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Peer Support Workers' Experiences of Wellbeing and their Role in the Implementation of Advance Statements

A systematic review and grounded theory study

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Chapter 1

Effects of delivering mental health peer support on peer support workers

A systematic review and narrative synthesis of personal recovery, wellbeing, burnout and job satisfaction in peer work

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Abstract

Introduction: Peer Support roles are an integral part of many mental health services and essential to the development of recovery oriented approaches in mental health care. Peer worker wellbeing is vital to the implementation and sustainability of such approaches. Qualitative evidence suggests that peer support has both positive and negative effects on peer worker wellbeing, which may be determined by features of the work environment. This systematic review therefore synthesises quantitative evidence related to peer worker outcomes including personal recovery, wellbeing, burnout and work-related stress, and role satisfaction. A secondary aim of the review was to identify any variables associated with these primary outcomes. **Methods:** A systematic search of five electronic databases was conducted in September 2023 with no date restrictions. Further records were identified through forward and backward citation searching. Included studies were synthesised using a narrative synthesis approach and appraised using the JBI Checklist for Analytical Cross-sectional Studies. **Results:** Twenty studies comprising 3,425 participants were eligible for inclusion in the review. Limitations were noted related to sampling, use of measures and defining peer work models, settings and contexts. Studies were primarily of cross-sectional design and included a high level of heterogeneity in peer work roles, settings and outcomes measured. Few studies examined personal recovery or wellbeing outcomes. Peer workers reported relatively high levels of job satisfaction and levels of burnout suggest that peer workers experience similar impacts of their work to their non-peer colleagues. There is some indication that burnout increases and job satisfaction decreases over time. Associations with workplace community, organisational culture, recovery orientation and being in true peer work roles were identified as candidate areas for further research in relation to reduced burnout and increased job satisfaction. **Discussion:** The findings of the review have implications for wider mental health workforce wellbeing indicating that there should be a focus on creating organisational contexts and cultures that are conducive to workforce wellbeing as a whole. Methodological limitations in the evidence base could be improved through use of control groups and randomised sampling processes, consensus on gold standard measures and clearer descriptions of peer work models and contexts.

Keywords: Peer Support Work, Recovery, Wellbeing, Burnout, Job Satisfaction

Background

Mental health peer support workers (PSWs) intentionally use experiential knowledge of mental health difficulties to support others. They build an equal, respectful and trusting relationship to provide support that is typically non-directive, strengths-focussed and based on recovery principles (Repper and Carter, 2011, National Collaborating Centre for Mental and Partners, 2020). Formalised peer support was believed to have potential as a means of realising human rights and recovery-oriented approaches within statutory mental health systems (Bradstreet, 2006), and to this end PSWs are increasingly employed in a range of clinical settings internationally.

Services initially raised concerns about PSWs' own wellbeing. Specifically that they might have greater vulnerability to stress than other mental health workers due to their lived experience of mental health difficulties, and would be exposed to stress levels that could make recurrence or worsening of mental health difficulties more likely (Repper and Carter, 2011). Similarly there were concerns about the perceived unboundaried nature of peer work increasing this risk. While qualitative research on peer work acknowledges that PSWs must navigate the challenge of managing fluctuations in their own mental health, the idea of PSWs as being too fragile for the role is now discredited (Repper, 2013).

Mutuality and reciprocity are key values of peer work (National Collaborating Centre for Mental Health and Partners, 2020) and it is well established that benefits should extend to the PSW as well as those accessing peer support services (Bradstreet, 2006, Solomon, 2004). These benefits are often attributed to the helper-therapy principle, which anticipates that helpers benefit from perceived interpersonal competence due to impacting on another's life; equal social exchange; learning through observing and modelling; and an enhanced sense of self through social approval (Skovholt, 1974). This theory has explanatory value in relation to interpersonal factors in peer work, however it does not account for important individual, social, organisational, or policy contexts that could impact on care delivery and PSW experiences in their role.

Sinclair et al. (2023) conducted a narrative review of inclusion as produced in mental health research on peer support using a consumer/survivor/ex-patient (CSX) movement lens. They argued that mental health research on peer support positions PSWs as lacking the disposition for mental health work and propose that, rather than having an inherent vulnerability, PSWs are required to assimilate into systems where they are potentially implicated in oppressive practices, and that experiences of emotional harm to PSWs in their work environments are frequently overlooked. The authors contend that there is a failure to examine structural issues in clinical mental health care that emotionally impact not just PSWs but all mental health workers. The evidence on burnout among mental health professionals more generally may support this, with indications that those working in mental health settings are at greater risk of developing burnout. A meta-analysis of 62 studies from 33 countries investigating burnout in mental health professionals found that around 40% of participants experienced professional burnout, with the proportion of respondents exceeding the ‘high’ cut-off more than double that in the general population (O’Connor et al., 2018). Burnout is in turn associated with physical, psychological and occupational consequences including job dissatisfaction (Salvagioni et al., 2017).

Existing qualitative research paints a mixed picture of both positive and negative impacts of the peer work role on personal recovery. Bailie and Tickle’s (2015) systematic review on the subject synthesised qualitative findings from 10 studies. Specific aspects of the role were highlighted as beneficial, such as learning about mental health and recovery and being prompted to support one’s own recovery when sharing knowledge with peers. Findings suggest the role could both improve PSW's sense of self, attributed to helping others and acting as a role model, and have negative effects on recovery, with some PSWs feeling confined to a PSW identity, having detrimental experiences of self-disclosure, or reliving difficult experiences through others who had been through similar circumstances. At an organisation level, factors identified to impact on personal recovery included the clarity of the role and available support to fulfil it, acceptance and belonging within the team, and how valued the role was perceived to be within the organisation.

Further qualitative research examining peer worker experiences, also highlighted that features of both the peer work role and wider systems impact on peer worker wellbeing. A qualitative metasynthesis (Watson, 2019) on the mechanisms underpinning peer support identified five processes that have effects on both the PSW and the peer: the use of lived experience both through direct sharing of experience and implicitly drawing on experience; Love Labour, defined as "the deliberate and skilled work that PSWs undertake to build relationships founded on mutuality, emotional honesty, love, reciprocity and authenticity" (Watson, 2019) strengths focussed social and practical support; having a liminal position, occupying the in-between identity of both service user and mental health worker; and the helper role. These mechanisms, relying on mutuality and reciprocity, were noted to positively or negatively impact on the PSW depending on the context peer support was delivered in. Watson (2019) concluded that the PSW's use of self and their own recovery become fused with their role, making maintaining their own wellbeing of essential importance. Peer work required the support of other peers or non-peer allies. Well supported roles may lead to PSWs feeling more engaged, having a greater sense of self-efficacy and accomplishment, higher job satisfaction and improved personal wellbeing. However, for lone PSWs in non-peer organisations, isolation, stigmatisation from non-peer colleagues, and role ambiguity could lead to lower job satisfaction, emotional exhaustion, and burnout (Mancini and Lawson, 2009).

