ltd.

Nuffield Trust (2015). NHS spending on the top three disease categories in England. https://www.nuffieldtrust.org.uk/chart/categories-of-nhs-spending-per-head

O'Hagan, M. (1996). Two Accounts of Mental Distress. http://www.maryohagan.com/resources/Text_Files/Two%20Accounts%20of%20Mental%20Distress.pdf

Pain, R., & Francis, P. (2003). Reflections on Participatory Research. *Area*, *35*(1), 46-54. https://doi.org/10.1111/1475-4762.00109

Parker, I. (2013). Discourse Analysis: Dimensions of Critique in Psychology. *Qualitative Research in Psychology, 10*(3), 223-239. https://doi.org/10.1080/14780887.2012.741509

Penny, D. (2017). Who Gets to Define “Peer support?”. www.madinamerica.com/2018/02/who-gets-to-define-peer-support

Perkins, R., & Farmer, P. (2009). Realising Ambitions: Better employment support for people with a mental health condition. Department of Work and Pensions. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228818/7742.pdf

Phelan, S., & Kinsella, E. A. (2009). Occupational Identity: Engaging socio-cultural perspectives. *Journal of Occupational Science*, *16*(2), 85-91. https://doi.org/10.1080/14427591.2009.9686647

Picket, K., Oliver, J. & Wilkinson, R. (2006). Income Inequality and the Prevalence of Mental Illness: A Preliminary International Analysis. *Journal of Epidemiology and Community Health*. *60*(7). 646-647. doi:10.1136/jech.2006.046631

Pilgrim, D. & McCranie, A. (2013). *Recovery and Mental Health: A Critical Sociological Account*. Palgrave Macmillan.

Pilgrim, D. (2005). *Key Concepts in Mental Health*. Sage.

Polt, R. (2013). *Heidegger: An Introduction*. Routledge.

Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative Phenomenological Analysis: A Discussion and Critique. *Nurse Researcher, 18*(3), 20-24. https://doi:10.7748/nr2011.04.18.3.20.c8459

Provencher, H. L., & Keyes, C. L. (2011). Complete Mental Health Recovery: Bridging Mental Illness with Positive Mental Health. *Journal of Public Mental Health*. *10*(1), 57-69. https://doi.org/10.1108/17465721111134556

Rafalin, D. (2010). *Therapy and Beyond: Counselling Psychology Contributions to Therapeutic and Social Issues.* John Wiley & Sons.

Reason, P. & Bradbury, H. (2006). *A Handbook of Action Research.* Sage.

Rebeiro Gruhl, K. L., LaCarte, S., Calixte, S. (2016). Authentic peer support work: challenges and opportunities for an evolving occupation. *Journal of Mental Health, 25*(1):78-86. doi: 10.3109/09638237.2015.1057322

Repper, J. (2013). Peer Support Workers: Theory and Practice. Implementing Recovery through Organisational Change, Briefing Paper. Centre for Mental Health. https://www.centreformentalhealth.org.uk/publications/peer-support-workers-theory-and-practice

Repper, J., & Carter, T. (2011). A review of the Literature on Peer Support in Mental Health Services. *Journal of Mental Health, 20*(4), 392-411. https://doi.org/10.3109/09638237.2011.583947

Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R., & Rennison, J. (2013). Peer Support Workers: A Practical Guide to Implementation. https://imroc.org/resources/7-peer-support-workers-practical-guide-implementation

Roberts, A. E., & Bannigan, K. (2018). Dimensions of personal meaning from engagement in occupations: A Metasynthesis. *Canadian Journal of Occupational Therapy*, *85*(5), 386-396. https://doi.org/10.1177/0008417418820358

Rose, D., MacDonald, D., Wilson, A., Crawford, M., Barnes, M. & Omeni, E. (2016). Service user led organisations in Mental Health Today, *Journal of Mental Health*, *25*,(3) 254-259. DOI: 10.3109/09638237.2016.1139070.

Rose, D. (2014). The Mainstreaming of Recovery. *Journal of Mental Health*, *23*(5), 217-218. doi: 10.3109/09638237.2014.928406

Rudman, D. L., & Dennhardt, S. (2008). Shaping knowledge regarding occupation: Examining the cultural underpinnings of the evolving concept of occupational identity. *Australian Occupational Therapy Journal*, *55*(3), 153-162. doi:10.1111/j.1440-1630.2007.00715.x

Salzer, M. S., & Shear, S. L. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal*, *25*(3), 281-288. https://doi:10.1037/h0095014

Scull, A. (2011). *Madness: A Very Short Introduction*. Oxford.

Shepherd G, Boardman J, Burns M. (2010). Implementing Recovery. A Methodology for Organisation Change. https://www.centreformentalhealth.org.uk/publications/implementing-recovery

Simpson, A., Flood, C., Rowe, J., Quigley, J., Henry, S., Hall, C., Evans, R., Sherman, P., & Bowers, L., (2014). Results of a pilot randomised controlled trial to measure the clinical and cost-effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK. *BMC Psychiatry, 14*(30). https://doi.org/10.1186/1471-244X-14-30

Simpson, A., Quigley, J., Henry, S. J., & Hall, C. (2014). Evaluating the Selection, Training, and Support of Peer Support Workers in the United Kingdom. *Journal of Psychosocial Nursing and Mental Health Services, 52*(1), 31-40. https://doi.org/10.3928/02793695-20131126-03

Simpson, A., Oster, C. & Muir-Cochrane, E. (2017). Liminality in the Occupational Identity of Mental Health Peer Support Workers: A Qualitative Study. *International Journal of Mental Health Nursing, 27*(2), 662-671. https://doi.org/10.1111/inm.12351 Skorikov V.B., Vondracek F.W. (2011) Occupational Identity. In: Schwartz S., Luyckx K., Vignoles V. (Eds) *Handbook of Identity Theory and Research*. Springer. https://doi.org/10.1007/978-1-4419-7988-9_29

Skorikov, V. B., & Vondracek, F. W. (2011). Occupational Identity. In *Handbook of Identity Theory and Research* (pp. 693-714). Springer.

