A Community Evaluation into Peer-to-Peer Service Provision in Mental Health
February 2015

Peer-to-Peer
Best Practice Model Development

Mothers Uncovered * Grassroots Suicide Prevention * Synergy Creative Community

Supported and funded by the Big Lottery Fund

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The project team would like to further acknowledge the organisations, academics and community initiatives referenced within this report and those whose ideas were not able to be captured through its scope. Finally, we would like to thank those dedicated to improving mental health provision and to all those who give their time to provide wellness support to others.

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Mothers Uncovered - A creative support for mothers (part of the Brighton charity Livestock). It runs arts groups, performances and events led by mothers who have participated in the programme. www.mothersuncovered.com

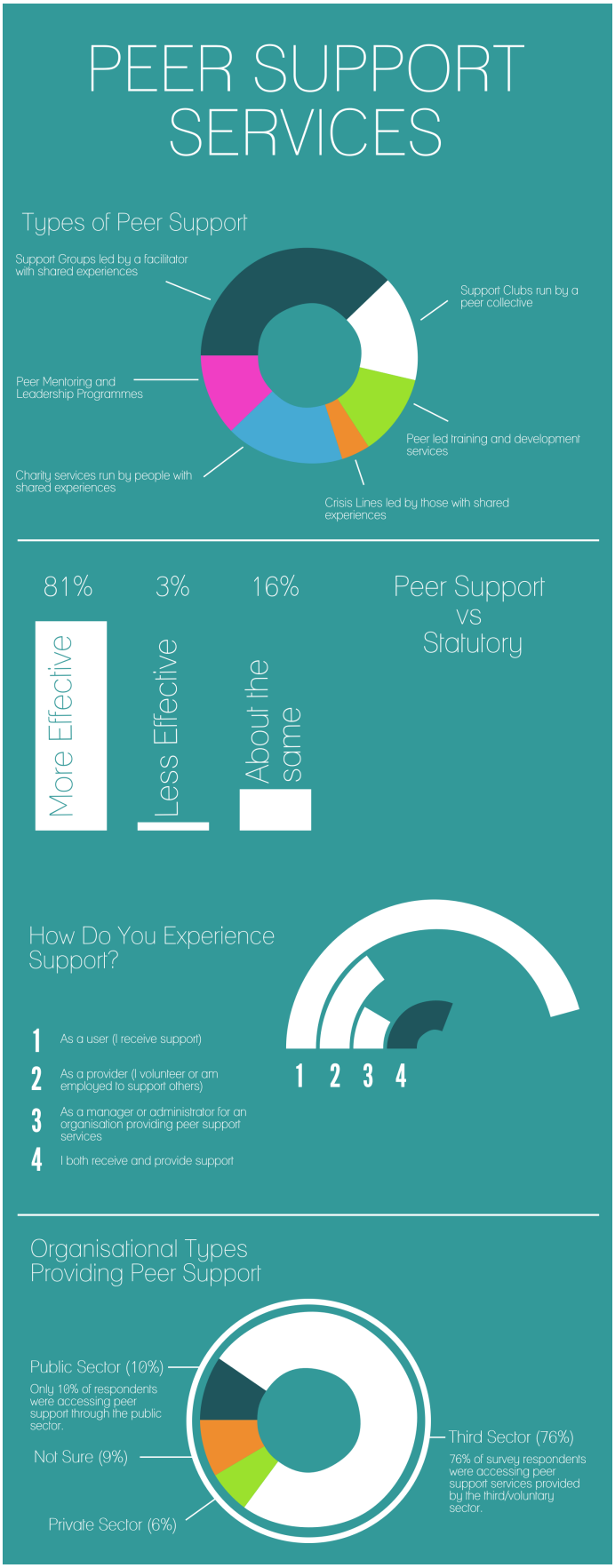
Grassroots Suicide Prevention - A Brighton-based charity that supports communities to prevent suicide through training, education, strategy and consultancy. http://www.prevent-suicide.org.uk/

Synergy Creative Community - A not-for-profit community organisation led and run by people with an interest in and experience of mental health care. The mission is to develop a community network of peer support and creative exchange. http://www.synergycreative.org.uk

SUMMARY

To understand how peer-to-peer could work within a community context, Mothers Uncovered, Grassroots Suicide Prevention and Synergy Creative Community captured the ideas of a total of 131 participants who had engaged with peer-to-peer services both as receivers and providers of support, primarily in East Sussex. A mixed-method approach was chosen to allow people to participate in the way they felt most comfortable, resulting in 97 people offering opinions via a survey (online and hard copy), 16 people participating in focus groups and 18 people participating via a community consultation day.

This review identifies peer-to-peer support services as an innovative approach to reducing suicide, self-harm, reliance on public health services (GPs, hospitals etc.) and engaging in unhealthy lifestyles such as using drugs, alcohol and involvement with criminal activity. In addition to offering a holistic and social approach to mental health, this review suggests that engagement in peer-to-peer activities reduces the stigma associated with mental health by providing leadership opportunities and increasing self-esteem.



This review highlights that the importance of third-sector groups in providing these supports. It was suggested a Network of Peer-to-Peer services would be the best model to collectively share best practices and work to improve individual, community and public health outcomes.

INTRODUCTION

Peer-to-Peer mental health services provide systems of support where people with shared experiences can aid each other in wellness (such as support groups, informal collectives or organisations that employ board members or staff with similar experiences to their members). International research suggests that services run by and for people who share personal or family experiences with mental health concerns could outnumber traditional/professional services by as much as 2:1 (Goldstrom et al., 2006). At the time of this report, the UK charity 'Together' in association with the National Survivor User Network (NSUN), is currently mapping peer-to-peer organisations on a national level (NSUN, 2014), however at present the prevalence of these organisations in England is unclear.

This community review was undertaken by three project partners: Mothers Uncovered (Project Lead), Grassroots Suicide Prevention and Synergy Creative Community. These groups saw firsthand the impact of the peer-to-peer approach within their own practices. They recognised that the theory surrounding peer-to-peer service provision within the United Kingdom did not match the extent that these services were being provided at a community level. In September 2014, funding was received from the Big Lottery Fund with the aim to:

1. Identify the prevalence and impact of the Peer-to-Peer approach in the region;
2. Develop a Peer-to-Peer Best Practice Model collectively with identified Peer-to-Peer organisations, leaders and service users;
3. Share this information with the community, local councils, academics and local and national Peer-to-Peer organisations to improve service provision.

Seeking to harness existing knowledge, Mothers Uncovered (Project Lead), Grassroots Suicide Prevention and Synergy Creative Community sought to work collectively with peer-to-peer groups, service users, providers, third-sector support organisations and statutory services. From October 2014-December 2014, a mixed-method approach was applied to identifying best practices including a literature review, a survey, focus groups and a public consultation day. The goal was to provide an opportunity for everyone to share their views in the way they felt most comfortable; that these ideas may inform future service provision.

As a community-led initiative, the project partners collectively developed and scrutinised all elements of the project including project aims, method selection, survey and focus group questioning and the design of the public consultation day. They involved further networks of peer-to-peer service providers to identify resources and

source material to guide the line of enquiry. It is hoped that the collective ideas will evidence the need for further sector level support and inform and inspire future research.

WHAT THE LITERATURE SAYS

Desk-based research surrounding peer-led lines of enquiry was undertaken to better understand where peer-to-peer services fit within context and to uncover:

1) What is the evidence of need?
2) Is Peer-to-Peer a valid approach for public health?
3) Are Peer-to-Peer services known to improve individual health outcomes?
4) What opportunities exist for peer-to-peer services to work collectively within the UK?

This section reviews the above questions and informed the design and direction of the community review:

WHAT IS THE EVIDENCE OF NEED?

The Organisation for Economic Co-operation and Development (2014), claims the need for innovative approaches to mental health is rising due to increased need and increased costs, stating mental health costs to the United Kingdom of over £70 billion per annum (equivalent to 4.5% of the GDP). Despite significant public investment, it is estimated up to 60% of those living with a mental health condition are living in poverty (OECD, 2014). In addition to health and economic disadvantage, those with severe mental health challenges are also less likely to have access to resources through social connections (Webber et al, 2015).

The Mental Health Foundation (2014) suggests one in four people are estimated to suffer from mental health issues in the course of a year. The National Institute for Health and Care Excellence (2013) estimates that 11% of people aged 16-74 will have depression or mixed depression and anxiety at any given time. Those experiencing life changes are also more vulnerable to mental distress with one in ten new mothers experiencing post-natal depression (NHS, 2011). The impact of mental health on avoidable deaths in England is also cause for concern with approximately one-third of the 100,000 people lost annually also suffering a mental illness (Russ et al, 2012).

According to the 2012/2013 Annual Report of Public Health, Brighton and Hove, a review of GP patient registers suggested the prevalence of depression is higher in this area than in the rest of England (13% versus 12%) and that up to one-third of adults in the area are vulnerable to depression. In association with the

Department of Health, the Public Health Observations in England (2013) noted Brighton & Hove residents have more than double the rates of self-harm related hospital admissions (446 in contrast with 207 in the rest of England). This area further has the highest rate in female suicides (3.7/100,000 females) and the third highest rate in male suicides (12.0/100,000 males) compared with the suicide rates in England (Scanlon et al, 2011).

IS PEER-TO-PEER A VALID APPROACH FOR PUBLIC HEALTH?

Health sciences have had a long history of introducing all disciplines to beneficial systems and approaches including a peer focus. From the introduction of peer-reviews to validate scholarly work in 1731 by the Royal Society of Edinburgh's Journal of Medical Essays and Observations (Birukou et al, 2011; Kronick, 1990), to the first reported self-help group, 'Alcoholics Anonymous' starting in America in 1935 (Borkman, 1999; Borkman, 2000), peer-based lines of enquiry have introduced methods to improve communication and advance knowledge. Today peer evaluation is an almost universal mechanism for validating scholarly work across all disciplines (Ingelfinger, 1974; Ware and Monkman, 2008) and peer-based collaborative services are a wide-reaching approach used not only to engage people with wellness support (Seaker, 2009; Carter & Reaper; 2011), but also as a means to engage marginalised groups with UK public services (see for example OPM, 2004; Nef, 2010).

In 2008 the World Health Organisation named 'meaningful participation' and 'social inclusion' as essential themes to improve global health outcomes (CSDH, 2008). By 2010, the Royal College of Psychiatrists released a report suggesting that general wellbeing for all people is improved by social inclusion and meaningful physical and mental engagement activities. That same year, the NHS's goal to put "patients at the heart of everything we do" (DH, 2010; 1), resulted in the creation of new structures to strengthen patient and public involvement. Since then, a number of academic reports and community initiatives have focused specifically on using a peer-to-peer approach and argued its effectiveness on the UK public health system.

Many of these documents can be accessed on-line and include, but are not limited to:

1. 'Developing Peer Support for Long Term Conditions' (Biggs et al, 2012)
2. 'Exploring Peer Support as an Approach to Supporting Self-management' (Biggs et al, 2012)

3. 'A review of the literature on peer support in mental health services' (Carter, Reaper, 2012)
4. 'Doing it for ourselves: Self-help groups for people with dementia living in extra care housing schemes' (Chakkalackal, 2013)
5. 'Mental health peer support in England: Piecing together the jigsaw' (Faulkner et al, 2013)

The common benefits of peer-to-peer support highlighted in the above reviews include possible benefits to improved treatment, increased agency and social connection for participants, potentially increased opportunities to engage hard-to-reach groups with health and wellbeing support, and an opportunity to increase public and patient involvement in service design and delivery. The above reports also have the following recommendations in common including a) the need to recognise and enhance the credibility of the peer-to-peer approach, b) the need to increase the volume of quality resources associated with peer-to-peer service provision; c) the need to review and increase access to training and employment development supports.