Of primary concern in considering the effects of peer work on PSWs is their wellbeing. Ibrahim and colleagues' (Ibrahim et al., 2020) systematic review additionally identified supporting PSW wellbeing as essential to the successful implementation of formal mental health peer support. However, while PSWs identify organisational stressors such as perceived direct and indirect stigma and discrimination, high workloads, not having PSW colleagues, and insufficient training and supervision (Vandewalle et al., 2016), recommendations for supporting peer wellbeing are highly individualised (self-care, ability to identify triggers for distress, regular mental health screening and reasonable adjustments) (Ibrahim et al., 2020). This individual focus, while important, could arguably miss opportunities to efficiently support worker wellbeing at a universal level.

This body of evidence suggests that the delivery of peer work has potential for both positive and negative effects on PSWs, with implications for their own personal recovery, wellbeing, experiences of stress and job satisfaction. The immediate work environment and wider systems context are consistently reported to influence these effects, with well supported roles in recovery-oriented environments linked to benefits in PSW personal recovery and wellbeing, and greater job satisfaction. Poorly supported roles may conversely have detrimental effects on recovery and wellbeing, increase risk of burnout, and reduce job satisfaction. This has important implications for PSW wellbeing and the sustainability of peer work programmes, as well as prompting reflection on how to create optimal conditions in mental health systems to support all mental health workers in their roles.

No systematic review has yet examined the quantitative evidence on personal recovery, wellbeing, or stress and burnout in peer workers. A Cochrane review (Pitt et al., 2013) noted that benefits and harms to PSWs had not been rigorously evaluated using appropriate quantitative measures. One systematic review (Chappell Deckert and Statz-Hill, 2016) has previously evaluated quantitative evidence on job satisfaction of peer providers employed in mental health centres. The review found that PSWs were more satisfied than unsatisfied with their roles, while role clarity, psychological empowerment, perceived organisational support, workplace integration and length of employment were predictors of job satisfaction. The authors noted that the original studies limited their findings, all were from the United States, sample sizes were small and homogenous, and data allowing for interpretation of contextual variability in job satisfaction were not included in the studies. Given the increase in quantitative studies in this field, a review of this research is warranted to examine the effects of delivering peer support on PSW wellbeing, personal recovery, job satisfaction and levels of burnout. Exploring variables that are associated with these outcomes may identify directions for future research into potential contextual factors that could be modified in services to optimise conditions for peer workers and wider mental health service delivery.

Aims

This review aimed to synthesise available quantitative evidence to understand the effects mental health PSWs experience in relation to delivering peer support. The review examined the following primary outcomes: personal recovery; wellbeing; burnout and work-related stress; and role satisfaction. A secondary aim of the review was to identify any variables associated with these primary outcomes.

Methods

Reflexivity Statement

Peer workers are often reported to be driven by a desire to give others a better experience of mental health care than the one they had themselves. As a mental health clinician in training, the author of this review was motivated by the idea that all mental health workers, and the systems we are part of, have a shared responsibility for creating services that are true to this aim. The author had a particular interest in the sustainability of the use of self in peer work in relation to peer worker wellbeing. While traditional mental health clinicians do not routinely share personal experience in our work, our practice also involves the careful consideration of the use of self and boundaries in clinical relationships. As such, in thinking about the working conditions that best support peer worker recovery, wellbeing and job satisfaction, there is a hope that the learning from this review contributes towards our understanding of how services can create the conditions for all mental health workers to practice sustainably, in recovery-oriented way, and safely provide a different approach to care at times when people may feel at their most vulnerable.

Protocol and registrations

The protocol was developed in accordance with PRISMA guidelines (Page et al., 2021) and registered on PROSPERO (International Prospective Register of Systematic Reviews) on 21st August 2023 reference CRD42023447697.

Search Strategy

Search terms were identified through literature review in the domains “peer worker”, “mental health (context)”, “personal costs and benefits”, “personal recovery”, “peer worker wellbeing” and “role satisfaction”. A broad search strategy was developed iteratively in consultation with a university librarian. Electronic databases MEDLINE (OVID), CINAHL

(EBSCO), Web of Science, Embase (OVID) and PsycINFO (OVID) were searched with no date restrictions. Final searches took place on 19th September 2023. Further papers were identified through forward citation searching using Web of Science and backward citation searching of included individual studies. All searches were limited to the English language. An example search strategy is outlined in appendix 2.

Eligibility criteria and study selection

Studies were eligible based on the inclusion and exclusion criteria described in Table 1. Search results were uploaded to Rayyan (Ouzzani et al., 2016) for screening. Duplicates were removed and titles and abstracts were screened against inclusion criteria. Full text studies were screened using a proforma. Where it was unclear whether a paper should be included, this was independently screened by a fellow clinical psychology trainee acting as second reviewer before discussing to reach consensus.

Table 1

Inclusion and Exclusion Criteria

	Include	Exclude
Research type	Quantitative or Mixed method empirical study Peer reviewed Published in English	Qualitative studies Reviews Editorials Brief reports Conference abstracts Grey literature
Population	Mental health peer support workers of any age	Non-peer staff Service users
Intervention/ Exposure	Formal mental health peer support with no age limits	Peer support in other areas Naturally occurring peer support, peer-to-peer support, befriending, mutual support groups For carers Research, training, education, or service development
Context	Mental health settings including Non-Governmental Organisations, health, and social care settings.	Universal health promotion activities Peer support in the workplace
Outcomes	Reports quantitative data on any of the following outcomes: Personal recovery as defined by the CHIME framework (Connection, Hope and optimism, Identity, Meaning, Empowerment) OR personal recovery measures Wellbeing Stress Burnout Role satisfaction	Does not report quantitative data on any included outcomes

Data extraction

Quantitative data were extracted manually from the included studies into Excel tables. This included study characteristics, sample characteristics, and quantitative data related to primary outcomes, as well as the method used to assess these outcomes. Variables significantly associated with the primary outcomes were also extracted, including the method of assessment and association. Where both bivariate and multivariable analyses had been conducted, multivariable analyses were prioritised for clarity of reporting.

Data synthesis

A high level of heterogeneity was anticipated in study design, characteristics and outcome data. As such, data were synthesized using Narrative Synthesis as described in Economic and Social Research Council Guidance (Popay et al., 2006). The below steps were followed using an iterative approach.

Preliminary synthesis of findings

Extracted data were organized in tables. Results in relation to study characteristics, sample characteristics and study findings were described, identifying initial patterns.