Slade, M. (2017). *Well-being Recovery and Mental Health.* Cambridge Press.

Slevin, O. (2001). An Epistemology of Nursing: Ways of Knowing and Being, in L. Basford and O. Slevin (Eds.), *Theory and Practice of Nursing: An Integrative Approach to Caring Practice.* Nelson Thorne.

Smith, J. A. (2017). Interpretative Phenomenological Analysis: Getting at lived experience. *The Journal of Positive Psychology, 12*(3), 303-304. https://doi.org/10.1080/17439760.2016.1262622

Smith, J. A., & Eatough, V. (2007). Interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 35–50). Sage Publications. https://doi.org/10.4135/9781446207536.d10

Smith, J., Larkin, M. & Flowers, P. (2009). *Doing Interpretative Phenomenological Analysis*. SAGE.

Smith, J.A., & Osborn, M. (2003). Interpretative Phenomenological Analysis, in J.A. Smith (Ed.) (2008) *Qualitative Psychology*: *A Practical Guide to Research Methods,* (2nd edition). London: Sage.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5(1), 9-27. https://doi.org/10.1080/17437199.2010.510659

Solomon, P. (2004). Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients. *Psychiatric Rehabilitation Journal* 27(4), 392-401. https://doi: 10.2975/27.2004.392.401

Starks, H., & Brown Trinidad, S. (2007). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research, 17*(10), 1372-1380. https://doi.org/10.1177/1049732307307031

Strawbridge, S. (2016). Science, Craft and Professional Values. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.). *The Handbook of Counselling Psychology* (4th ed., pp. 20-38). Sage.

Stets J.E., Serpe R.T. (2013) Identity Theory. In: DeLamater J., Ward A. (Eds) *Handbook of Social Psychology. Handbooks of Sociology and Social Research,* (pp. 31-60). Springer. https://doi.org/10.1007/978-94-007-6772-0_2

Stevenson, D. & Farmer, P. (2017). Thriving at Work: The Independent Review of Mental Health and Employers. www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

Stewart, S., Watson, S., Montague, R. and Stevenson, C. (2008). Set up to fail? Consumer Participation in the Mental Health Service System, *Australasian Psychiatry, 16*(5):348-53. https://doi:10.1080/10398560802047367

Toloie-Eshlaghy, A., Chitsaz, S., Karimian, L., & Charkhchi, R. (2011). A Classification of Qualitative Research Methods. *Research Journal of International Studies, 20*(20), 106-123.

Thompson, N. (2017). *Promoting Equality. Working with Diversity and Difference.* Palgrave.

Tuffour, I. (2017). A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach. *Journal of Healthcare Communications*, *2*(4), 52. http://doi:10.4172/2472-1654.100093

Trachtenberg, M., Parsonage, M., Shepherd, G., & Boardman, J. (2013). Peer support in mental health care: is it good value for money? Centre for Mental Health. https://www.centreformentalhealth.org.uk/publications/peer-support-mental-health-care-it-good-value-money

UCL Partners. (2020). Developing the Peer Support Worker Role in Mental Health. https://uclpartners.com/work/developing-the-peer-support-worker-role-in-mental-health/

Unruh, A. M. (2004). Reflections on: “So… what do you do?” Occupation and the Construction of Identity. *Canadian Journal of Occupational Therapy, 71*(5), 290-295. https://doi.org/10.1177/000841740407100508

Van Tosh, L. Ralph, R. O., Campbell, J. (2011). The Rise of Consumerism. *Psychiatric Rehabilitation Skills, 4*(3), 383-409. https://doi.org/10.1080/10973430008408630

Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: A Metasynthesis of Qualitative Findings. *Psychiatric Rehabilitation Journal*, *36*(1), 28-34. http://doi:10.1037/h0094744

Warner, R. (2010). Does the scientific evidence support the recovery model? *The Psychiatrist*, *34*(1), 3-5. https://doi.org/10.1192/pb.bp.109.025643

Waterman, A. S. (1999). Identity, the Identity Statuses, and Identity Status Development: A Contemporary Statement. *Developmental Review, 19*(4), 591-621. https://doi.org/10.1006/drev.1999.0493

Watson, E. (2017). The Growing Pains of Peer Support. *Mental Health and Social Inclusion, 21*(3), 129-132. https://doi.org/10.1108/MHSI-03-2017-0017

Whalley Hammell, K. R. (2013). Client-centred practice in occupational therapy: Critical Reflections. *Scandinavian journal of occupational therapy, 20*(3), 174-181.