ARE PEER-TO-PEER SERVICES KNOWN TO IMPROVE INDIVIDUAL HEALTH OUTCOMES?

In stark contrast to traditional treatment models based on provider/user approaches, peer-to-peer support suggests equal benefits to both parties (Mead et al, 2001). A social care approach has recently been suggested to improve individual health outcomes (Webber et al, 2015) and studies suggest employing social engagement and participatory action can prevent the development of health problems (see for example Belle-Isle, 2014) and reduce stress (Jen et al, 2010).

In 2004, the Office of the Deputy Prime Minister released the 'Social Exclusion Unit Report, Mental Health and Social Exclusion'; concluding that social inclusion via vocational and social engagement reduces the risk of suicide and contributes to improved mental and general health stating that, 'adults with long-term mental health problems are one of the most excluded groups in society' (DPM, 2004; 3). By 2006, the
"Commissioning Guidance: Vocational Services for People with Severe Mental Health Problems" produced in partnership by the Department of Work and Pensions and the Department of Health, echoed these sentiments. Suggesting health and wellbeing is improved when individuals engage with "some kind of valued activity that uses their skills and meets the expectations of others" (DWP & DH, 2006; 4), the report further concluded:

"Having used mental health services may be a positive advantage for prospective applicants through being able to utilise their experience of using mental health services. This in turn can serve to improve the quality of mental health care by involving people with direct experience in the care of others." (DWP & DH, 2006; 6).

In 'A Review of the Literature on Peer Support in Mental Health Services' published by the Journal of Mental Health in 2011, Carter and Reaper admitted the notion of "peer support is relatively innovative and unresearched" (p. 392). To better understand how peer-led services can improve UK mental health, Carter and Reaper (2011) analysed seven randomised and mostly international-based control trials (including Clarke et al., 2000; Davidson et al., 2004; Dummont & Jones, 2002; O'Donnell, Parker, & Proberts, 1999; Rogers et al., 2007; Sells, Davidson, Jewell, Falzer, & Rowe, 2006; Solomon & Draine, 1995). They uncovered that the inclusion of peer service provision was proven to be as effective in maintaining readmission rates as traditional services and in some cases, significantly reduced hospital rates. For example, research from (Chinman et al. 2001) shows a 50% reduction rate in re-admissions to hospitals, studies by Lawn, Smith, and Hunter (2008) demonstrated that over 300 bed days were saved over a three-month period when peer-support workers were employed, and a three-year study by Min, Whitecraft, Rothband, and Salzer (2007) highlights the longer-term benefits of peer supports in reducing hospital admissions. This review concluded peer support workers in mental health could support public health services and may reduce the burden on the UK public health system. Carter & Reaper (2011) also noted peer-based services offer something traditional services lack, saying:

"What PSWs (Peer Support Workers) appear to be able to do more successfully than professionally qualified staff is promote hope and belief in the possibility of recovery; empowerment and increased self-esteem, self-efficacy and self-management of difficulties and social inclusion, engagement and increased social networks (Carter & Reaper, 2011: 400).

Support of social engagement initiatives that improve access to meaningful participation and employment have recently been argued to be the best vehicle in improving mental health outcomes and also aid in reducing the stigma associated with mental illness (OECD, 2014).

WHAT OPPORTUNITIES EXIST FOR PEER-TO-PEER SERVICES IN THE UK?

Internet searches revealed a number of peer-to-peer initiatives that have recently been initiated within the UK. National mental health charity 'Together', in association with the National Survivor User Network (NSUN) is currently mapping peer-to-peer service provision in relation to mental health across England and now offer accredited training for peer leaders (NSUN, 2014). MIND charity provides a directory of peer-to-peer services and run several peer participation services including their wellbeing service and lighthouse recovery support for people with personality disorders (Mind, 2014). The CAPITAL Project Trust, is a charity dedicated to reducing mental health stigma through accredited training and the promotion of peer support and service-user involvement (CAPITAL, 2014) and RAISE Mental Health Ltd offers training and consultancy run by people with experiences of mental health challenges (RAISE, 2014). Education which values 'lived experiences' as a complement to mental health treatment, is also apparent within England's Recovery Colleges (see for example South West London Recovery College, 2014). The Peer Led Peer Support Collaboration (2014) is a UK network of nearly 17,000 per-led mental health support initiatives to increase promotion and improve service provision. The Scottish Peer Education Network (2014) developed the Professional Development Award (PDA) in Mental Health Peer Support, an accredited training Offered by Colleges and Training Providers in Scotland.

More locally, Southdown Housing Association developed the Peer2Peer service in 2007 in partnership with Brighton Housing Trust (BHT) providing peer-led services within Brighton and Hove (Southdown Housing Association, 2014). Sussex Partnership Trust has developed numerous resources and training surrounding peer-to-peer services in mental health; promoting the inclusions of social firms, social enterprises and other 'vocational rehabilitation' as a valid approach to mental health service provision (Sussex Partnership Trust, 2014). Recovery Partners, is "100% user-led and run" and offers services such as free 1-to-1 and peer group sessions for people facing mental health challenges run by those with personal experience (Recovery Partners, 2014). Further local groups were identified through the community review- demonstrating the wealth of experience within the area.

Internationally, innovative examples of partnership working within a peer-to-peer context can be found. For example, in Vancouver Canada 'Peer Network BC' offers a physical space for peer-to-peer groups and provides collective training and access to shared equipment (Peer Network BC, 2014). The National Peer Support Collaborative Learning Network in the United States of America collectively works to

champion peer-based approaches to address a both physical and mental illnesses (NPSCLN, 2014). In Australia, The Centre of Excellence in Peer Support (2014) provides an online clearing house of peer-to-peer resources and research. Examples of collective research initiatives can also be found. For example, The European Commission has recently received funding for two large-scale, multi-country best practice studies on peer-led addiction support (Correlation Network, 2013; Trautman and Barendregt, 1994).

PEER-TO-PEER:
A COLLECTIVE REVIEW OF BEST PRACTICE

Drawing conclusions from desk-based research, this community review into peer-to-peer best practice was informed by the following:

Need: Innovative approaches are required to fill gaps in mental health service provision.

Public Health: The peer-to-peer approach fits within current government policy and international research suggests potential reduced pressures on public services.

Individual Health Outcomes: Preliminary research suggests peer-to-peer service provision is an effective treatment approach; providing reciprocal benefits to service users and providers.

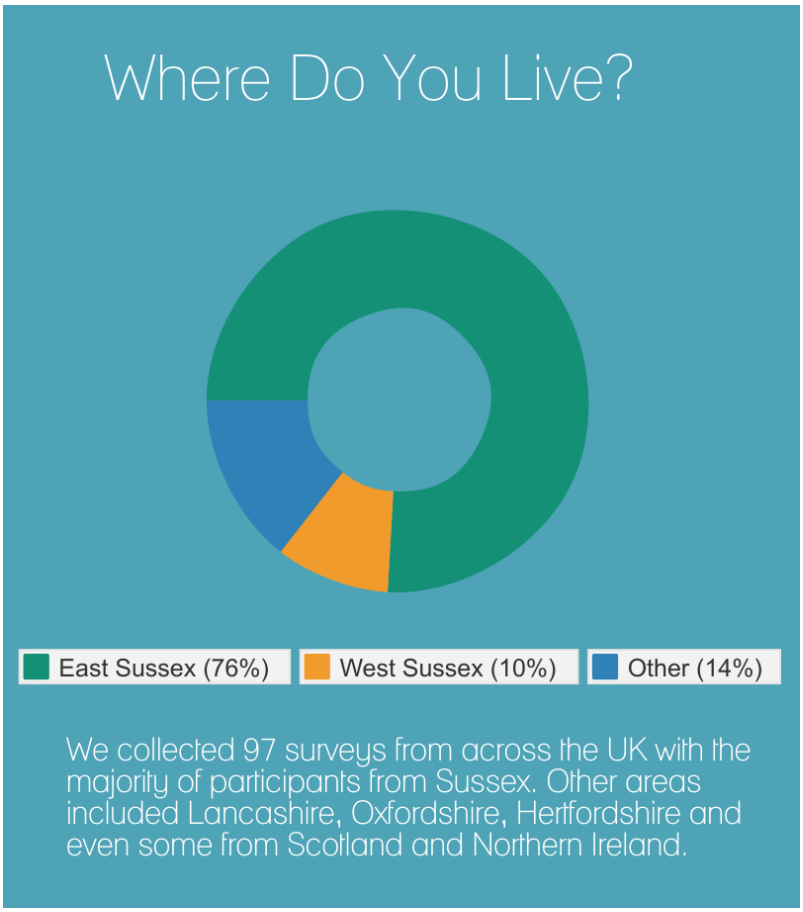
Opportunities: The potential to link concurrent reviews of peer-to-peer services and the expertise to integrate peer-to-peer service provision into statutory services exists.

To understand how peer-to-peer could work within a community context, Mothers Uncovered, Grassroots Suicide Prevention and Synergy Creative Community captured the ideas of a total of 131 participants who had engaged with peer-to-peer services both as receivers and providers of support primarily in East Sussex. A mixed-method approach was chosen to allow people to participant in the way they felt most comfortable resulting in 97 people offering opinions via an online survey, 16 people participating in three focus groups and 18 people participating via the consultation day.

Short-term funding time-lines common with third-sector funding were noted by project partners, which restricted the scope of this review. Time-lines would not allow for a prior academic ethical review, the project partners collectively developed and scrutinised all elements of the review including project aims, method selection, survey and focus group questioning, and the design of the public consultation day. Full disclosure of the project aims and intentions was embedded into every area of the project.

The overall goal was to provide a resource that was reflective of the needs and expertise of our community and that could both inspire increased interest and support for the peer-to-peer approach.