Exploring relationships within and between studies

Patterns and variation within and across individual studies were compared in terms of relationships between study characteristics and findings within individual studies, and between the findings of different studies.

Assessing the Robustness of the Synthesis

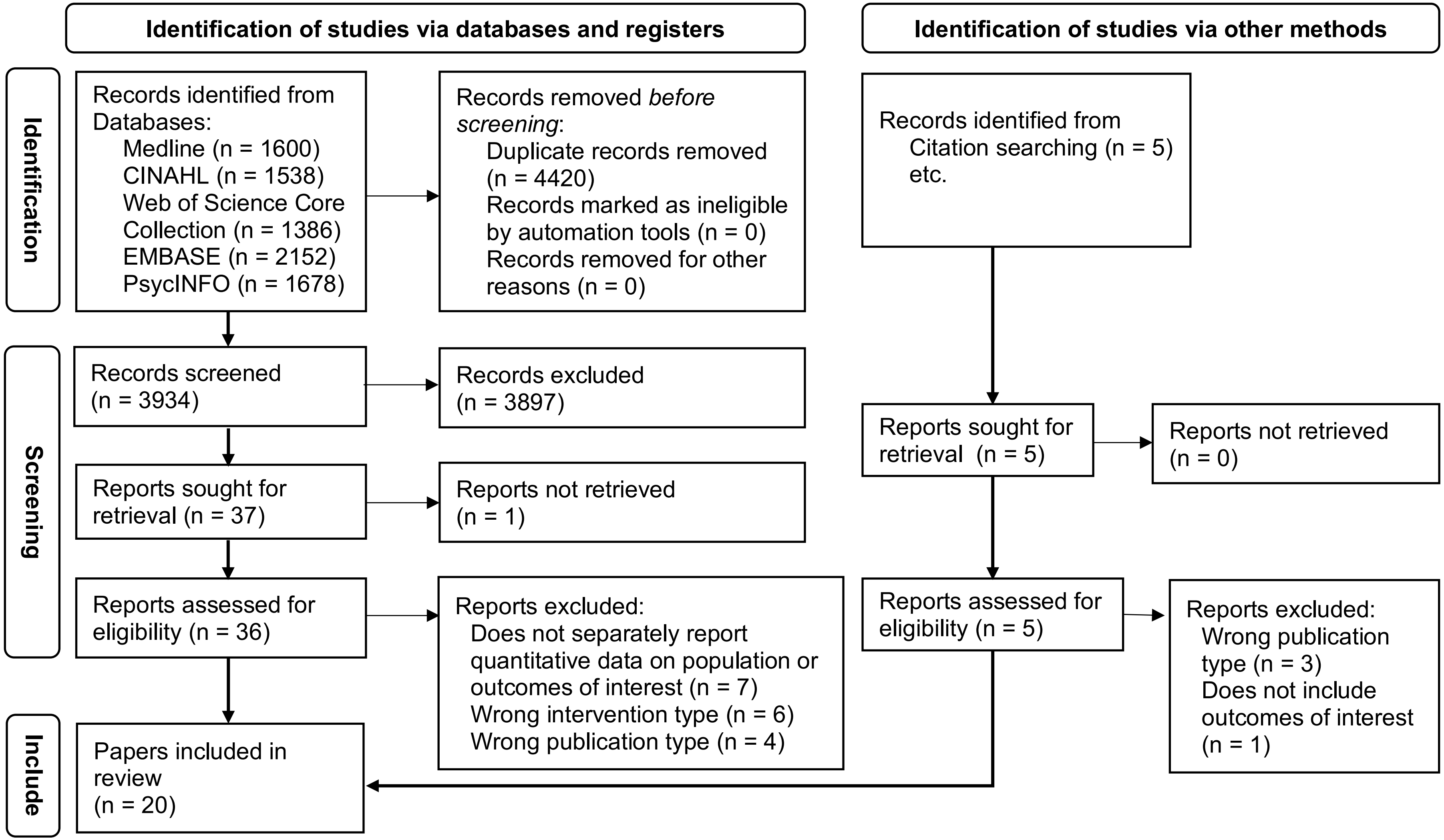
A modified version of the JBI Checklist for Analytical Cross-sectional Studies (Moola et al., 2020) was used to assess risk of bias. As scoping searches suggested that studies would be heterogenous in design including primarily cross-sectional and non-randomised longitudinal studies, items 9 (“Was follow up complete, and if not, were the reasons to loss to follow up described and explored?") and 10 ("Were strategies to address incomplete follow up utilized?") from the JBI Checklist for Cohort Studies (Moola et al., 2020) were incorporated to allow for assessment of follow-up over time. All papers were assessed by the author and a random sample of included studies (n = 6, 30%) were additionally rated by a fellow clinical psychology trainee. The checklist was piloted using three papers in an initial calibration phase before assessments were compared between raters. Consensus was reached through discussion where discrepancies arose. This informed the assessment of the remaining studies.

Results

The electronic search identified 8,354 possible reports across five databases. Of these, 4,420 records were identified as duplicates. Title and abstract of the remaining 3,934 records were screened and 37 reports sought for retrieval. One report could not be retrieved. The remaining 36 full text papers were assessed for eligibility using a proforma which was independently piloted by two reviewers using eight full text papers and discussed to ensure that inclusion and exclusion criteria were being applied consistently. Following full text review 17 papers were excluded. A further five reports were identified for screening through forward and backward citation searches of the included studies. Of these, one paper was found to be eligible. Based on this search strategy, 20 papers were included in the review. The process is detailed in figure 1.

Figure 1

Prisma Flow Diagram



From: *Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.*

Included studies

Characteristics of the included studies and participants are described in table 2. Some papers were found to report on data from the same cohort of participants, with the 20 papers reporting on a total of 16 participant cohorts. Where multiple papers report on data from the same cohort these are grouped in table 2. Sixteen studies were from the United States of America (USA), two from the United Kingdom (UK), one from Israel, and one from Australia. Of the 20 included papers, 18 reported on cross-sectional designs and two on longitudinal studies. Neither longitudinal study recruited a separate comparison group but rather compared data from existing reported samples. None of the included studies examined youth/child peer work interventions.

Participants

There were 3,425 participants in the included studies. Based on 9 studies, the mean age of participants was 47.9 years (SD 11.9). Age ranges were provided in four further studies and no data on age of participants was reported in three studies. Data on gender were reported for all participants in 12 studies; 1,811 (52.9 %) participants were female or a woman, 994 (29.0%) male or a man, 29 (0.85%) were transgender, queer, non-binary or gender non-conforming, 7 (0.2%) people said that no choice described them of declined to answer, data was missing for 18 (0.53%) participants. Two studies reported only the proportion of female participants for participants employed in peer support roles. One study reported only on sex of PSWs and another did not separately report data on sex or gender for PSWs.