Wilcock, A. (2001). Occupational Science: The Key to Broadening Horizons. *British Journal of Occupational Therapy*, *64*(8), 412– 417. https://doi:10.3109/11038128.2012.752032

Wilkinson, R., & Pickett, K. (2010). *The Spirit Level: Why Equality is Better for Everyone.* Penguin Group.

Williams D.R. (2018). Stress and the Mental Health of Populations of Color: Advancing our Understanding of Race-related Stressors. *Journal of Health and Social Behavior, 59*(4), 466-485. https://doi.org/10.1177/0022146518814251

Williams, J., Leamy, M., Bird, V., Harding, C., Larsen, J., Le Boutillier, C., & Slade, M. (2012). Measures of the recovery orientation of mental health services: Systematic review. *Social Psychiatry and Psychiatric Epidemiology*, *47*(11), 1827-1835. https://doi:10.1007/s00127-012-0484-y

Willig, C. (2013*). Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Open University Press.

Yardley, L. (2008). Demonstrating Validity in Qualitative Psychology. *The Journal of Qualitative Psychology, 12*(3), 295-296. https://doi.org/10.1080/17439760.2016.1262624

Appendices

Appendix A: Flyer advertising the study

LONDON
METROPOLITAN
UNIVERSITY

I am a counselling psychologist in training at London Metropolitan University and will be conducting a study to discover more about the experiences of mental health peer support workers (PSWs), and in particular how they are experiencing their occupational identity.

The objectives are to explore the unique and personal experiences of peer supporters and to create a better understanding of what influences, informs and shapes PSW theory and practice. Exploration of the personal resources PSWs draw on in their work will highlight issues that may arise from negotiating the identities of ‘patient’ in relation to mental health ‘worker’.

Criteria for participants

PSWs are defined as individuals with lived experience of mental distress who are currently in recovery. The intended participant group are experienced PSWs employed within the National Health Service (NHS). Participants must be working with service users in psychiatric in-patients or community settings.

Have you got a minimum of six months experience? Are you happy to talk about your work experience during an interview? If so I would like to hear from you.

Should you decide to take part travel expenses will be given a £25 Marks and Spencer voucher and your travel expenses covered. I would like to thank you very much for your consideration and please contact me for further details of this research.

My mobile number is xxxxxxxx or if you prefer, please email at: eiw0017@my.londonmet.ac.uk. I look forward to hopefully hearing from you.

Appendix B: Letter of invitation

LONDON
METROPOLITAN
UNIVERSITY

Dear

Research Title: How do peer support workers experience their occupational identity within the NHS?

I am a counselling psychologist in training at London Metropolitan University and will be conducting a study to discover more about the experiences of mental health peer support workers (PSWs), and in particular how they are experiencing their occupational identity.

Research in this area predominantly focuses on how PSWs interact with professionals at work and how the role can be improved via policy and organisational changes. There is no research that has solely explored PSWs experience of reconstructing an occupational identity. Equally, very limited research has been conducted that specifically considers the factors that keep peer workers well.

The interview would last approximately one hour and will be audio recorded. This will be a confidential process. Data from your interview will be used for my doctoral level counselling psychology thesis. Participation is voluntary, and if you choose to participate, you will be free to withdraw at any point up until 30th September 2019 without question. All recordings will be kept securely and destroyed once the project is completed, or you choose to withdraw.

Before you decide to participate, it is essential that you read the participant information sheet attached. Please take your time in considering if this is a process you would like to participate. You are under no obligation to take part in this research and should feel no pressure to do so.

Should you decide to take part travel expenses will be paid and you will be given a £25 Marks and Spencer voucher for your participation.

Participants must be over the age of 18 years and have at least six months experience working as a peer support worker with ELFT.

I would like to thank you very much for your consideration and please contact me should you have any further queries.

My mobile number is xxx or if you prefer, email: xxx. You may also contact my research supervisor Dr Verity Di Mascio, her email address is xxx.

I look forward to hopefully hearing from you.

Eileen Ward
Counselling Psychologist In-Training

Appendix C: Semi-Structured interview questions and prompts

Semi-structured interview questions and prompts

1. Can you tell me a little about your experience of being a peer support worker (PSW)?

Prompts:

a. How long have you been qualified?
b. When did you join your current company?
c. Early stages up to present time?
d. Best and worse elements?

2) What kind of training course did you attend, to prepare you for this role?

a. Did the training approach draw on a particular model/approach?
b. How has your personal development has been affected?
c. In terms of an occupational identity has working influenced how you feel about yourself?
d. What do you find most helpful/unhelpful?

3) Can you tell me about your daily interactions with members of staff within your current organization?

a. Interacting with medical staff?
b. Helping Service Users?
c. What aids or restricts you?
d. Do you work as part of an MDT? If so, which professionals do you find most helpful
e. Are there any examples you can talk about?

4) How do you feel your work effects/aids your own recovery and how you feel about occupying your time in this way?

a. Hinders or fosters positive change?
b. Changes in the support you need or medication you take?
c. What do you find most enjoyable and/or displeasing?

5) Do you think gender, language or culture are important in providing PS?

a. Have you worked with peers from cultures or ethnicities that vary from your own, if yes, how have you dealt with the relationship?

6) Would you like to add anything that could help me understand your experience in more detail?

7) How have you experienced this interview; how do you feel having revealed these data?

8) How do you see yourself and the role of PS developing?
a. Do you have any suggestions for the development of the role

Appendix D: Consent form

Dear

Study title: ***How do peer support workers experience their occupational identity within the NHS?***

Thank you for considering taking part in my research. Before doing so, it is essential that you read the points below and acknowledge your agreement of them.