SURVEY

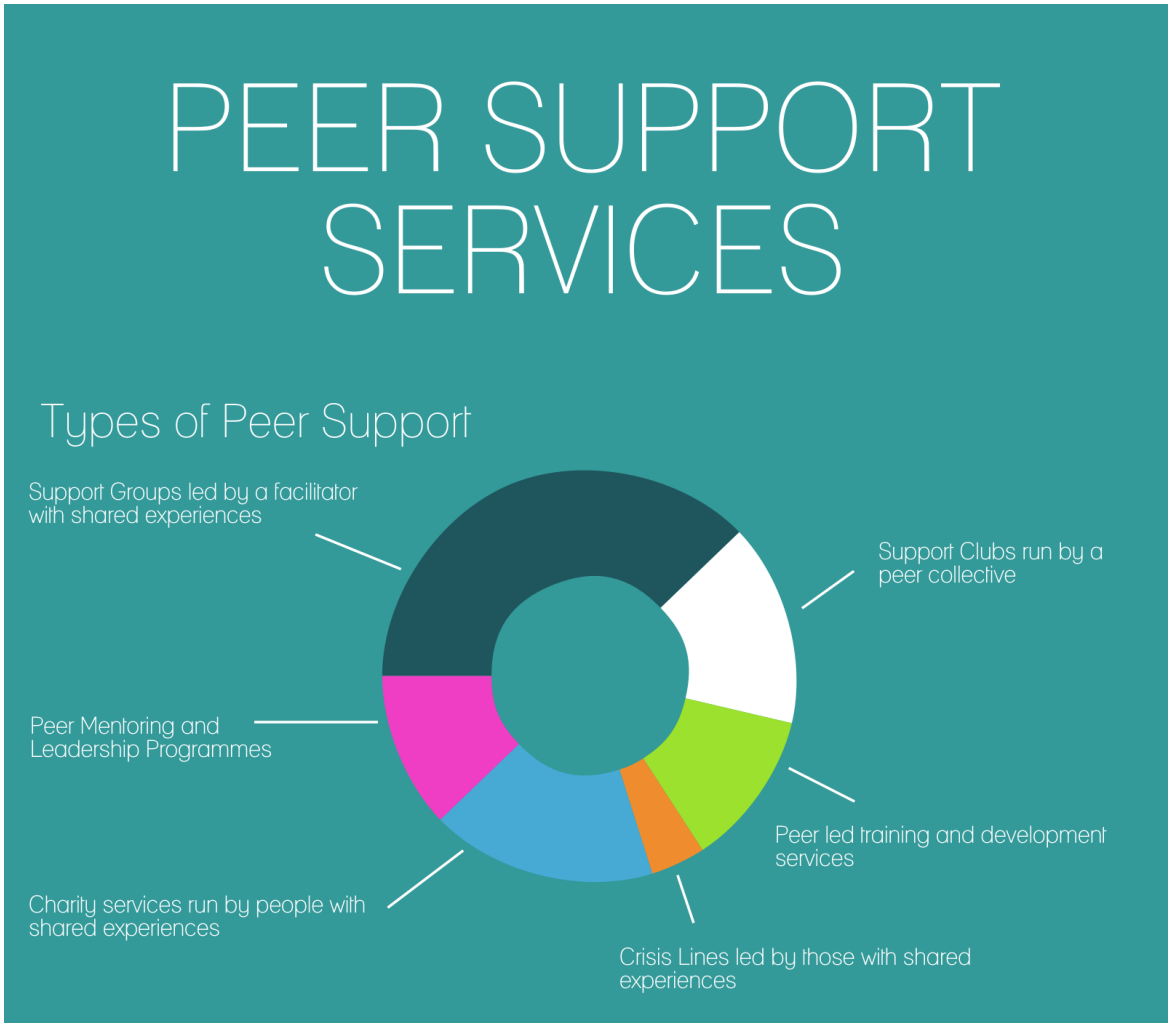


97 people were surveyed to better understand peer-to-peer service provision. 31% of survey respondents noted they both received and provide peer-to-peer services.

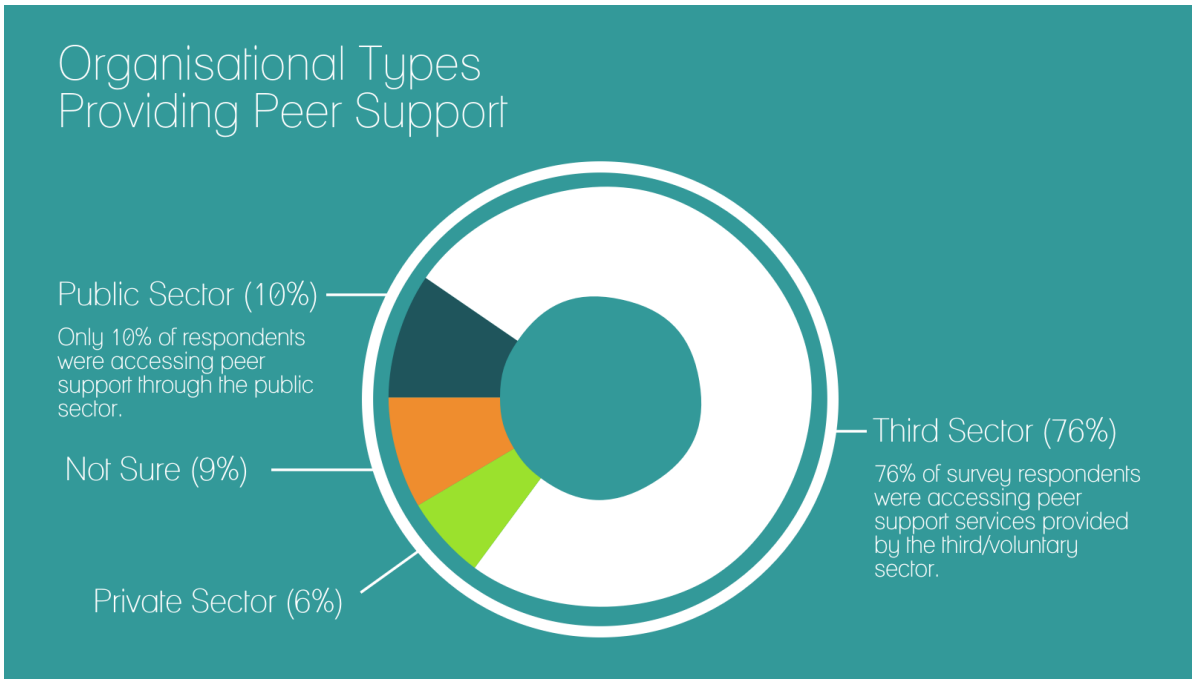
An internet survey was selected as one means of data collection as it a) allowed for wider distribution across the region, b) allowed participants to participate from their home should they have social or mobility concerns and, c) provided participants additional time to review the on-line participant information sheet prior to participation or directly contact the project partners for more information prior to participating.

The survey was distributed via the project partners to their network of service users and providers, and organisations providing peer-to-peer services identified within initial research. The survey was also distributed via Community Works Network to 500 voluntary sector members. It was further made available at the public consultation day, where laptops were available at survey stations and printouts of the information sheets were available for easy access.

The 97 respondents surveyed noted they had engaged with Peer-to-Peer support in the following ways:



The most common form of peer-to-peer support in the Brighton area was the model delivering support groups led by a facilitator with shared experiences, with 66% of survey respondents accessing this type of support. A further 31% were accessing charity services run by people with shared experiences. 28% accessed support clubs run by a peer collective. Peer mentoring and leadership programmes were also fairly popular, being accessed by 21% of our respondents.



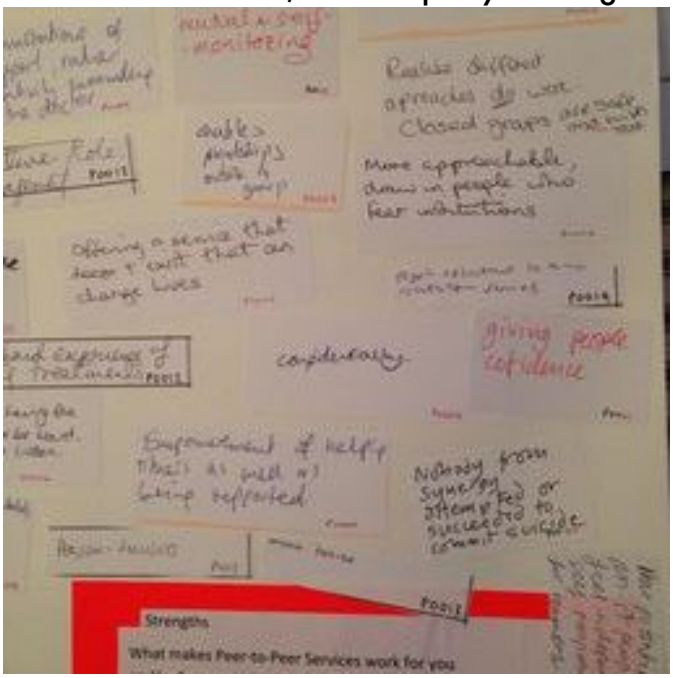
The most common group providing peer support was the third sector, which provided considerably more peer support services than other sectors according to our survey respondents.

46% of survey respondents experiencing peer support were users (receiving support), though 31% were both receiving and providing support. 15% of respondents were providing support, and we collected feedback from 9% who were managing or administrating a peer support service.

Focus Groups

Three focus groups were undertaken involving a total of sixteen people who engage in peer-to-peer service provision through receiving and providing support. The participants were identified by the project partners through their networks. Approximately 1/3 of focus group respondents both receive and provide peer-to-peer support, with the majority receiving support.

During the project design, the partnering agencies wished that participants could communicate ideas without being able to be identified, while equally wishing that participants are recognised as individuals. In order to be sensitive to this need, participants in focus groups were provided with sticky labels and their ideas were captured in their own handwriting and displayed on consultation day and within the report to showcase their individuality. So as not to exclude anyone, participants were told at the start of the focus group that, should they have any concerns about their handwriting being displayed, that the facilitator would rewrite their answers before they were shared. This was done for two reasons, the first to further safeguard participants who may have safety concerns about being identified by their handwriting, and secondly, to be sensitive to the fact that some people feel self-conscious of their written literary skills.



During the focus groups, participants were guided to 1) Identify the qualities, traits and attributes of a positive peer-to-peer leader, 2) complete a SWOT analysis on peer-to-peer service provision, 3) Identify risks and challenges of the approach and possible solutions, 4) Identify training and development needs of peer-to-peer leaders and, 5) Share any other thoughts on peer-to-peer service provision. The questions were discussed as a group, with participants having an opportunity to share and further explain their answers, bounce ideas off each other and engage in a supportive debate surrounding what was needed and what works best.

Public Consultation Day

Finally, the project included a public consultation day to co-validate initial results with the community. Organisations providing this support were invited to share their ideas around supporting peer-to-peer leaders and sector support needs. A total of eighteen participants attended the open consultation day. In addition to three open discussions surrounding training, employment support and sector support requirements, participants were invited to review the responses of focus group participants which were on display and to contribute their own ideas. Hard copies of select resources were made available and participants were provided with an opportunity to list additional resources and identify further peer-to-peer organisations.

The public consultation day was comprised of three open-discussions:

1. What training and development do Peer-to-Peer leaders need?
2. How can employers best support Peer-to-Peer workers within their organisation?
3. How can Peer-to-Peer Services benefit from, complement and work with existing services?

At the end of the day, participants were given the opportunity to leave their contact details so they could receive information about the final report, be invited to the public dissemination event and to participate in future research initiatives. A total of 16 participants signed this sheet and all wished to be included at all levels of the project.

RESULTS

The evaluation section of this review includes results from focus groups, survey responses and discussions at the community public forum. This will follow the same structure as the literature review that parallels may be drawn.

1) Is Peer-to-Peer a valid approach for public health?
2) Are Peer-to-Peer services known to improve individual health outcomes?
3) What opportunities exist for peer-to-peer services locally to work collectively?

IS PEER-TO-PEER A VALID APPROACH FOR PUBLIC HEALTH?

"If this group didn't exist, I would have lost my marriage, I would have had my child taken away from me and been suicidal. This group showed me I was normal. I'm now very happily married with three beautiful children, and have my whole life in front of me."

"I tried to get referred to a counselling group, but I was on the waiting list and then I just never heard back - here I could get help right away and now if my referral happened, I wouldn't need it anymore."

The above quotes from focus group participants illustrate that peer-to-peer support has the potential to immediately support vulnerable people in crisis. The majority of peer-to-peer service users we consulted via the survey sought emotional support (70%), dealing with a life change affected 51%, 45% were seeking support for loneliness and isolation, 41% for mental health concerns and 22% for support with feeling suicidal.

"There is a difference between professional and nonprofessional services - it works because it is unconventional but we don't have the professional capacity or the training which puts the group at risk of being shut down."