Differences were observed in conventions on the reporting of ethnicity and race across countries; four studies reported no data on the race or ethnicity of participants, six reported on combined race/ethnicity, two reported on both race and ethnicity as separate constructs , two on race only, and one on ethnicity only. Across the 12 studies which reported on any of these constructs there was also variation in the categories and divisions used. Reported divisions reflect the language used in the included studies. Eleven studies reported a total of 515 (15.0%) Black, African American or Black British African participants, 12 studies reported a total of 2,084 (60.8 %) White or 'Caucasian' participants, five studies reported 45 (1.3%) Native American/American Indian/Native Hawaiian/Pacific Islander/Asian participants, 3 studies separately reported 6 (0.0%) Asian participants. Four studies reported 62 (1.8%) participants with mixed ethnicity. Nine studies reported 303 (8.8%) Hispanic/Latinx participants. Across seven studies, 206 (6.0%) people were reported as non-white or other. Two studies reported the sexual orientation of participants; 54 (0.02 %) participants identified as lesbian or gay and 50 (0.01%) as bisexual. Four studies reported the mean number of months in role for 1,184 participants (*M* = 39.3, *SD* = 38.6 months). Two studies reported mean years in role, however it was not possible to calculate a pooled estimate. Five studies reported ranges, these ranged from less than 6 months in role to 35 years. Six studies did not report this data.

Table 2 - Included Studies

Author, year of publication, country	**Abraham, 2022, USA**
Study setting	Recruitment via InterNational Association of Peer Supporters (iNAPS) annual conference (2014) and online peer newsletters.
Study design	Cross-sectional study
Inclusion/exclusion criteria	Age 18+, Currently working as peer support specialist in an agency or organisation in USA
Sample size	117
Mean age (SD)	46.6 (11.5)
Gender N(%)	Data for sex (gender not reported): Female 90 (76.9), Male 25(21.4), Missing 2 (1.7)
Other demographic characteristics (ethnicity/sexuality) N (%)	Black/African American 16 (13.7), White/ 'Caucasian' 79 (67.5), Hispanic 11 (9.4) Native American/American Indian/Native Hawaiian/Pacific Islander 2 (1.7), Mixed Race or Ethnicity 7 (6.0) Missing 2 (1.7)
Years in role	*M* = 48.6 months, *SD* = 45.7
Role description (formal training, supervision arrangements, peer work model/intervention, job setting	**Supervision:** *Frequency of Supervision* n (%)*:* Twice Weekly or More 17 (14.5); Once per Week 28 (23.9); Every Other Week 16 (13.7); Once Per Month 28 (23.9);< Once per Month 4 (3.4); As Needed 10 (8.5); Missing 14 (12.0) *Length of Supervision:* <15 min 4 (3.4); 15 min 3 (2.6); 30 min 29 (24.8); 45 min 8 (6.8); 1 h or More 49 (41.9); As Long as Needed/Varies 9 (7.7); Missing 15 (12.8) *Supervisor's Discipline:* Social Worker 41 (35.0); Counsellor 15 (12.8); Peer Support Specialist 13 (11.1); Psychologist 11 (9.4); Nurse 3 (2.6); Psychiatrist 2 (1.7); Don't Know 14 (12.0); Missing 14 (12.0) **Peer work model:** *Activity* n (%): Direct Service to Consumers 104 (88.9);Management or Supervision 3 (2.6); Organizational, Outreach, Systems-related 7 (6.0); Missing 3 (2.5) **Job setting:** Mental Health Centre 57 (48.7) Inpatient Psychiatric Hospital 10 (8.6) Department of Veterans Affairs 9 (7.7) Clubhouse/Drop-in Centre 9 (7.7) Crisis Call Line/Centre 6 (5.1) Health Department 4 (3.4) Substance Abuse Rehab. 2 (1.7) Physical Health Rehab/Assisted Living 2 (1.7) Hospital 2 (1.7) Consumer Led Programs 2 (1.7) Other 7 (6.0) Missing 8 (6.8)

Table 2 - Included Studies [Contd.]

Author, year of publication, country	**Brooks, 2021, USA, Wu, 2022, USA**	**Bujanover, 2022, Israel**
Study setting	Recruitment through iNAPS and email networks of peer support specialists trained through statewide peer certification programs in South USA.	Recruitment through national vocational programmes in Israel.
Study design	Cross-sectional study	Cross-sectional study
Inclusion/exclusion criteria	Self-reported diagnosed mental health condition, Age 18 +, Living in the community, Completed either certified peer specialist (CPS) or peer recovery support specialist training, Currently employed as a peer specialist	Participant in national vocational rehabilitation programmes for people with a psychiatric disorder
Sample size	121	69
Mean age (SD)	47.86 (10.8)	Age range *n (%),* 20–30 3 (4), 31–40 32 (46), 41–50 22 (32), 51–60 9 (13), 61–70 3 (4)
Gender N(%)	Male 36 (29.8), Female 84 (69.4), Transgender 1 (0.8)	Man 28 (41), Woman 41 (59)
Other demographic characteristics (ethnicity/sexuality) N (%)	'Caucasian'/White 79 (65.3), African American 15 (12.4), Hispanic 23 (19.0), Native American 1 (0.8), Other 3 (2.5)	Not reported
Years in role	Not reported	Not reported
Role description (formal training, supervision arrangements, peer work model/intervention, job setting)	**Training:** Completed either CPS or peer recovery support specialist training	**Job setting:** Participants working in various community and hospital settings.

Table 2 - Included Studies [Contd.]

Author, year of publication, country	**Burke, 2018, UK**
Study setting	Participants recruited from statutory mental health services, independent organisations, Twitter, and snowballing via recruited participants.
Study design	Cross-sectional study
Inclusion/exclusion criteria	Age 16 +, Personal experience of a mental health problem, Provided support to another person with a mental health problem as part of a formal role within a UK organisation in the last 5 years.
Sample size	147
Mean age (SD)	41.2 (14.0)
Gender N(%)	Male 43 (29.3), Missing 5 (3.4), Female 99 (67.3)
Other demographic characteristics (ethnicity/sexuality) N (%)	Not reported
Years in role	Not reported
Role description (formal training, supervision arrangements, peer work model/intervention, job setting)	**Training:** *Amount received* n(%): None 20 (13.6); <1 full day 3 (2.0); 1 full day 10 (6.8); 2-3 full days 21 (14.3); 4–5 full days 22 (15.0); 6+ full days 71 (48.3). *Formal qualification received* n(%): Yes 61 (41.5); No 66 (44.9); Not applicable (no received) 20 (13.6). **Supervision:** *Frequency of managerial supervision*, n (%): None 21 (14.3); <1 per month 27 (18.4); monthly 71 (48.3); Every 2 weeks 9 (6.1); Weekly 19 (12.9). *Frequency of professional supervision,* n (%): None 28 (19.0); < 1 per month 38 (25.9); Monthly 60 (40.8); Every 2 weeks 8 (5.4); Weekly 12 (8.2). **Job setting:** *Organisation providing peer support in*, n (%): Voluntary/charity 63 (42.9); Statutory health (NHS) 76 (51.7); Other 8 (5.4). *Working in mental health/clinical team*, n (%): Yes 80 (54.4)

Table 2 - Included Studies [Contd.]