Please feel free to ask me for any further clarification you may require:

☐ I formally confirm that I have read and understood the participant information sheet for this research and I have had enough time to question anything that was unclear on that sheet.

☐ I am volunteering to take part in this study and understand that I do not have answer any questions I find objectionable, without reason. I also acknowledge that I can withdraw my data from the study at any time up to two weeks after the interview date.

☐ I understand the interview will be audiotaped for data analysis, and further confirm that I am willing to answer questions about my work as a peer support worker.

☐ I am aware that the data will be anonymised with all identifying information removed. The transcripts will be used in a doctoral thesis which could potentially be published at some future date.

☐ I understand that the tapes and transcripts will be kept for up to 5 years and will then be destroyed. A copy of the doctoral thesis will be available in the library at London Metropolitan University.

☐ I understand that confidentiality will be maintained, but maybe mitigated if I disclose a danger of harm coming to myself or others according to the BPS Code of Conduct & Ethics (2018).

☐ I understand that after the interview I will be given a debriefing sheet, which contains additional information about the study and that I will have the opportunity to discuss any concerns with the interviewer.

I agree to participate in the research

____

Name of Research Participant

____

Date/Signature

____

Name of Researcher Eileen Ward

Date/Signature

____

Please send me a summary of the research findings: YES / NO (please circle).

Address to which details should be sent:

____

E-mail address:

____

Appendix E: Debriefing Sheet

Dear

Thank you very much for taking part in this study.

Your time and effort is greatly appreciated. If you have any concerns or questions about your interview with me, you can contact the research supervisor, Dr Verity Di Mascio by email v.dimascio@londonmet.ac.uk.

However, should you feel the need for emotional support after the interview, please see the list of support services listed below.

As mentioned before, you can request a copy of the completed study. Which will be available by September 2020.

Thanks again for your help with this research.

Yours sincerely

Eileen Ward
Counselling Psychologist In-Training

Rethink Mental Illness - Support and advice for people living with mental illness. Phone: 0300 5000 927 (Mon-Fri, 9.30am-4pm) Website: www.rethink.org

Samaritans - Confidential support for people experiencing feelings of distress or despair.

Phone: 116 123 (free 24-hour helpline) Website: www.samaritans.org.uk

SANE - Emotional support, information and guidance for people affected by mental illness, their families and carers. SANEline: 0300 304 7000 (daily, 4.30-10.30pm). Textcare: comfort and care via text message, sent when the person needs it most: http://www.sane.org.uk/textcare Peer support forum: www.sane.org.uk/supportforum Website: www.sane.org.uk/support

Appendix F: Distress Protocol for use with distressed participants

This protocol will be invoked if any of the participants involved in this research become distressed and/or agitated during their interviews about occupational identities as Peer Support Workers (PSWs). As PSWs are employed to provide help and support to people with mental health disorders. it is not anticipated that participants will experience severe distress during this interview process.

The PSWs may talk about their own previous mental distress during the interview which could evoke strong feelings. This protocol has been put in place to deal with this possibility. I will monitor and manage situations where distress becomes apparent by using the following protocols:

Mild distress: Potential signs such as tearfulness, difficulty speaking, voice becoming choked to an extent that the participant is no longer able to follow the discussion.

Action Plan: Offer the participant time to re-compose themselves, and then establish if they wish to continue or defer. Remind them they can stop at any time if they become too distressed.

Severe distress: Potential signs of severe distress include: uncontrolled crying, incoherent speech, panic attack - e.g. hyperventilation, shaking, sweating.

Action Plan: The researcher will terminate the interview immediately and start the debriefing process.

Support will be offered in the form of mindful breathing to regulate breathing and reduce agitation. The researcher will acknowledge and validate the participants distress and reassure them that their experience is a normal reaction to talking about emotional difficulties.

If any unresolved issues arise during the interview the participant will also be reminded that this is not a therapeutic session but details of counselling/therapeutic services will be provided, as detailed below.

Peer support forum: www.sane.org.uk/supportforum

Rethink Mental Illness - Support and advice for people living with mental illness. Phone: 0300 5000 927 (Mon-Fri, 9.30am-4pm) Website: www.rethink.org

Samaritans - Confidential support for people experiencing feelings of distress or despair. Phone: 116 123 (free 24-hour helpline) Website: www.samaritans.org.uk

SANE - Emotional support, information and guidance for people affected by mental illness, their families and carers. SANEline: 0300 304 7000 (daily, 4.30-10.30pm). Textcare: comfort and care via text message, sent when the person needs it most: http://www.sane.org.uk/textcare. Website: www.sane.org.uk/support

Appendix G: Section of one transcript with notes - Arthur

Symbiotic process between peer support workers, service users and professionals

Acceptance and being understood allowing a sense of meaning

Survival through life changing identity status

Emerging occupational identity

Purpose and meaning through occupation

Being, belonging

Life changing purpose

Belonging and achieving, adding value

R: Peer support worker is really life-changing with the uniqueness of a lived experience sharing with other service users and this is like giving the hope to co-patients, other patients like recovery is possible and the best thing in peer support work is you, you are supervised and supported by professionals and also because you are in a working environment but at the same time you also have full support from the professionals who knows your conditions and understand and motivate you towards, towards adoption of working pattern. Really, it's excellent and I must say its life changing. If we, we umm couldn't get this opportunity obviously our destiny, our destiny was forever in a shell of unwellness and where like just we hide ourselves under the beds and blankets and when we have professional support co-opting the voices and giving ourselves time and also acknowledging the voice, "Yea, we hear them and we understand," and instead of fighting with them, we make a timetable, a time setting with them. And its umm really **very very** excellent approach and very life changing.