To understand how the peer-to-peer approach could fit within public health service provision, we worked with the focus groups to complete a SWOT analysis. We further unveiled a potential social return on investment via the survey which suggested reduced reliance on public services such as GPs and a reduced involvement in unhealthy lifestyles such as drug use.

While there were no shortage of suggestions for the strengths of peer support, the majority of responses were focused around the ability of peer-to-peer support groups to help people recover from mental health concerns, and the support system created by bringing together people with shared lived experiences.

One of the key weaknesses identified was a lack of training, which was also highlighted as an area of concern by the focus group participants. Feedback from the Consultation Day and an in-depth focus group discussion on how to alleviate this situation highlighted the following solutions to addressing training needs.

It was felt that open-access and accredited local training would be useful for quality assurance, but it was felt the first stage would be to develop a set of unaccredited training which could be tested, and then accredited when it had been proven successful.

Topics to be covered in training were suggested to include:

- Professional Boundaries;
- Facilitation Skills including funding, administration and signposting skills;
- How to Create Legal Documents to enable agreed boundaries and group agreements;
- Peer leader skills such as self-care and emotional resilience;
- Mental health awareness including responding to crisis, social isolation and Assist (applied suicide intervention skills)

Focus groups discussed the best ways for such training programmes to be developed. Suggestions included the development of a peer-led training programme and a central source of peer resources accessible to all local groups. 82% of survey respondents felt specific peer-to-peer training would help peer services to be more effective. Focus groups discussed lack of funding as hindering access to training.

Many focus group participants expressed that lack of funding was seen to be the reason behind poor publicity and a heavy reliance on volunteers (two of the most common weaknesses identified). Collectively working with other peer-to-peer groups was strongly suggested by all three focus groups as the best vehicle through which groups could improve best-practices and further access funding.

The opportunities identified for peer support groups were focused around the impact increasing access to peer support could have on the general population. It was felt

there were real possibilities to exponentially affect levels of depression, reduce suicide, and drastically improve mental health and wellbeing.

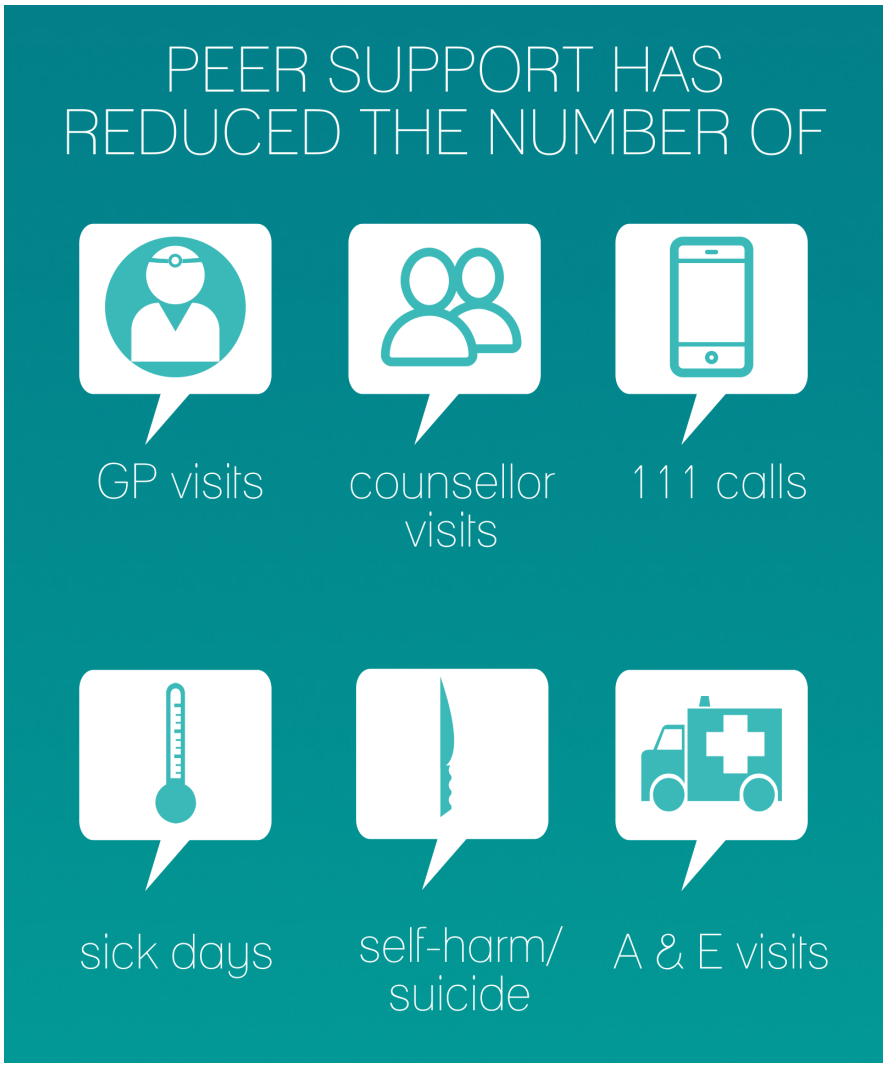
The term 'compassion fatigue' was mentioned by a number of participants as a real concern. Compassion fatigue is usually used in connection to care-givers working in environments with people who have experienced significant trauma, where they are presented with regular emotional challenge (CFAP, 2014). Focus group discussions further highlighted a concern for 'compassion fatigue' amongst peer leaders.

At both the Consultation Day and within the focus groups, there was a lot of discussion about the amount of work required of a peer-to-peer support group leader, how emotionally draining the position can be, the lack of support for the leader and heavy reliance upon volunteers.

Nearly a third of focus group respondents both receive and provide peer-to-peer support, which is similar to the 31% of survey respondents who also claim to fill both roles. The project further identified additional support required for peer-to-peer leaders who have personal experiences with mental health challenges, and in some cases, provide reciprocal support in what they consider part of their ongoing wellness plan.

The need for peer leaders to receive ongoing support was a concern shared by all the groups we consulted. Suggestions for this included having access to shared resources including policies and procedures, a network of peer support leaders, and improved training.

To understand what impact engaging with peer-to-peer services has on the public health care system, we asked the 97 survey respondents to what extent their involvement in peer support had had an impact on reducing their need to rely on any other services. The results showed a reduction in GP visits, counseling visits, and even a considerable reduction (12%) in the number of suicide attempts a person had.



GP Visits
22% reduced by 1-3 GP visits per year.
8% reduced by 4-9 visits

Counsellor visits
7% reduced by 1-3 visits
7% reduced by 4-9 visits

111 calls
6% reduced by 1-3 calls

Sick Days
9% reduced by 1-3 days
9% reduced by 4-9 days
4% reduced by over 20 days

Self-harm/Suicide attempts
12% reduced by 1-3 times
6% reduced by 4-9 times

A & E Visits
9% reduced by 1-3 visits

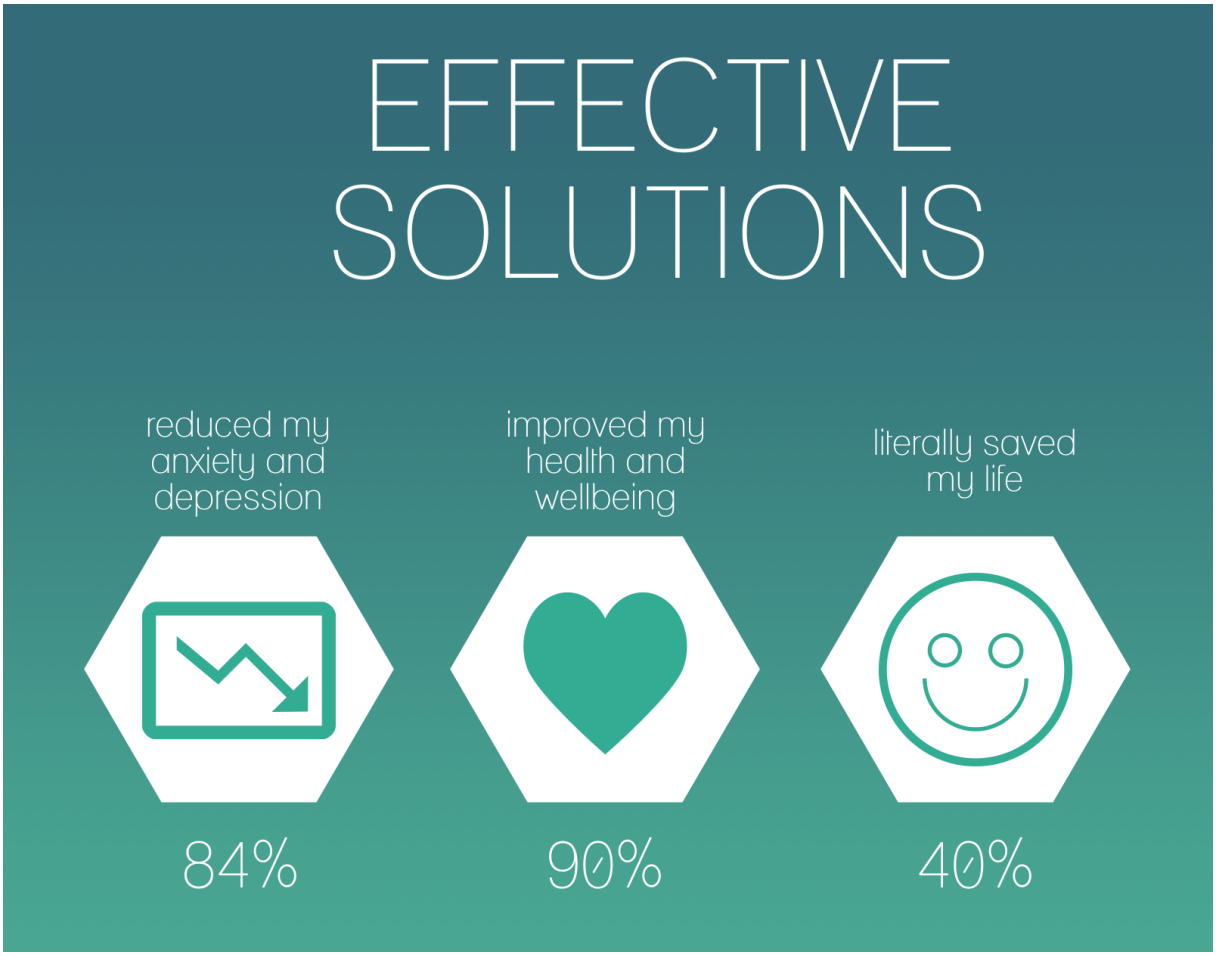
Overnight Hospitalisation
3% reduced by 1-3 nights
3% reduced by 4-9 nights

It is beyond the scope of this project to complete a comprehensive cost-benefit analysis on this. However, while the cost of peer-to-peer services differs from project

to project, there is a potentially large social return on any investment in terms of positive outcomes for users - all of which divert public spending in the above areas.

ARE PEER-TO-PEER SERVICES KNOWN TO IMPROVE INDIVIDUAL HEALTH OUTCOMES?

Key findings of the survey showed significant benefits of peer support. For 84% of respondents, it reduced anxiety and depression, 90% claimed their health and wellbeing had improved and 40% said it had literally saved their lives.