Author, year of publication, country	**Chang, 2016, USA, Eisen, 2015, USA, Park, 2016, USA**	**Clossey, 2018, USA**
Study setting	Recruited via email through National VHA services for nationwide survey.	PSW organisations in Pennsylvania and New Jersey.
Study design	Cross-sectional study, Cohort Study	Cross-sectional study
Inclusion/exclusion criteria	All peer specialists currently Employed by department of Veteran's Affairs	On PSW listserv (June 2016 - April 2017)
Sample size	152	165
Mean age (SD)	52 (8.52)	Age range *n* (%), 18-49 83 (50), 50–60+ 83 (50)
Gender N(%)	Male 121 (80), Female 31 (20)	Male 55 (33.3), Female 109(66.1), Missing 1 (0.6)
Other demographic characteristics (ethnicity/sexuality) N (%)	White 86 (56.6), African American 62 (40.7), American Indian 4 (2.6), Latino 8 (6)	Non Hispanic/White 144 (88.3), Hispanic/ African American/ Other 19 (11.6)
Years in role	Time in role *n (%),* <6 months 29 (19.5), 6–12 months 7 (4.7), 1–2 years 26 (17.5), 2–5 years 87 (58.4)	Not reported
Role description (formal training, supervision arrangements, peer work model/intervention, job setting)	**Training:** *CPS n* (%): 110 (72.4), **Supervision:** *Hours supervision n* (%): None 19 (13), <1 hr/week 44 (30), 1-2 hrs/week 48 (32), >2 hrs/week 37 (25) **Peer work model:** *Job activities include (in order of most to least endorsed):* Attend staff meetings; Use computerized record system; Provide 1:1 mentoring; Share recovery experiences; Write notes, memos, etc.; Challenge negative self-talk; Teach social skills; Serve as role model; Help veterans set goals; Advocate for veterans; Participate in conference calls; Lead groups; Teach problem solving; Help community integration; Transport veterans; Conduct outreach activities; Help regarding disability benefits; Help veterans find work; Help with job skills; Facilitate peer training; Perform clerical work (copying and filing); Serve on committees; Present at conferences; Perform other patient care activities; Supervise peer providers.	**Job Setting:** n (%) Employed in traditional setting (outpatient mental health clinic, psychiatric hospital, residential facility or day treatment program) 120 (73.6); Employed in peer-run direct services 43 (26.4).

Table 2 - Included Studies [Contd.]

Author, year of publication, country	**Cronise, 2016, USA**
Study setting	Snowball recruitment through local and national peer specialist organisations and state mental health program officials.
Study design	Cross-sectional study
Inclusion/exclusion criteria	Certified and uncertified peer support providers in the USA or U.S Territories, July - December 2014
Sample size	597
Mean age (SD)	Age range *n* (%), 18-24 13 (2.2), 25-34 69 (11.7), 35-44 111 (18.8), 5-54 185 (31.4), 55 < 211 (35.8)
Gender N(%)	Female 380(63.7), Male 203 (34.0), Transgender 3 (0.5), Missing 11 (1.8)
Other demographic characteristics (ethnicity/sexuality) N (%)	White 437 (74.4), Black/ African American 91 (15.5), Hispanic/Latino 57 (9.7), Native American/ American Indian/ Alaska Native 27 (4.6), Mixed 22 (3.7), Asian 4 (0.7)
Years in role	Years in role *n* (%), < 1 90 (17.5), 1-2 18 (23), 2-5 167 (32.5), 5-7 61 (11.9), > 7 78 (15.2)
Role description (formal training, supervision arrangements, peer work model/intervention, job setting)	**Training:** *Amount of received* n(%): None 20 (13.6); <1 full day 3 (2.0); 1 full day 10 (6.8); 2-3 full days 21 (14.3); 4–5 full days 22 (15.0); 6+ full days 71 (48.3). *Formal qualification received* n(%): Yes 61 (41.5); No 66 (44.9); Not applicable (no received) 20 (13.6). **Supervision:** *Frequency of managerial supervision*, n (%): None 21 (14.3); <1 per month 27 (18.4); monthly 71 (48.3); Every 2 weeks 9 (6.1); Weekly 19 (12.9). *Frequency of professional supervision,* n (%): None 28 (19.0); < 1 per month 38 (25.9); Monthly 60 (40.8); Every 2 weeks 8 (5.4); Weekly 12 (8.2). **Job setting:** *Organisation providing peer support in*, n (%): Voluntary/charity 63 (42.9); Statutory health (NHS) 76 (51.7); Other 8 (5.4). *Working in mental health/clinical team*, n (%): Yes 80 (54.4)

Table 2 - Included Studies [Contd.]

Author, year of publication, country	**Edwards, 2023, USA**
Study setting	Convenience sampling and snowballing. Listserves of Academy of Peer Services and iNAPS.
Study design	Cross-sectional study
Inclusion/exclusion criteria	Age 18+, Currently employed for >6 months, Providing mental health treatment and /or recovery oriented services, Resident in USA or US Territories
Sample size	507
Mean age (SD)	49.3(11.7)
Gender N(%)	Man 140 (27.6), Woman 346 (68.2), Transgender woman, gender queer, gender nonbinary 14 (2.8), No choice describes me 6 (1.2) Missing 1 (0.2)
Other demographic characteristics (ethnicity/sexuality) N (%)	White 359 (70.8), Black or African American 69 (13.6), American Indian, Alaskan Native, Asian, Pacific Islander 11 (2.2).From multiple races 31 (6.1), No choice describes me 32 (6.3), Hispanic/Latino 44 (8.7), Gay 27 (5.3), Lesbian 25 (4.9), Bisexual 47 (9.3), No choice describes me 32 (6.3)
Years in role	*M* = 5.5 years, *SD* = 3.42
Role description (formal training, supervision arrangements, peer work model/intervention, job setting)	**Training:** n (%): CPS 411 (81), Substance use peer support certification 124 (25.0), Other 69 (14.0) **Peer work model:** *Job titles*: peer specialist, peer support specialist, peer support worker, peer counsellor, peer advocate. **Job setting:** Hospital 74 (14.6), Community-based organization 281 (55.4), Respite center 21 (4.1,)Crisis services 21 (4.1), Housing/residential services 39 (7.7), Criminal justice reentry services 10 (2.0) Office 32 (6.3), Peer recovery services 18 (3.6), Other 11 (2.2).