I: You said four years, is that four years with this trust?

R: That's right, yes. Initially when it was started by Dr [redacted] obviously there was no funding and by one of the staff at the headquarter they, they secured some charity funding and that's how we started with limited hours and initially, we didn't know nothing about it but obviously with continued support of Dr [redacted] and that time we had a star, [redacted], she was also very supportive. Even all the committee recovery team staff, they understood us and they were really encouraging and supportive and there was no hard time, there was no hard goals like we had to meet certain, certain pressure, I mean in the beginning, bringing in commercial or in a working atmosphere, it was not, it was not easy but because the colleagues, they knew our situation and they took us very

Valuing own experience as unique and meaningful

Feeling hopeful by being understood

Using first person plural to review to self – **nosism**, maybe to deflect painful memories

Similarly, using metaphor to account for past – allows distancing self

Word repetition to accentuate gratitude

Sense of pride when giving history of the role within the Trust

The role maybe dependent on individual line-managers

Sense of pride and achievement through encouragement

Meaningfully occupied allows a sense of self

Sense of belonging to a greater community

Re-integrating and valued

Valued – part of the whole again

Limited contracts?

Owning the occupational identity of peer support worker

Embracing a new identity

lightly and very helpfully, like you know they guided us how to perform our duties, how to meet and set up meetings with other patients. It was <u>life changing.</u>

I: So initially, when you started in those early days you said that there was lack of funding, were you a volunteer at that time?

R: No, it was like I told you <u>one of the leads was a star for people participation</u>, he had secured some charity money.

I: Okay and they used the money to pay you ?

R: That's right. Yes, that charity money was given to us weekly and it was some people participation awards who were getting in the beginning, but because at that time it was sort of a pilot project and ehh, all the records were kept and all sessions were recorded on the paper form and after a year, I mean, after that we started compiling the data and graphs and, and then from there it was presented by Dr [redacted] to headquarter and because the outcome was really good not only for us, for service users, but also for the patient for the service users who were involved and we were taking out in the community. And from there it did give a total, <u>new approach to the trust</u> also and they really like appreciated it started from CRT community recovery team in Newham to borough-wide, <u>I think now it is in all four boroughs</u> and even Tower Hamlets and I think now Luton and Beds also. They say it has spread in the whole of the trust.

I: Good, good, were you given formal training?

R: Yes, yes, yes, we had eight weeks training and, in that training, obviously, all the timekeeping and tree of life and there was, <u>all the training was provided</u> and how to manage it was nice.

I: So you learn lots?

Still seems to be Incredulous of the positive changes to self

Re-connecting

Differentiating between staff

Ability to support the PS growth admin

Value and commitment

Gratitude

Life-changing and forward focused

Sense of pride in the growth of PS

Maybe dismissive of early training

Transitioning to professional identity

Questioning PS role due to contract length

Feeling meaningfully occupied

Confident to move forward

Identifying as professionals

Confident in own ability to lead others

R: Yes. Right from the beginning, it was well supported by the teachers, by the staff, by Dr [redacted] by the consultants, everybody. After training, while we were working 10 hours a week, we feel like we are being looked after nicely, yes, yes very professionally.

I: Was this four years ago?

R: That's right, yes. But before, for a couple of years it was with the charity funding and we were claiming it weekly. Then there was obviously, like some changes in the transfer and office movement, and this and that but last year I have been employed by the trust for a year, this is 12 months contract and now I'm employed by the trust for a year, this year going on.

I: That's wonderful how did they band you?

R: That's right, yes, they started it with band three, yea but it's really life-changing for me like and I mean I will be moving on in my life. I'm looking for other employment.

I: Moving away from peer support?

R: Yes. I think I'll be moving on it's not moving away. Maybe, I mean I will look for a further opportunity when I complete this contracted one year with the trust. So if I see in the trust there is any opportunity or like obviously it has become a passion for me to do further research and help more people because it's like I have been given a task, given an opportunity of, though in my condition, I can help others and that feeling is great. When I take other service users out in the community and I share my story, like I mean I understand how they are and where they are and then I tell like, I've been there. The approach from other services users, other patients is different. Like they also appreciate and because they see me, like, I had experience of walking in their shoes and they say like, when I tell them, I have been

Gathering confidence in the role

Pleased to have a 12 month contract, perhaps feeling more secure

Identity change seems to own a more professional identity with the confidence to change jobs

Worried about earlier survival maybe feels beholden to the Trust

Reflection on previous sense of self – empty, meaningless

Sharing identity of SU

Embracing the role

Owning occupational identity of PSW

Survival Lifeline

Re-developing a sense of self

Embracing OI

there how they are feeling, so I know. I also acknowledge we understand how hard it is for them. And their approach is different to us rather than when they're dealing with a professional, with a consultant or with CPN's, they trust us more and they then share their real feelings. When they hear like, recovery is possible, they don't trust in the beginning. Obviously, we have 12 sessions with every service user's and that, that, we have in my experience, I've seen like you know what I mean other service users getting well and moving on to education, further education or to some cases in jobs as well.