Focus group respondents echoed this:

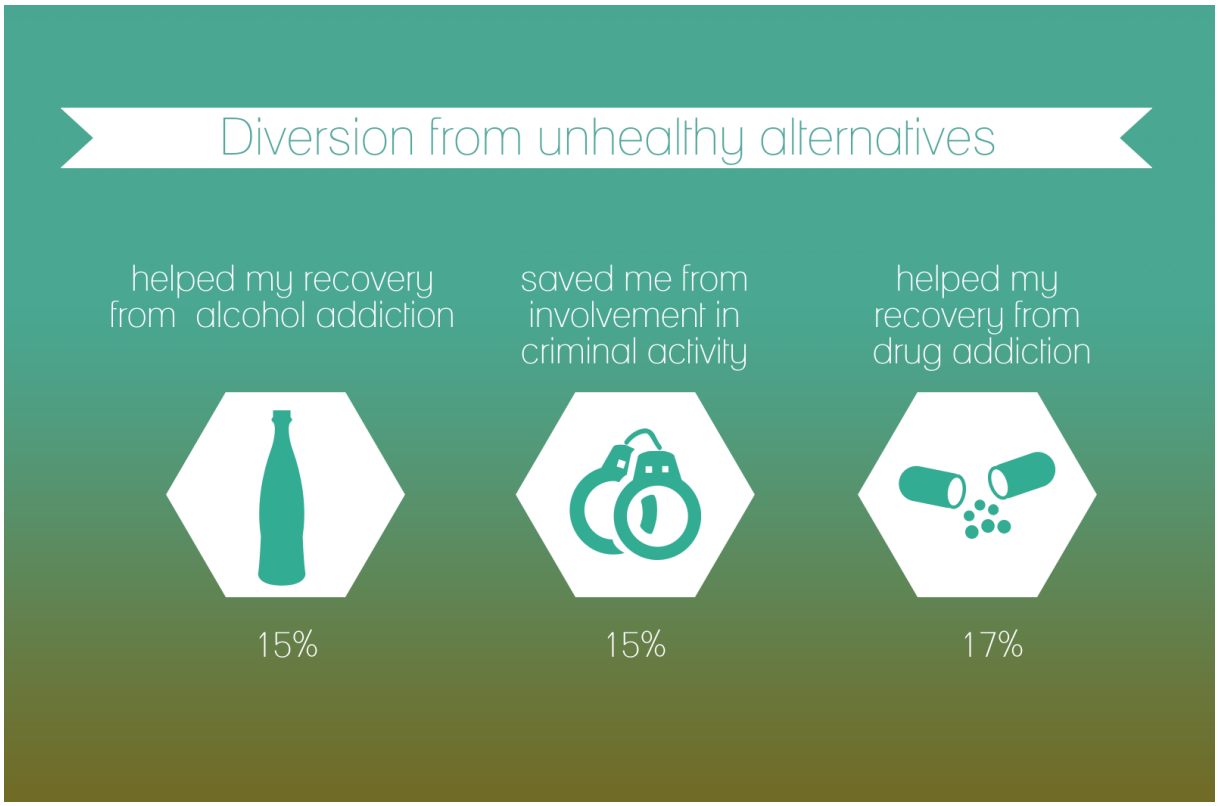
"It helps me re-build my life." *"It inspires confidence."*

"It helps self-esteem to volunteer in the community."

"When I'm suicidal, this group puts a stop to the idea."

"It makes life bearable." *"It develops self-respect."*

While not directly addressed within focus groups, we discovered that 15% of our survey respondents had been helped to recover from alcohol addictions, 17% from drug addiction and 15% had been saved from involvement in criminal activity. This shows a significant impact of peer-to-peer support on the bigger picture of wellbeing in a person's recovery journey.



Some focus group participants however said they sought peer-to-peer support as an alternative to prescribed medication:

"The first thing they (doctors) do is offer you drugs, but some drugs are addictive so it's like a domino effect."

"The medical profession needs to realize there is more than one way to help someone. It is not all about medicines. People out there who want to help, who can listen, support, care etc. and this should be taken up."

When asked which service was most effective in supporting their health and wellbeing, 81% felt peer support services were more effective than statutory support.

"You can be scared your baby may be taken or someone may be called in when actually that person just needs to talk and know they are safe and are supported and it won't be a mountain out of a molehill situation. Peer-to-Peer can offer this."

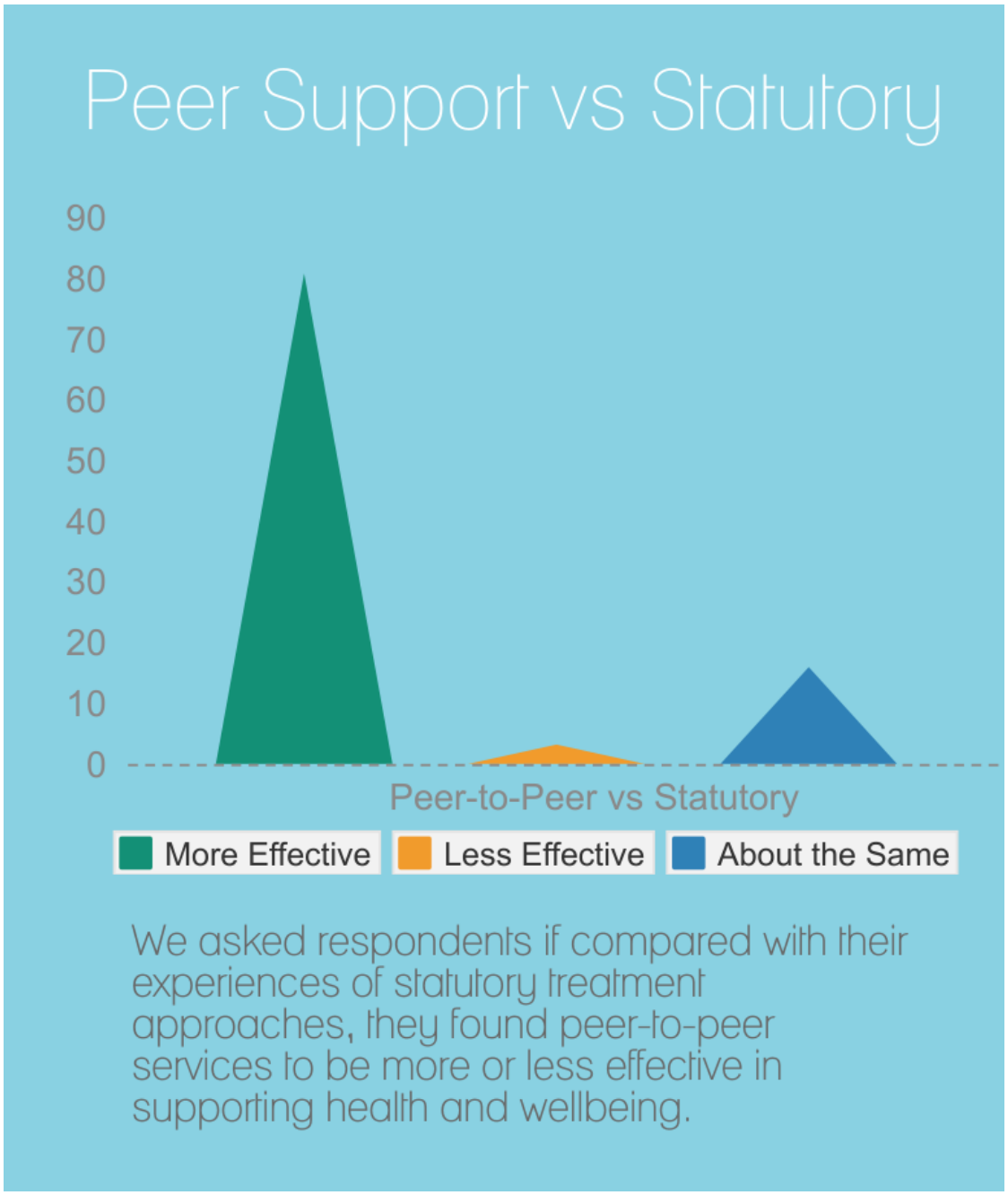
Feedback from focus groups suggested that the benefit of peer-to-peer service was its less formal approach. There seemed to be a feeling that peer-to-peer support offered a better emotional support system, which in general was seen to be a more long-term solution.

"For me, this is the one place every week I sit down with other people and share a meal."

"It is such a big group that it is almost impossible to escape the net."

"90% of the things I do every week are seeing people from the group. For me, this is family."

"If I didn't have this group, I would have no one to come visit me when I was in hospital and nowhere to turn when I come out."



"The thought of going into a hospital to get well is such a foreign concept - you go there when you're a hassle to society."

"For some people doctors are not the answer, people can be anxious or worried about answers given by GP."

It also appeared to help people build confidence:

"When people say 'what do you do' I can say 'I run an art group' - I don't have to say that I am a lady that lunches."

"'Through talking it is like you had gone through a traumatic experience not that there was something wrong with you".

"This group made me realise how much I have experienced and learned through motherhood".

Participants stressed however that there is still a need for statutory projects to help a person in crisis – it should not be a case of peer support or statutory support, as both have their place. One survey respondent who is a peer leader commented:

"An example of a worst case scenario would be to send someone in need of hospitalization for six weeks to us instead, expecting our peer-to-peer support to deal with someone in crisis. We are not trained professionals. Supportive friendships IN NO WAY WHATSOEVER can replace the need for professional support."

This was also recognised by those receiving support:

"It's great in addition to NHS services."

"It's the second step when released from hospital."

Approximately one third of focus group and survey participants both receive and provide peer-to-peer services. Increasing opportunities for those who have experienced or are experiencing mental health challenges was communicated to reduce real and perceived social stigma by showcasing the leadership talents of this minority.

WHAT ARE THE CHARACTERISTICS OF A POSITIVE PEER LEADER?

In focus groups, and at the public consultation, we asked what the characteristics of a positive peer leader were. The most common one-word answers included "*Supportive*" and "*respectful*", with "*empathy*", and "*humour*" also identified as top priorities.

Longer worded answers were focused around alertness, ability to manage boundaries, assertiveness, commitment to equality and non-discrimination. Additional skills such as creative ability, group organisation and promotion skills, acknowledging the need for breaks and being "good at making tea" were also highlighted. Focus group respondents agreed those who had experienced mental health challenges often possessed these qualities and could be supported to give back.

It was felt essential that the peer leader also had a support system in order that they could ask for help. The role was identified as being challenging and with considerable responsibility, therefore focus group discussions identified areas of risk, which could be minimised with additional support for peer leaders.

WHAT OPPORTUNITIES EXIST LOCALLY FOR PEER-TO-PEER SERVICES TO WORK COLLECTIVELY?

A number of creative ideas for community partnerships were suggested including:

- A 'mobile peer-to-peer mentor'- a trained facilitator that can go to visit groups and provide constructive feedback to the group and lend printed resources;
- A 'peer-to-peer providers help-line' to allow leaders to debrief;
- A peer-to-peer leader 'buddy' or 'mentoring' service;
- A peer-to-peer community centre with shared space;
- A drop-in group for peer leaders staffed by peer-to-peer support staff from multiple agencies to foster networking;
- A community garden for peer-to-peer groups to help lower meal costs;
- Peer Boards (it was noted that Brighton Housing Trust is setting this up);
- Shared Facebook Page - potentially linked to a national network (it was noted Recovery Partners has an open group);
- A digital 'resource centre' of peer-to-peer support research, guidance, activities, training and functional templates;
- A Publication/Zine (Recovery Partners is interested in managing this if funding can be secured).

A collective approach was suggested as a means to improve access to training for peer-to-peer leaders and service providers.