Table 2 - Included Studies [Contd.]

Author, year of publication, country	**Gillard, 2022, UK**	**Grant, 2012, USA**
Study setting	Seven NHS mental health services in England. Part of an RCT of peer support for discharge from inpatient to community settings.	Recruited through Peer Specialist Training, Kansas.
Study design	Cohort Study	Cross-sectional study
Inclusion/exclusion criteria	Peer worker employed in ENRICH RCT	Currently employed CPS, Trained through Wichita State University 2007-9
Sample size	32	59
Mean age (SD)	42.9 (9.0)	47 (11.02)
Gender N(%)	Female 21(66), Male 10 (31.3), Prefer not to say 1 (3.1)	Female 40 (68), Male 19 (32)
Other demographic characteristics (ethnicity/sexuality) N (%)	White British 20 (66.7), White Irish 3 (9.0), White other 2 (6.7), Arab 1 (3.1), Black/ Black British African 1 (3.1), Asian/ Asian British Pakistani 1(3.1), Mixed White & Asian 1 (3.1), Other Mixed background 1 (3.1), Bisexual 3 (9.7), Lesbian/Gay 2 (6.5), Heterosexual 22 (71), Prefer not to say 4 (12.9)	'Caucasian' 48 (81), African American 7 (12), Hispanic 1 (2), Asian 1 (2), Other ethnicity not listed 2 (3)
Years in role	*M* = 17.7 months, *SD* = 8.2	Not reported
Role description (formal training, supervision arrangements, peer work model/intervention, job setting)	**Training:** 8 whole-day sessions and handbook, coproduced by peer workers. Training development informed by people with peer work experience. Training has individual strengths-based focus, and involves mapping and appraising community-based resources and social supports. **Supervision:** Regular group supervision provided by a peer worker coordinator. Individual supervision available ad hoc. **Peer work model :** 1:1 in NHS inpatient and community settings over at least one meeting prior to discharge and 13 meetings over 4-months post discharge. Meetings are flexible, lasting up to 2 hours. Intervention focuses on being alongside the participant as they engage with social spaces and activities in the community. Peer workers use their experience as part of a reciprocal relationship. **Job setting :**Part of a peer work team working in both inpatient and community settings.	**Training**: All peer workers certified. Attended a five-day program held by Wichita State university in 2007-9.

Table 2 - Included Studies [Contd.]

Author, year of publication, country	**Hayes, 2022, USA**	**Kuhn, 2015, USA**
Study setting	Recruited across USA via mental health organisations and Peer Supporters' online discussion groups and snowballing Complete online survey.	Recruitment through Texas state CPS Training Program.
Study design	Cross-sectional study	Cross-sectional study
Inclusion/exclusion criteria	*Inclusion:* Age 18+, Employee or volunteer, Hired based on personal mental health experiences, Trained peer supporter, Core responsibility to provide direct mental health support to individuals in recovery *Exclusion:* Solely engaged in mutual aid or self-help groups, Primarily family support provider	Completed the Texas recognized CPS Training Program in March 2010 - July 2012. Currently working in a peer specialist capacity In the mental health field
Sample size	738	86
Mean age (SD)	48.21 (11.9)	Age > 40 n = 66 (79.8%)
Gender N(%)	Female 478 (64.8), Male 251 (34.0), Nonconforming/ transgender/ other 9 (1.2)	Female 52 (60.5)
Other demographic characteristics (ethnicity/sexuality) N (%)	White 572 (77.5), Hispanic/Latino 116 (15.7), African American/Black 83 (11.2), Other (Asian, Pacific Islander, Native American, multiethnic or other unspecified ethnicity) 112 (15.2)	White/ 'Caucasian' 65 (75.6), Black/ African American 13 (15.1), Hispanic 11 (13.1)
Years in role	*M* = 40.59 months, *SD* = 38.3	Not reported
Role description (formal training, supervision arrangements, peer work model/intervention, job setting)	**Training**: CPS n (%): 642 (81) **Job settings :**Peer- or consumer-operated organization 32 (4.3), County or state mental health service 76 (10.3), Nonprofit organization 164 (22.2), For-profit organization 24 (3.3), Informal network or mutual support group 12 (1.6), Inpatient setting 21 (2.8), Outpatient or community-based setting 122 (16.5), Forensic setting 14 (1.9), Substance abuse treatment facility 60 (8.1), Veterans health administration 137 (18.6), Other service setting 63 (8.5).	**Training***:* All peer specialists were trained and state certified.

Table 2 - Included Studies [Contd.]

Author, year of publication, country	**Mowbray, 2021, USA**	**Ostrow, 2022a, USA, Ostrow, 2022b, USA**
Study setting	State-wide training conference in Georgia, USA.	Peer supporters certified in 2019/20 in Pennsylvania, North Carolina, Texas and Oregon.
Study design	Cross-sectional study	Cross-sectional study
Inclusion/exclusion criteria	CPS	Age 18 +, Peer (re)certification dated 2019/20, Certified in Pennsylvania, North Carolina, Texas or Oregon
Sample size	325	59
Mean age (SD)	not reported	46.6 (11.8)
Gender N(%)	Male 70 (34.04), Female 135 (65.96)	Female 214 (65.8)
Other demographic characteristics (ethnicity/sexuality) N (%)	White non-hispanic 94 (45.83), Black/African American 95 (46.25), Other 16 (7.92)	White 240 (73.8), Black/African American 63 (19.4), Other non-white 22 (6.8), Latinx 32 (9.8)
Years in role	*M* = 4.13 years	*M* = 35 months, *SD* = 37
Role description (formal training, supervision arrangements, peer work model/intervention, job setting)	**Training:** All peer specialists were trained and state certified. **Peer work model** *: Participants endorsed providing peer support in the following areas in order of frequency:* Peer support provision; Encouragement of self-determination; Personal responsibility; Health and wellness; Addressing hopelessness; Developing friendships; Addressing stigma in the community; Education; Wellness recovery action planning; Communication with providers; Leisure and recreation; Family relationships; Illness management; Spirituality and religion; Employment; Transportation; Dating/romantic relationships; Parenting; Developing psychiatric advance directives; Citizenship.	**Training:** CPSs

Table 2 - Included Studies [Contd.]