I: Do you work in the community with them or on the ward?

R: No. We work in the community.

I: So they come to the centre?

R: That's right, yes.

I: For 12 sessions?

R: That's right. Our working pattern is we are not allowed to go to patient's houses because we are working in community recovery team, so our patients are also I mean from community recovery team itself and sometimes, we do get some patients who are recommended by occupational therapists. So we do invite them to the recovery team or sometimes, initially, like we do have session called introduction sessions where the referrer of service user introduce us to the service user in the recovery team meeting point. From there, we set our 12 sessions' goals. Like within 12 sessions when we prioritize our session according to the service user's needs and service users like to get involved into the physical health activities or some are more worried about their benefits or they have their own issues of housing and certain things. So we make this, we make this feeling in the service users like they are leading

Identifying with SU's using uniqueness to connect

Develop a greater sense of self through work and sharing own MH story

Feeling free from ex/internal stigma

Reflections on helplessness and an earlier identity of SU

Identifying the need to reconnecting with self

Collective identity drawing confidence through connection these sessions and we make them feel like we will do what they want and we will work on their issues right there. We are not expert in anything and we are not expert in benefits advice and any advice, but still, we gather some information. As I said, we are supervised and supported by the professionals throughout the process, so we get their demands and their requirements and get supported by the occupational therapists and CPNs and the consultants like you know what I mean and we take back their demands, their requirements to the professionals and they guide us the already available resources within the borough and within the trust and we tap on their doors and we say, "We have this service user who is looking for this help." Then we get to the professionals who are trained for that support, so then we get that support to them. Also, in the community, when we take to them to libraries or into the different active groups, where they're on their own, they're unable or it's totally not possible for them to attend regularly, but with our motivation and regular reminders, they come across and they do those things.

External identity

Corporate identity

Label change

Positive sense of se

Taking pride in his work and being part of the professional team

In a position of power to help affect change for SU

In a position of power to help affect change for SU

I: Is that how it worked for you when you started? Did you feel that you were leading, or being led? That's a lovely approach that you have now that you've just described. Is that how you experienced it when you were just training in your early days?

R: That's right. Yes. In the early days, obviously I mean, we were taught. We were also supervised but because, I'll say we had very good staff but it got changed. All of them all throughout the way, they were guiding us and helping us. Also, [redacted] mentioned in our meetings, we used to gather our information and discuss our caseload with all the other peer support workers in the presence of the consultant.

Comradery between PSWs

I: Just between yourselves?

Green Shoots of identity

Purpose and confidence from identifying as PSW

R: That's right and then we were getting advice from each other as well as from the consultant. And ehh that really worked well for us because sharing information and also helping each other, that would give us more boost because we are doing the same thing and it also gave us some confidence which really we were lagging behind. That confidence really did get us going in our professional ourselves. I must say, it has changed our life.

Recovering and awareness of the past, removing the shackles of labelling

Stressing the importance of sharing to reinforce own recovery

I: You say it's a life-changing, has it changed how you feel about yourself or how well you are? Can you talk a little bit about how it's changed your self-identity?

Recovery journey back to self

R: Yes definitely, obviously, I had a very bad time. I had become very, very scared of my life. Even there were times when I wanted to just end my life. It was so miserable. And ehh obviously, with medication and then counselling, and then everything was working. At that time when I was asked to attend this and attended the training. Did my training and after that from the hospital. Initially, I was good for nothing like I mean I had no, no motivation, no urge to live at all.

Acknowledging initial change and previous self

Reflections on recovery and the significance to his life

I: When you say good for nothing, that's how you felt about yourself at that time?

Developing a self-identity

R: That's right. That time, I was totally house bounded, and I was scared of even everything. The doorbell used to ring I used to hide under the bed or in the cupboard, I used to say like, I used to hear the voice, I used to cry a lot. It was a terrible life I was having but with the passage of time especially training and when I joined this, things started changing. With the passage of time, getting confidence and now I feel like I'm an entirely different person. Because now I have confidence in myself that I have helped so many other people. Peer support work with sharing my story and with sharing my lived experience with

Previous state of helplessness, coming from low base

Making sense of past experiences to the greater good other service users has helped other service users as well. It has changed their life at the same time it has changed my life also. Now I feel like I'm a member of a bigger team. This is [redacted] Trust and our [redacted] Foundation as a company, its life is to respect others and help others just tell them we all are same. This hard time can come on anybody and we should not give up. We should keep hope in ourselves and help each other. We can become part of the larger society again as we were before. It is really life changing. Now, I feel like I'm working again and that's a big thing and this card, it has given us identity, we're very proud. We've got an identity and we are a staff of the organization.

I: What did it mean to be given that identity card and to be able to say you now belong to this company? What did that mean for you?

R: It feels proud and it feels like yes, we are well enough to be part of a company and we have identities.

I: How do you identify?

R: I say, yes, I'm a peer support worker and I'm a working person. Before even my relatives, the people who know me, they say, he is a mad person, I was branded as a mental patient, but now I'm a staff, I'm a working person.

I: Who branded you as a mental patient?

R: Everybody, even my family, they used to call me a mad person and in the society I was known as a mental patient, but now I feel like I'm well enough to be called a working person and now staff and I'm working in NHS and I'm a peer support worker.