The Consultation Day participants further discussed how training and knowledge could be shared via open-access. Currently few open-access peer-to-peer training support exists with training provided primarily to organisational staff and volunteers. This review however highlighted the following organisations that deliver specific peer-to peer training:

Local:

- Southdown Housing Association
- Mind
- The Capital Project Trust (Level 4, Accredited through Middlesex University)

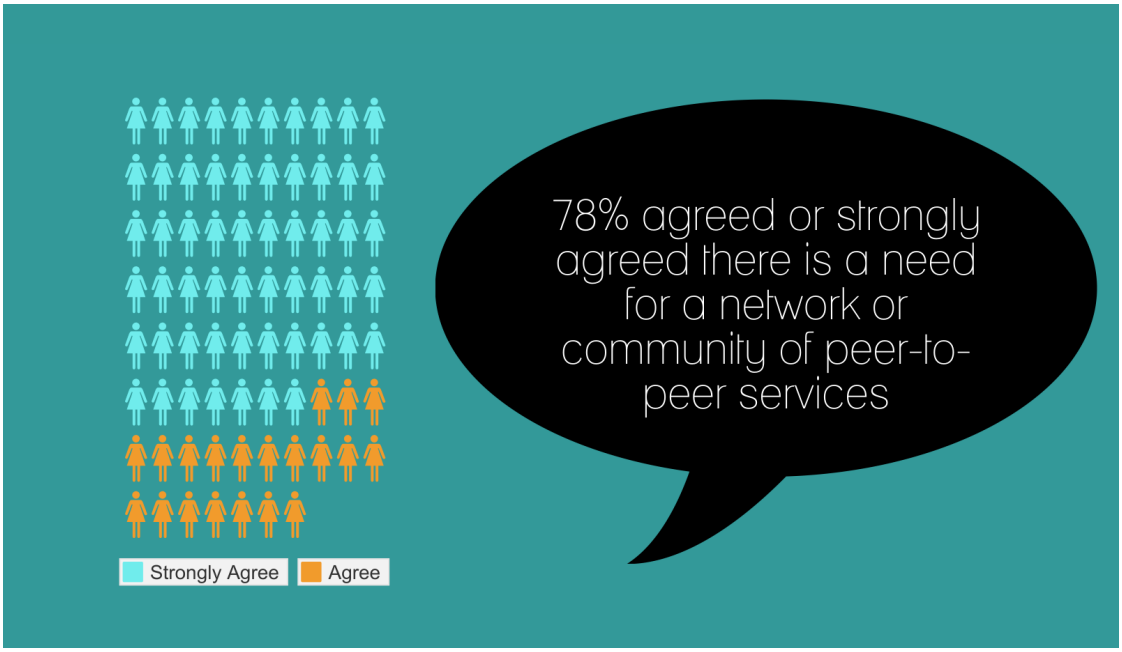
National Training:

- Together (Level 4, Accredited through Middlesex University)
- Nottingham Recovery College (Accredited through Sheffield Hallam University)

Peer Enhancement of Teaching and Learning (PETAL) training was recommended by participants in the Consultation Day.

It was suggested that a collective could potentially pool training resources. For example, it was suggested that funding could be received to enable a group with existing resources to facilitate training to other groups.

Throughout the focus groups, Consultation Day and survey responses, it was felt the establishment of a network of peer support groups would be the best vehicle through which groups could improve service, increase training provisions and foster collective funding partnerships. 78% of survey respondents felt a network or community of peer-to-peer services would improve the effectiveness of peer services.



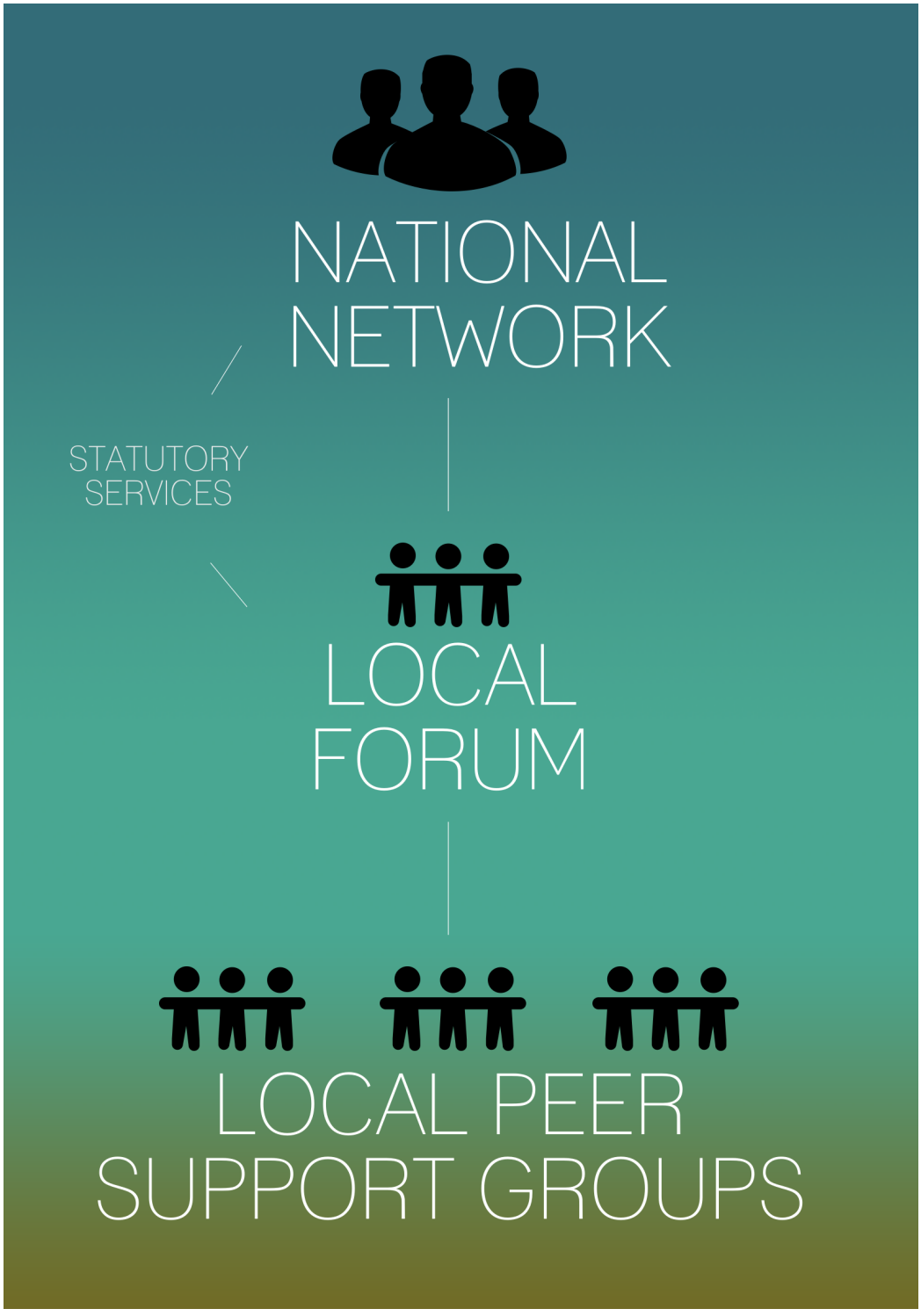
Consultation day findings further demonstrated this need. Recovery Partners noted they received similar requests for networks on a survey they had completed the year prior. A Network was stressed especially by the providers consulted who felt this would assist in signposting to other services as needed.

Consultation Day participants noted the following benefits of Network:

- Give a set standard of training - promote good practice (by-product of networking in shared environment);
- A platform to discuss standards;

- An opportunity to share updates on new developments in mental health recovery;
- Share research and funding applications (partnerships not competitions);
- Shared knowledge - members can report back from conferences, training etc. Upload resources;
- Wider scope of resources - roll out surveys across network;
- Map provision (gaps in service better addressed by signposting);
- Easier for commissioners to contact sector (also shared administrative time for groups attending meetings, take minutes etc.);
- Responds to needs of sector – streamlines the answers to common questions and acts on them;
- Unified voice - more recognition from existing statutory services of the peer sector, better opportunities for joint funding bids;

An open discussion took place around the type of model this Network should take represented in the following diagram:


NATIONAL
NETWORK
STATUTORY
SERVICES
LOCAL
FORUM
LOCAL PEER
SUPPORT GROUPS

RECOMMENDATIONS FOR THE DEVELOPMENT OF A PEER SUPPORT NETWORK

Structure:

- Quarterly meetings (it was noted that the number of meetings required may change over time)
    - 2 training meetings annually (shared training, guest speakers, mental health updates)
    - 2 other meetings - Annual General Meeting & 1 Research Meeting (identify partnership opportunities for joint research and funding)
- Rolling chair from member organisations;
- It was noted that like a 'providers meeting' it needs administration function;

Membership:

- Need to consider what organisations count as 'peer-to-peer'- Terms of References suggested to be collectively created at first meeting;
- Needs to be inclusive: not limited to mental-health based groups (arguably all peer-to-peer groups that help diminish loneliness, isolation and stress help with mental health);

Function:

- Provide a collective voice for those who engage with peer-to-peer service (peer-to-peer groups and those that receive and provide services).
- Share and develop collective resources;
- Share and develop collective research;
- Work with national networks and public services to improve community wellbeing through peer-to-peer support;
- Potentially assist in enabling work experience, mentoring and shadowing activities for peer-to-peer leaders across Network Organisations (it was noted this would need to be further explored due to administration requirements such as increased DBS checks);
- It was also suggested that the groups make a joint bid to be included in the second wave of the Prime Minister's Challenge Fund;

During the Consultation Day, most participants felt they could assign a member of staff to attend quarterly meetings, and Southdown Housing Association expressed an interest in taking on administration responsibilities to get this project started (such as

taking Minutes and organising meetings) if funds were provided to cover additional costs.

This project identified a number of groups providing peer-to-peer services in the area that may be interested in becoming part of a network:

- Allsorts Youth
- Creative Future
- Federal Centre for Independent Living
- Grassroots Suicide Prevention
- Health in Mind
- Lothian Centre for Inclusive Living
- Lunch Positive
- Men Get Eating Disorders Too
- Mind (Peer Support and LiVE project)
- Mindful Mamas
- Mothers Uncovered
- RAISE Mental Health Ltd
- Recovery Partners
- Rise UK
- Southdown Housing Association
- Synergy Creative Community Creative Community
- The Capital Project Trust
- The Expert Patient Programme
- The National Survivors Network (NSUN)
- The Peer Led Peer Support (PLSP) Collaboration
- Together: Working for Wellbeing
- Wide Berth Mothers Group
- Wish

Each of these groups has a unique function and represents various approaches to peer-to-peer service provision, however each was identified to include and promote peer-to-peer engagement in some capacity.

DISCUSSION

This project acknowledges that further research into peer-to-peer services is needed as identified for example by Carter & Reaper (2011). It also acknowledges that larger studies are required. Of the 131 people consulted, almost all expressed that they had engaged with peer-to-peer services either as providers, service users or both. *"Inequalities in health are frequently investigated using grouped data"* (Kakwani et al., 1997; 3) and caution should be drawn in attributing the results of this review to the wider population. This review is by our community and for our community, however it is hoped that this will inspire further interest and research into this approach.

The focus group and consultation day participants stressed that they would like to be part of undertaking any further research. They recommended future reviews should aim to include peer-to-peer groups that provide support not specifically related to mental health to give a broader understanding of this approach. Longer time frames were suggested to enable volunteers and those with fluctuating health needs to contribute ideas. To accomplish this they suggested a Network of peer-to-peer services, which could dedicate one of four meetings annually to collaborative research. It was felt this would widen the scope of surveys and consultations and minimise groups 'being asked the same thing' multiple times. It would also widen the voice of the sector and enable partnership building with government, public health providers and academics.