Author, year of publication, country	**Scanlan, 2020, Australia**	**Weikel, 2022, USA**
Study setting	Mental health services in New South Wales. Community and inpatient settings.	Community-based mental healthcare providers in rural Pennsylvania.
Study design	Mixed-methods cross-sectional study	Cross-sectional study
Inclusion/exclusion criteria	*Inclusion:* Currently working in an identified peer worker role In New South Wales *Exclusion:* Has lived experience working in non-peer roles	Employee of county-contracted mental health service In a two-county area have a diagnosed mental illness use this experience in their work with clients
Sample size	67	38
Mean age (SD)	Not reported	Not reported
Gender N(%)	Female 47 (70.1), Male 18 (26.9), Transgender Man 2 (3.0)	data for peer providers not reported separately
Other demographic characteristics (ethnicity/sexuality) N (%)	Not reported	Not reported
Years in role	**<1 year n (%)** 18 (26.9), 1–2 22 (32.8), 3–5 17 (25.4), 6–10 4 (6.0), 11–20 4 (6.0), >20 2 (3.0)	1-35 years
Role description (formal training, supervision arrangements, peer work model/intervention, job setting)	**Supervision:** *Receive supervision n* (%): 53 (79.1). *Delivered by n (%)*: a senior peer worker 25 (37.3), a peer worker at the same level 1 (6.7), a mental health worker 21 (31.3), "other" 6 (9.0). **Peer work model:** *Job Title n* (%): Peer Worker / Peer Support Worker 45 (67.2), Senior Peer Worker / Senior Peer Support Worker 4 (6.0), Consumer Advocate 3 (4.5), Health Peer Support Worker / Peer Health Coach 4 (6.0), Other 10 (14.9). **Job setting:** Community and inpatient mental health service settings.	**Job settings:** Inpatient, outpatient, case management, in-home/mobile, crisis and social rehabilitation/ drop-in programmes.

Role description

Role description data was not consistently reported and, where available, described significant variety in PSW roles, training and organisational contexts. Data on peer work models were available for nine studies. Only one study examined a clearly defined peer work intervention (Gillard et al., 2022). Detail in other studies ranged from a list of job titles (Scanlan et al., 2020), to specific activities (Mowbray et al., 2021).

Eleven studies provided information regarding the organisation or setting PSWs worked in. Of these, seven included a range of state and peer-run organisations, in community and inpatient settings. Three papers studied the same sample of participants, exclusively employed by the Veterans Association (VA), however details of setting were not reported. One study reported data exclusively from PSWs in the UK National Health Service (NHS) supporting people in the transition from inpatient to community settings.

Fifteen studies reported on the level of training of participants. All participants in seven studies were certified peer specialists, seven studies reported on both certified/formally qualified and uncertified peer specialists. In one study PSWs completed training designed for their specific intervention. Four studies provided data on the length of training received (range 0-80 hours) and two reported on the content of the training. Seven studies provided data on supervision. Five reported the frequency of supervision, ranging from no supervision through to twice weekly supervision. Four reported the length of supervision ranging from under 15 minutes to as long as needed, three the profession of supervisors, and one reported group delivery.

Primary Outcomes

Outcomes

Five studies investigated personal recovery outcomes. Of these, two included Personal Recovery as multidimensional construct, three examined Empowerment, one Meaning and one Hope. Two studies investigated PSW wellbeing. One study focussed on work-related wellbeing and one on mental wellbeing. Eight studies investigated burnout, with one study also considering general stress and work-related stress. Thirteen studies investigated role satisfaction as both a single and multidimensional construct.

Measurement

Across the included studies, 18 measures were used for these primary outcomes. Two measures were used to assess personal recovery; two studies (Brooks et al., 2021b, Burke et al., 2018) used the Questionnaire about the Process of Recovery (QPR) (Law et al., 2014). One study (Brooks et al., 2021b) used the Social Support for Recovery Scale (Laudet et al., 2000). Three measures assessed aspects of the CHIME recovery framework. To measure empowerment, two studies (Abraham et al., 2022, Edwards and Solomon, 2023) used Spreizer's (1995a, 1995b) self-report scale referred to variously as the Measure of Intrapersonal Empowerment and the Psychological Empowerment Scale (PES). One study (Burke et al., 2018) used the total score on the Mental Health Confidence Scale (MHCS) (Carpinello et al., 2000) as a measure of empowerment and the optimism subscale of the MHCS as a measure of hope. Meaning was measured in one study (Bujanover et al., 2022) using the Meaning in Life Questionnaire (MLQ) (Steger et al., 2006). Two measures were used to assess wellbeing; one study (Bujanover et al., 2022) measured emotional wellbeing and optional functioning at work using the Work-Related Flow Inventory (WOLF) (Bakker, 2008) and one study (Gillard et al., 2022) used the Warwick-Edinburgh Mental Wellbeing

Scale (WEMWBS) (Tennant et al., 2007). Three measures were used to assess burnout and two to assess other aspects of stress. Seven papers used a version of the Maslach Burnout Inventory (MBI) (Maslach et al., 1997). The MBI: Human Services Survey (MBI-HSS) was used in six papers. Two studies (Abraham et al., 2022, Hayes and Skeem, 2022) used just the 9-item emotional exhaustion subscale of the MBI-HSS to measure burnout. One paper (Ostrow et al., 2022a) used the MBI: General Survey (MBI-GS). One paper (Scanlan et al., 2020) used the Oldenburg Burnout Inventory (OLBI) (Demerouti et al., 2003). One study (Hayes and Skeem, 2022) used the Perceived Stress Scale (PSS-10) (Lee, 2012) as a measure of general stress and the Secondary Traumatic Stress Scale (STSS) (Bride et al., 2004) to measure helping-related stress.

Five dimensional scales were used to measure role satisfaction, whereas three questionnaires used a single-item approach. Of the studies that employed a dimensional measure, The Indiana Job Satisfaction Survey (IJSS) (Resnick and Bond, 2001) was used in four papers (Abraham et al., 2022, Edwards and Solomon, 2023, Grant et al., 2012, Mowbray et al., 2021) and Mowbray et al. (2021) used an adapted 17-item version of the scale. Two papers (Brooks et al., 2021b, Wu et al., 2023) used the Job Satisfaction of Persons with Disabilities Scale (JSPDS) (Brooks et al., 2021a). Clossey et al. (2018) assessed job satisfaction using 6-items of their 24-item self-rated questionnaire on perceived barriers to and facilitators of peer work. One study (Gillard et al., 2022) used the Measure of Job Satisfaction (MJS) (Traynor and Wade, 1993)), and one paper (Ostrow et al., 2022b) used the Brief Index of Affective Job Satisfaction (BIAJS) (Thompson and Phua, 2012). Regarding single item measures, two papers (Chang et al., 2016, Eisen et al., 2015) used the Job Satisfaction Index (JSI) of the Department of Veterans Affairs All Employee Survey (Osatuke et al., 2012, p. 31). Burke et al. (2018) devised the 23-item self-report Experience of Providing Peer Support Scale (EPPS) for the purposes of their study. Eight items relating to role satisfaction were used as single-item variables in their analyses. One study (Cronise et al., 2016) used the Peer Support Provider Education, Compensation, and Satisfaction Survey (PSPECS) (National Association of Peer Supporters, 2013) which was adapted for the purposes of the study. Two studies (Kuhn et al., 2015, Scanlan et al., 2020) used a single item to measure overall job satisfaction on a Likert scale.