I: This is wonderful.

R: It is, yes.

Meaning and purpose in life

Living with an OI that promotes change

Supporting others by embracing the role

Not a form of tokenism relevant to the organisation

Feeling authentic and part of the community

Embracing the benefits, initial identity seems tied to the NHS identity card

optimism

Owning the identity of PSW collectively? wanting to promote the same for others

Being employed provided a bridge of identities

Stigma from family internalised to own the label

Appendix H: Example of preliminary superordinate and subordinate themes

Superordinate themes	Subordinate themes
Symbiotic Relationships	Survival and reconnecting
	Learning and Leading
	Keeping Hope in ourselves
Meaningfully occupied	Purpose and Meaning
	Embodying the role
	The Emerging Self
Unclear pathways blurred vision	Limited identity
	Unclear role, need to change track

Data for initial themes:

Symbiotic Relationships

Subtheme 1 – Survival and Reconnecting
"If we didn't get this opportunity obviously our destiny, was forever in a shell of unwellness where we just hide ourselves under the beds and blankets" L4 Arthur
"I thought let's just give it a go because if I don't move and do something, my mind will take me into some very dark places, so it was really a question of survival" L44 Martin
"It gives me an excuse to get out of bed in the morning, it gives me structure to my day, it's aiding to my recovery as well because I'm there doing something" L20 Wilfred
"I will try and take my holidays when I need them. I always do that, that's how I manage it, I'm on medication I have had some type of therapy in the

past but it's about managing the illness" L110 Wilfred
"I have to have a mental health condition to do this job, I come with this vulnerability and openness because personally, I'm quite a private person about my life" L68 Nancy
"it's a two-way process. You can't just say I've got mental health, I'm on my own and I need to recover if you are within a system where you need the staff to engage you to get the support you need to understand" L37 Nancy
"in the past I'd struggled with work from time to time not because I lacked effort, but I was battling low self-esteem, I was still good at my job and I got on with it and everything, but I just didn't feel I was the same" L143

Subtheme 2 - Learning and leading
"peer support work is sort of like an opportunity which comes to you without trying and also where you earn, but also you learn, and you improve yourself. I don't see any role even a professional role in his society which will match this one where you also get better, you're working on your health to improve your health and you're working as well, it's really, really life changing as it is magic" L408 Arthur
"In the beginning being in a commercial working atmosphere it was not easy but because the colleagues, they knew our situation and they took us very lightly and very helpfully, like you know they guided us how to perform our duties, how to meet and set up meetings with other patients, it was life-changing" L22 Arthur
"in the beginning obviously, I was still very naïve, and I was reluctant to do certain things but now after four years' experience I feel like I have helped, my core peer support workers, I have helped other patients also and even helped consultants and the CPN's. We have played a positive role in the trust in this NHS, we have proven, with this approach of involving the patients, the patients who are the main core of the whole NHS system" L208 Arthur
"when a peer support worker starts coming to work, the first thing they get is feeling like they're professionals as well, now they are working with nurses and consultants. Nurse and consultants also appreciate them, especially in business meetings" L246 Arthur
"I suppose peer support work is not really about you, in some ways it's about service users and what they've been through. This whole disclosure thing ...it's not like you say this is my story and I'm amazing ....and I have recovered, it's what's going on for them.....disclose when it's appropriate" L75 George
"I wish someone had told me that staff are just as important and valid" L118 Nancy
"if you are seeing someone all the time you start to know the triggers and the way they talk, I have to work with those staff that understand the service users and what's going on for them, their experience is just as valued" L122 Nancy
"staff can sometimes really engage with service users in the ward because they've been through life experiences, so that's still valued but mental health adds a different important dimension" L153 Nancy
"I think from about four to six months, it started easing because I think that people got comfortable with you and they relax, and you get to know staff, so it doesn't happen overnight" L183 Nancy

“I think I knew that it was a good opportunity because like I said to help people when they need something, that was my values………I like the trust and their values and certain things they did and I felt right” 554 – 558 Nancy
“coming into the NHS I saw that diversity was quite on display, and it was comforting to see that if you work hard, you can get on, whereas I didn’t feel that in what I used to do …. I feel a bit more satisfied knowing that I’m using my experience to turn somebody else’s experiences into a more positive situation” L88 George“
“It is comforting to see that if you work hard, you can get on, whereas I didn’t feel that in what I used to do” L85 George
“I’m using my experiences of going through the system, and helping them learn from their experiences …. for instance, a lot of them are creative, lots of peers are creative and it’s inspired me to go back and do some art drop in classes L20-24 Wilfred
“a patient once told me, I thought because you’ve got mental health problems that was the end of me. I didn’t realise I could go on and do what you are doing” Jordan L210
“when I’m with someone, I’m very open with them about my diagnosis and all that, I feel like it gives them a bit of comfort to know that I know what they are going through and when they see me doing this, they realize that there is hope for them to move on” L384

Subtheme 3 – Keep hope in ourselves
“I was known as a mental patient, but now I feel like I’m well enough to be called a working person and now staff, I’m working in the NHS” L141 Arthur
“I think from about four to six months, it started easing because I think that people got comfortable with you and they relax, and you get to know staff, so it doesn’t happen overnight” L183 Nancy
“I haven’t had any serious relapse, I’ve had bad times but then I’ve taken time off and it’s been quite flexible for me so that’s been good because I want to make sure I’m okay so it’s nice and I’ve got support for that” L304 Nancy