If not run exclusively by volunteers, much of the work into peer-to-peer service within the local area appears to have been undertaken by community groups and third-sector organisations. These groups possess a wealth of knowledge in providing peer-to-peer services within East Sussex and a willingness to work collectively. The SWOT analysis highlighted limited funding and limited access to training as two of the greatest challenges in fostering collaborative partnerships and sharing knowledge more widely. A number of innovative ideas were presented to support the sector such as a peer-to-peer drop-in centre for peer leaders; however the two most prevalent suggestions were the creation of a Network for peer-to-peer organisations and the need for open-access peer-to-peer training.

Lastly, it should be noted that charities and third-sector groups rely on funding to offer their services. Readers of this review are encouraged to speak to named organisations directly to confirm what services they currently have on offer.

Conclusion

The findings of this review have shown the positive impacts of peer-to-peer service provision echoing existing research. It highlights potential savings to the public sector as suggested by Carter & Reaper (2011) by reducing GP appointments, 111 calls and visits to A&E. It found that Peer-to-peer services have further contributed to the local economy by reducing the number of sick days taken and offering meaningful employment opportunities; echoing sentiments by the Department of Health (see for example DH, 2004; DWP & DH, 2006) and The Organisation for Economic Co-operation and Development (2014). Knowledge gained from the three focus groups in particular suggested engaging with peer-to-peer service provision benefits both users and providers such as was found by academics (Mead et al, 2001). It was also found to reduce social stigma by improving skills and confidence; also suggested by recent research (see for example OECD, 2014). Studies suggest employing social engagement initiatives can prevent the development of health problems (Belle-Isle, 2014, Jen et al, 2010). Evidence from the survey goes further to suggest these services may also reduce tendencies to choose unhealthy lifestyles such as engaging with drugs, alcohol and criminal activity. Perhaps most locally applicable due to high rates of suicide in Brighton and Hove (Scanlon et al, 2011), this review identifies peer-to-peer as an innovative approach to reducing suicide and self-harm as previously suggested by the Department of Health (DH, 2004).

The strength of the peer-to-peer approach is in its ability to provide social care that improves public health and individual health outcomes as suggested by (Webber et al, 2015). It offers participants a strong social network of people who cannot only understand what they are experiencing, but who can offer friendship and support. These qualities were suggested by Carter & Reaper (2011) as to what peer workers in mental health offer that public services do not. This review strongly suggested those engaging with these services felt they were more beneficial than statutory services; however participants stressed that these should be provided in addition to traditional services. Participants suggested a Network of peer-to-peer services could provide a platform to work more collaboratively with public health services. It was also felt a Network could increase the scope and of future reviews and expand their impact and provide sector supports such as training and resource sharing.

While the short-time frames of this review limited the project's ability to contribute to academic research, it has demonstrated the capacity of peer-to-peer service providers/users to work collectively, the willingness to share knowledge and the desire to develop peer-to-peer sector support. Webber et al (2015), suggests mental health service provision in the UK can be improved by providing continuation

funding for innovative approaches, which have demonstrated early success. The peer-to-peer approach is evidently worthy of such investment.

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APPENDIX 1: CONSENT FORM

CONSENT FORM

Title of Project: Peer-to-peer support services - Best Practice & Model Development

Project Partners: Mothers Uncovered (Lead), Grassroots Suicide Prevention and Synergy (Support from Shona Maguire Consultancy and Mirika Flegg -Equal for Rights Research & Consultancy)

Contact details:

Address: | |

Tel: | |

Email: | |

Please initial box

1. I confirm that I have read and understand the information sheet for the above review-based project and have had the opportunity to ask questions.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	
3. I understand that any personal information that I provide to the project team will be kept strictly confidential	
4. I agree to take part in the above review.	

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent (Member of the Project Team)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

APPENDIX 2 – PARTICIPANT INFORMATION SHEET

PEER-TO-PEER SUPPORT SERVICES
BEST PRACTICE & MODEL DEVELOPMENT

A project-based review is being conducted by three organisations seeking to understand how to best provide Peer-to-Peer services in Sussex. These groups are Mothers Uncovered (Project Lead), Grassroots Suicide Prevention and Synergy and Shona Maguire Consultancy and Equal for Rights Research & Consultancy are supporting them. The project/research team includes: Maggie Gordon-Walker, Chris Brown, Odi Oquosa, Mirika Flegg and Shona Maguire.

Background

Peer-to-Peer services provide a system of support where people with shared experiences can give and receive help to one another (such as support groups, informal collectives or organisations that employ staff with similarities to their members). The project was initiated when three third-sector organisations providing health and wellbeing support services in Sussex collectively wanted to understand how to best provide Peer-to-Peer services and how to best support Peer Leaders and Peer-Led initiatives.

Overview

A participatory research project was developed to offer individuals and groups who provide/and or receive Peer-to-Peer services in Sussex an opportunity to contribute ideas and expertise.

Collectively we aim to:

1) Identify the prevalence of the Peer-to-Peer approach in the region

2) Develop a Peer-to-Peer Best Practice Model collectively with identified Peer-to-Peer organisations, leaders and service users

3) Share this information with the community, local councils, academics and local and national Peer-to-Peer organisations to improve service provision

This will include:

I. A review of academic Literature on Peer-to-Peer, Peer-Support in Mental Health, Peer-Led Service Provision and other keywords identified through the project;

II. A survey where individuals who receive or provide Peer-to-Peer supports can contribute their ideas and expertise into the development of a best-practice model;

III. Focus groups comprised of Peer-to-Peer leaders, Peer-to-Peer Service users and support-staff of organisations providing peer-led/peer-focused services;

IV. A community consultation event where initial results are shared with Peer-to-Peer groups, Peer-to-Peer Leaders and Peer-to-Peer service users and further needs can be identified, discussed and individual and collective recommendations can be made;

V. Analysis of (I-IV) will be carried out and fed-back to the community via a written report and results presented at a public event in the spring of 2015.

What will you be required to do?

Participants in this project will be asked to:

- Share their opinions on Peer-to-Peer service provision that we may assess how it works and under what conditions it works best.

Information will be collected via survey, focus groups and open consultations and you are asked to participate in any or all ways you feel comfortable expressing your opinion. Participation is voluntary and you may at any time express that you no longer wish your ideas to be recorded (only information you shared up until the time you withdraw consent will be reviewed).

To participate in this review project:

You will be an individual living within Kent, Surrey and Sussex who self-identifies as receiving and/or providing Peer-to-Peer supports based on the below description:

Peer-to-Peer services provide a system of support where people with shared experiences can give and receive help to one another.

Further involvement from individuals and groups who provide managerial/administrative or training supports to organisations providing Peer-to-Peer services will also be welcomed.

Please note that you will have an opportunity to identify your involvement in Peer-to-Peer services (user, leader, user/leader, support organisation) in all activities for the purposes of analysing results.

Procedures

You will be invited to share your ideas anonymously in the way you feel most comfortable in expressing them (survey, focus group, community consultation day).

Feedback

We will be happy to provide you with a summary of our project findings at the end of the study. (*Please see dissemination of findings below*).

Confidentiality

All data will be made anonymous (i.e. all personal information associated with the data will be removed) and consent forms will be stored securely in accordance with the Data Protection Act 1998.

Please note that public information (for example names of organisations providing Peer-to-Peer services) will appear in the final report as it relates to assessing the prevalence of this approach in our region.

Dissemination of results

The project will be written up in a report for the project funders and will be shared with the community, local councils, academics and local and national Peer-to-Peer organisations to improve service provision.

A Community Event will take place in Spring 2015 where the results will be presented.

Deciding whether to participate

If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact a named member of the team identified below. Should you decide to participate in the participatory activities, you will be free to withdraw at any time without having to give a reason.

Any questions?

Please contact
Maggie Gordon-Walker, Mothers Uncovered: maggie@livestock.org.uk
www.mothersuncovered.com

APPENDIX 3 - SURVEY

Peer-to-Peer Support Services Survey

Peer-Peer Leadership and its benefits on mental health

We (Mothers Uncovered, Grassroots Suicide Prevention and Synergy, three peer-to-peer leadership projects) are undertaking a project to better understand peer-to-peer service provision, identify local organisations using this approach and collectively create a best-practice model to support these formal and informal groups.

What do we mean by Peer-to-Peer:
Peer-to-Peer services provide a system of support where people with shared experiences can give and receive help to one another such as support groups, informal collectives or organisations that employ staff with similarities to their members.

While this is not a new approach, we want to highlight what is working and what is having the most impact, as well as identify any gaps in service provision, any improvements that can be suggested and reduce any overlapping. These results will be shared with our community, local council, academics and local and national Peer-to-Peer organisations to improve service provision.

For more information about the project and the project partners, please go to (http://www.mothersuncovered.com/peer-support.html).

This project has been made possible by funding from The Big Lottery, Awards for All.

1. How effective do you think Peer-to-Peer services are in supporting improvements in health and wellbeing? Please rate how strongly you agree or disagree with the following statements:

	Strongly agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not applicable
Peer-to-Peer support has improved my health and	○ Peer-to-Peer support has improved	○ Peer-to-Peer support has improved	○ Peer-to-Peer support has improved	○ Peer-to-Peer support has improved	○ Peer-to-Peer support has improved	○ Peer-to-Peer support has improved

	Strongly agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not applicable
wellbeing	my health and wellbeing Strongly agree	my health and wellbeing Agree	my health and wellbeing Neither Agree nor Disagree	my health and wellbeing Disagree	my health and wellbeing Strongly Disagree	my health and wellbeing Not applicable
Peer-to-Peer support is an effective treatment for mental health conditions	Peer-to-Peer support is an effective treatment for mental health conditions Strongly agree	Peer-to-Peer support is an effective treatment for mental health conditions Agree	Peer-to-Peer support is an effective treatment for mental health conditions Neither Agree nor Disagree	Peer-to-Peer support is an effective treatment for mental health conditions Disagree	Peer-to-Peer support is an effective treatment for mental health conditions Strongly Disagree	Peer-to-Peer support is an effective treatment for mental health conditions Not applicable
Peer-to-Peer support has reduced my need for other treatment	Peer-to-Peer support has reduced my need for other treatment Strongly agree	Peer-to-Peer support has reduced my need for other treatment Agree	Peer-to-Peer support has reduced my need for other treatment Neither Agree nor Disagree	Peer-to-Peer support has reduced my need for other treatment Disagree	Peer-to-Peer support has reduced my need for other treatment Strongly Disagree	Peer-to-Peer support has reduced my need for other treatment Not applicable
Peer-to-Peer support has made me feel less isolated	Peer-to-Peer support has made me feel less isolated Strongly agree	Peer-to-Peer support has made me feel less isolated Agree	Peer-to-Peer support has made me feel less isolated Neither Agree nor Disagree	Peer-to-Peer support has made me feel less isolated Disagree	Peer-to-Peer support has made me feel less isolated Strongly Disagree	Peer-to-Peer support has made me feel less isolated Not applicable
Peer-to-Peer support is effective at	Peer-to-Peer	Peer-to-Peer	Peer-to-Peer	Peer-to-Peer	Peer-to-Peer	Peer-to-Peer

	Strongly agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not applicable
reducing anxiety and depression	support is effective at reducing anxiety and depression Strongly agree	support is effective at reducing anxiety and depression Agree	support is effective at reducing anxiety and depression Neither Agree nor Disagree	support is effective at reducing anxiety and depression Disagree	support is effective at reducing anxiety and depression Strongly Disagree	support is effective at reducing anxiety and depression Not applicable
Peer-to-Peer support has helped me to contribute towards society	Peer-to-Peer support has helped me to contribute towards society Strongly agree	Peer-to-Peer support has helped me to contribute towards society Agree	Peer-to-Peer support has helped me to contribute towards society Neither Agree nor Disagree	Peer-to-Peer support has helped me to contribute towards society Disagree	Peer-to-Peer support has helped me to contribute towards society Strongly Disagree	Peer-to-Peer support has helped me to contribute towards society Not applicable
Peer-to-Peer support has literally saved my life	Peer-to-Peer support has literally saved my life Strongly agree	Peer-to-Peer support has literally saved my life Agree	Peer-to-Peer support has literally saved my life Neither Agree nor Disagree	Peer-to-Peer support has literally saved my life Disagree	Peer-to-Peer support has literally saved my life Strongly Disagree	Peer-to-Peer support has literally saved my life Not applicable
Peer-to-Peer support has helped my recovery from alcohol addiction	Peer-to-Peer support has helped my recovery from alcohol addiction Strongly agree	Peer-to-Peer support has helped my recovery from alcohol addiction Agree	Peer-to-Peer support has helped my recovery from alcohol addiction Neither Agree nor Disagree	Peer-to-Peer support has helped my recovery from alcohol addiction Disagree	Peer-to-Peer support has helped my recovery from alcohol addiction Strongly Disagree	Peer-to-Peer support has helped my recovery from alcohol addiction Not applicable

	Strongly agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not applicable
Peer-to-Peer support has helped my recovery from drug addictions	Peer-to-Peer support has helped my recovery from drug addictions Strongly agree	Peer-to-Peer support has helped my recovery from drug addictions Agree	Peer-to-Peer support has helped my recovery from drug addictions Neither Agree nor Disagree	Peer-to-Peer support has helped my recovery from drug addictions Disagree	Peer-to-Peer support has helped my recovery from drug addictions Strongly Disagree	Peer-to-Peer support has helped my recovery from drug addictions Not applicable
Peer-to-Peer support has helped save me from involvement in criminal activity	Peer-to-Peer support has helped save me from involvement in criminal activity Strongly agree	Peer-to-Peer support has helped save me from involvement in criminal activity Agree	Peer-to-Peer support has helped save me from involvement in criminal activity Neither Agree nor Disagree	Peer-to-Peer support has helped save me from involvement in criminal activity Disagree	Peer-to-Peer support has helped save me from involvement in criminal activity Strongly Disagree	Peer-to-Peer support has helped save me from involvement in criminal activity Not applicable

*

2. What types of peer-to-peer services have you accessed or been involved with? (Tick all that apply)

- [ ] None - I have never accessed peer-to-peer services
- [ ] Support Groups led by a facilitator with shared experiences
- [ ] Support Clubs (such as arts and recreation programmes run by a peer collective)
- [ ] Peer Mentoring and Leadership programmes
- [ ] Crisis Lines led by those with shared experiences
- [ ] Charity Services which are run (board members and/or staff) by people who share similar experiences and/or personal characteristics
- [ ] Training and Development services which are peer-led/peer-focused.
- [ ] The peer-to-peer services I have accessed have not supported my wellbeing

Other (please specify)

*

3. How do you currently experience these services?

- ○ As a user (I receive support)
- ○ As a provider (I volunteer or am employed to support others)
- ○ As a manager or administrative support for an organisation providing Peer-to-Peer services
- ○ I both receive and provide support

Other (please specify)

*

4. Which of the following concerns did you seek support for? (Select all that apply)

- ☐ Emotional support
- ☐ Loneliness and isolation
- ☐ Mental health concerns
- ☐ Physical health conditions
- ☐ Dealing with a life change/change in circumstances
- ☐ Dealing with a disability concern
- ☐ Managing addiction concerns
- ☐ Thoughts of suicide

Other (please specify)

*

5. To what extent has your involvement in peer support services had an impact on the following (if any):

	No change in treatment need	1-3 times per year	4-9 times per year	10-20 times per year	Over 20 times per year	Not applicable
Reduced the number of times I stayed over in hospital	○ Reduced the number of times I stayed over in hospital No change in treatment	○ Reduced the number of times I stayed over in hospital 1-3 times per year	○ Reduced the number of times I stayed over in hospital 4-9 times per year	○ Reduced the number of times I stayed over in hospital 10-20 times per year	○ Reduced the number of times I stayed over in hospital Over 20 times per year	○ Reduced the number of times I stayed over in hospital Not applicable

	No change in treatment need	1-3 times per year	4-9 times per year	10-20 times per year	Over 20 times per year	Not applicable
	need					
Reduced my number of visits to A&E	Reduced my number of visits to A&E No change in treatment need	Reduced my number of visits to A&E 1-3 times per year	Reduced my number of visits to A&E 4-9 times per year	Reduced my number of visits to A&E 10-20 times per year	Reduced my number of visits to A&E Over 20 times per year	Reduced my number of visits to A&E Not applicable
Reduced my number of visits to my GP	Reduced my number of visits to my GP No change in treatment need	Reduced my number of visits to my GP 1-3 times per year	Reduced my number of visits to my GP 4-9 times per year	Reduced my number of visits to my GP 10-20 times per year	Reduced my number of visits to my GP Over 20 times per year	Reduced my number of visits to my GP Not applicable
Reduced the number of visits to my counsellor	Reduced the number of visits to my counsellor No change in treatment need	Reduced the number of visits to my counsellor 1-3 times per year	Reduced the number of visits to my counsellor 4-9 times per year	Reduced the number of visits to my counsellor 10-20 times per year	Reduced the number of visits to my counsellor Over 20 times per year	Reduced the number of visits to my counsellor Not applicable
Reduced the number of sick days I took	Reduced the number of sick days I took No change in treatment need	Reduced the number of sick days I took 1-3 times per year	Reduced the number of sick days I took 4-9 times per year	Reduced the number of sick days I took 10-20 times per year	Reduced the number of sick days I took Over 20 times per year	Reduced the number of sick days I took Not applicable
Reduced the						

	No change in treatment need	1-3 times per year	4-9 times per year	10-20 times per year	Over 20 times per year	Not applicable
number of times I called 111	Reduced the number of times I called 111 No change in treatment need	Reduced the number of times I called 111 1-3 times per year	Reduced the number of times I called 111 4-9 times per year	Reduced the number of times I called 111 10-20 times per year	Reduced the number of times I called 111 Over 20 times per year	Reduced the number of times I called 111 Not applicable
Reduced the number of times I self-harmed or attempted suicide	Reduced the number of times I self-harmed or attempted suicide No change in treatment need	Reduced the number of times I self-harmed or attempted suicide 1-3 times per year	Reduced the number of times I self-harmed or attempted suicide 4-9 times per year	Reduced the number of times I self-harmed or attempted suicide 10-20 times per year	Reduced the number of times I self-harmed or attempted suicide Over 20 times per year	Reduced the number of times I self-harmed or attempted suicide Not applicable

*

6. Which of the following organisational types do you receive your peer-to-peer support from?

- Public sector services - Statutory (GP, Hospital, Specialist Appointments) or NHS services
- Third sector services (Charity, community group, social enterprise, not for profit)
- Private sector services (Private hospital, Private GP, Private Provided Counselling/Residential Treatment Services, etc.)
- I'm not sure

Other (please specify)

*

7. Compared with your experiences of statutory treatment approaches to supporting health and wellbeing, do you feel peer-to-peer services are:

- More effective
- Less effective
- About the same

Please tell us why

*

8. Please tell us how strongly you agree/disagree with the following statements? What kinds of support do peer-to-peer services need in order to be effective?

	Strongly agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Specific peer-to-peer training	Specific peer-to-peer training Strongly agree	Specific peer-to-peer training Agree	Specific peer-to-peer training Neither Agree nor Disagree	Specific peer-to-peer training Disagree	Specific peer-to-peer training Strongly Disagree
More promotion and awareness of the benefits of peer-led support	More promotion and awareness of the benefits of peer-led support Strongly agree	More promotion and awareness of the benefits of peer-led support Agree	More promotion and awareness of the benefits of peer-led support Neither Agree nor Disagree	More promotion and awareness of the benefits of peer-led support Disagree	More promotion and awareness of the benefits of peer-led support Strongly Disagree
More recognition of the value of personal experience in employment criteria	More recognition of the value of personal experience in employment criteria Strongly agree	More recognition of the value of personal experience in employment criteria Agree	More recognition of the value of personal experience in employment criteria Neither Agree nor Disagree	More recognition of the value of personal experience in employment criteria Disagree	More recognition of the value of personal experience in employment criteria Strongly Disagree
Improved financial/in-kind investment into Peer-to-Peer Service Provision	Improved financial/in-kind investment into Peer-to-Peer Service Provision	Improved financial/in-kind investment into Peer-to-Peer Service Provision	Improved financial/in-kind investment into Peer-to-Peer Service Provision	Improved financial/in-kind investment into Peer-to-Peer Service Provision	Improved financial/in-kind investment into Peer-to-Peer Service Provision

	Strongly agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
	Strongly agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
An increase in the evidence base - more academic research to prove what works (and what doesn't)	An increase in the evidence base - more academic research to prove what works (and what doesn't) Strongly agree	An increase in the evidence base - more academic research to prove what works (and what doesn't) Agree	An increase in the evidence base - more academic research to prove what works (and what doesn't) Neither Agree nor Disagree	An increase in the evidence base - more academic research to prove what works (and what doesn't) Disagree	An increase in the evidence base - more academic research to prove what works (and what doesn't) Strongly Disagree
Improved models of practice to ensure quality	Improved models of practice to ensure quality Strongly agree	Improved models of practice to ensure quality Agree	Improved models of practice to ensure quality Neither Agree nor Disagree	Improved models of practice to ensure quality Disagree	Improved models of practice to ensure quality Strongly Disagree
Increased recognition of personal experience in applications to Schools and formal Training and Development Institutions.	Increased recognition of personal experience in applications to Schools and formal Training and Development Institutions. Strongly agree	Increased recognition of personal experience in applications to Schools and formal Training and Development Institutions. Agree	Increased recognition of personal experience in applications to Schools and formal Training and Development Institutions. Neither Agree nor Disagree	Increased recognition of personal experience in applications to Schools and formal Training and Development Institutions. Disagree	Increased recognition of personal experience in applications to Schools and formal Training and Development Institutions. Strongly Disagree
An online network/community of Peer-to-Peer Services	An online network/community of Peer-to-Peer Services Strongly agree	An online network/community of Peer-to-Peer Services Agree	An online network/community of Peer-to-Peer Services Neither Agree nor Disagree	An online network/community of Peer-to-Peer Services Disagree	An online network/community of Peer-to-Peer Services Strongly Disagree

	Strongly agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
A database of peer support services	A database of peer support services Strongly agree	A database of peer support services Agree	A database of peer support services Neither Agree nor Disagree	A database of peer support services Disagree	A database of peer support services Strongly Disagree

Please add any additional thoughts or comments here.

9. Can you tell us the names of organisations you know who use a peer-to-peer service model so we can begin to build a database of these services locally?

10. Do you have any concerns about the peer support model? Please indicate below.

Yes - if so please give more details in the box below.

No

Other (please specify)