Superordinate theme 2: Meaningfully Occupied

Purpose and Meaning
“it shows I've got a purpose and umm shows to the peers I work with that ......-- I know what they are going through, I've got lived experience, I've not read a book by a doctor or a nurse or a psychiatrist and they know that when I tell them my diagnosis, they know I work for the NHS, but it's got a different feeling from meeting your care coordinator or therapist. You're meeting someone that's gone through the same thing as you and they open up more. They tell you a little bit more of what they won't say to their OT or their therapist. They feel more comfortable talking to us” L363
“it’s given me back my life, it’s given me meaning and purpose and, it’s given me something to do, better just sitting at home living on benefits” …. L447 Jordon
"Yes, I'm a peer support worker and I'm a working person." Before even my relatives, the people who know me, they say, "He's a mad person." I was branded as a mental patient, but now I'm a staff, I'm a working person”. L138 Arthur

"There's very, very few if any place where having a mental health problem is actually something that you can put on your CV with the sense of pride and honesty" L58 Martin
"it's given me purpose and it's one of the best jobs I've had as well because I'm working by myself and it's how you define it yourself. It's not always just they tell you what to do because a lot of people don't know what peer support is until they meet someone who's a peer support worker and they see at work and they say, okay then I can see where they are coming from L51 Winifred
"It is pressurized, it can be emotionally draining but because you leave with a smile on your face L342 Winifred

Embodying the role
"It has become a passion for me to do further research and help more people because it's like I have been given a task, given an opportunity, thought my condition, I can help others and that feeling is great" L60 Arthur
"since I started my peer support role, I stopped going to the doctors as much, I would go there quite often but then I started saying, "well if I'm helping people ..that won't look good. I don't know really if I want to look good not that I felt ashamed or anything, but it just reduced me going to doctors because I felt well, I'm helping people. So, it's best if I can help myself a bit more so I guess it kind of made me try to do a bit more for myself, build up my resistance and stuff like that" L373 George
"I think I grew as a person to where I wasn't frightened, but you have to be a certain type of person ..you have to really care because sometimes things get tough and you have got to have this resilience. In fact with the training and the support you keep going because you have got to love it..it's a lot of caring" L50 Nancy
"It felt tokenistic because it's another service user coming in but the label means I've got a right entitlement to do the job but there's more to the job because it's still caring.....I'm not here to just put that label on. Mental health helps buts it's about the whole listening communication.....it was a new role, so you have to learn through the trial and error of peer support ....we adjusted to what the staff needed, what the service users needed, then my identity is not purely tokenistic, " L88- 110 Nancy
"I feel protected from outside you know. I feel that I've built a barrier that err that doesn't make-- Some people have really horrible-- not horrible stories but live in managing some really difficult stuff. I just see it as another part of the job, you know like a mechanic on a line, I do my little bit and then it goes on to somewhere else you know . I don't see it as a personal thing anymore you know it's just how best can I help this person. George L436
"It's given me structure in my life ..... I've had loads of different jobs, nothing that's lasted this long" L299-302 Jordan
"Getting to see my peers move on that what motivates me...getting to see how far they've come in the 12 weeks we've worked with them, to see how we started and then where we are now" L349 Jordan

The Emerging Self
"This hard time can come on anybody and we should not give up, we should keep hope in ourselves and help each other, we can become part of the larger

society again as were before, it is really life changing, now I feel like I am working again that's a big thing and this card, it has given us identity and we are staff of the organisation" L126 Arthur
"being busy on my terms and doing something that I want to do and I don't have to pretend to be normal, I can be open because I'm tired of struggling with things and not saying anything" L50 Martin
"I do enjoy it. It was good to be in a room full of people where mental health was the leveler" L98 Martin
"I just get to see that I'm a lot further on, in my recovery than I believed before … a lot further on in terms of my resilience, where I go for things and how I process things L611George
"I think I'm totally different, I was literally like a different person" L568 Nancy
"I think most of them have actually been through the NHS so your familiar to a certain degree with the other side. To see how it works from the other when you're actually working in there, it's different but because its familiar you don't feel like a stranger" L267 Winifred
"when you do admin it can be interesting everything else like that but it's not an easy job to do and it's very pressurized, peer support enables me to express myself to be myself and just to use all the skills that I have like computer skills and things like that and put them together and also my experiences of being in the system and how to recover and how to, even if you can't recover, how to manage your illness" L339 Winifred

Appendix I: Approval Letter from NHS Health Research Authority

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mrs. Eileen Ward

Email: hra.approval@nhs.net

HRA and Health and Care Research Wales (HCRW) Approval Letter

Dear Mrs Ward

Study title: **How do mental health peer support workers experience their occupational identity? An Interpretative Phenomenological Analysis**

IRAS project ID: **263162**

Sponsor **London Metropolitan University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation.
The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below. Your IRAS project ID is **263162**. Please quote this on all correspondence.

Yours sincerely

Juliana Araujo
Approvals Specialist
Email: hra.approval@nhs.net

Appendix J: Ethics Approval Letter from London Metropolitan University

LONDON
METROPOLITAN
UNIVERSITY

To whom it may concern

This is to confirm that Eileen Ward had her Research ethics approved on 21/2/2019 by Professor Mark Wheeler.

Kind Regards

Research and Postgraduate Office