Comparison groups

Four studies recruited a comparison group. These included: people with a mental health diagnosis in the same vocational programme working in 'non peer-helping vocations' (Bujanover et al., 2022); Vocational Rehabilitation Specialists also working in the Veterans Health Administration (VHA) mental health services, who have a current or history of disability (Chang et al., 2016, Eisen et al., 2015); CPSs currently working in a non-peer role (Ostrow et al., 2022a, Ostrow et al., 2022b); and non-peer mental health workers employed in the same geographical area (Weikel and Fisher, 2022). Three studies used data from existing studies or normed samples to make comparisons in their analyses; non-peer mental health clinicians in the same health service (Park et al., 2016, Scanlan et al., 2020); and general population, nurses and health visitors from the same country (Gillard et al., 2022). Three studies made within-group comparisons, including between those working in the health service and those in the total peer work sample; those who had themselves received peer support and those who had not; and those who had negative experiences working in a mental health team and those who had not (Burke et al., 2018); those working in peer and non-peer organisations (Weikel and Fisher, 2022); and those currently experiencing significant symptoms of a mental health difficulty with those not currently experiencing significant symptoms (Hayes and Skeem, 2022).

Description of findings

Personal recovery

Data related to personal recovery outcomes are presented in table 3. Two studies (Burke et al., 2018, Bujanover et al., 2022) conducted within or between group comparisons. Only scores for presence of meaning in life were significantly higher for PSWs than comparisons in non-helping roles (Bujanover et al., 2022).

Wellbeing

Data related to wellbeing are presented in table 4. Bujanover et al. (2022) found that there were no significant differences in wellbeing between PSWs and people with a mental health diagnosis in working in non-helping roles. Gillard et al. (2022) found that across three-time points peer-worker wellbeing was slightly lower than general population normative samples assessed by visual inspection. A significant decrease in PSW wellbeing was observed between completing training and four months after starting work, however the difference between baseline and 12 months was not significant.

Table 3 - Personal Recovery Outcomes

Study (author, year)	**Abraham, 2022**	**Edwards, 2023**	**Burke, 2018**	**Brooks, 2021**	**Brooks, 2021**
Construct	Empowerment	Empowerment	Empowerment	Support for recovery	Process of recovery
Measure	PES	PES	MHCS-Total	SSRS	QPR
Descriptive data	n = 103, M = 5.50, SD = 1.24 (Range 1-7)	n = 470 M = 4.05 SD = 0.61 (range 1-5)	n = 75 M = 71.8 SD = 12.9 (Range 16-96)	n = 121 M = 3.11 SD = 0.54 (Range 1-4)	n = 121 M = 4.28 SD = 0.70 (Range 1-5)
Comparisons	n/a	n/a	No significant differences found	n/a	n/a
Key secondary outcome measures	n/a	IJSS	MANSA, ISMI-10	JSPDS	JSPDS
Analyses	n/a	Hierarchical regression	Bivariate analyses	Hierarchical multivariable regression	Hierarchical multivariable regression
Significant associations	n/a	Empowerment predicted higher levels of overall job satisfaction, general satisfaction, pay satisfaction, advancement/ security satisfaction, supervision satisfaction and feelings on the job.	Empowerment showed a positive correlation with Quality of Life and negative correlations with total personal costs experienced and Internalised Stigma.	Higher scores on support for recovery predicted greater job satisfaction.	Higher scores on process of recovery predicted greater job satisfaction.

Table 3 - Personal Recovery Outcomes [Contd.]

Study (author, year)	**Burke, 2018**	**Burke, 2018**	**Bujanover, 2022**
Construct	Process of recovery	Hope	Meaning in Life
Measure	QPR-total	MHCS-H	MLQ
Descriptive data	n = 76 M =59.8 SD = 9.9 (Range 0-60)	n = 75 M = 26.8 SD = 5.5 (Range 6-36)	*n*, M (SD) Total 69, 52.33 (10.07) (Range 10-70) Presence 69, 27.22 (6.16) (Range 5-35) Search 69, 25.12 (7.19) (Range 5 - 35)
Comparisons	No significant differences found	No significant differences found	The mean level of 'MLQ Presence' among the peer-helping vocations group was significantly higher than in the non-helping vocations group with a small effect size.
Key secondary outcome measures	MANSA, ISMI-10	MANSA, ISMI-10	WOLF, ROPP
Analyses	Bivariate analyses	Bivariate analyses	Parallel multiple mediation model
Significant associations	Process of recovery showed positive correlation with Quality of life and negative correlation with Internalised Stigma.	Hope showed positive correlation with Quality of Life and negative correlation with internalised stigma.	MLQ-Presence was found to serve as a mediator of the relationship between ROPP-Total and WOLF-Total. ROPP-Total was positively related to MLQ-Presence, which was positively related to WOLF-Total scores.

PES - Psychological Empowerment Scale; MCHS - Mental Health Confidence Scale; SSRS - Social Support for Recovery Scale; QPR - Questionnaire about the Process of Recovery; MLQ -Meaning in Life Questionnaire ; IJSS - The Indiana Job Satisfaction Survey; MANSA - Manchester Short Assessment of Quality of Life; ISMI - 10 - Internalised Stigma of Mental Illness scale – brief version; JSPDS - Job Satisfaction of Persons with Disabilities Scale; WOLF - The Work-Related Flow Inventory; ROPP - Recovery Oriented Peer Provider.

Table 4 – Wellbeing Outcomes

Study (author, year)	Bujanover, 2022	Gillard, 2022
Construct	Work-related wellbeing	Mental Wellbeing
Measure	WOLF	WEMWBS
Descriptive data	(Range 1-7) Absorption M = 3.96 SD = 1.21 Enjoyment M = 5.15 SD = 1.30 Motivation M = 4.62 SD = 1.15 Total M = 4.58 SD = 1.01	T1: Baseline T2: 4 months T3: 12 months n, M (SD) (Range 14 - 70) T1: 32, 49.8 (9.07); T2: 20, 47.7 (9.17); T3: 21, 48.7 (11.73)
Comparisons	No significant differences with comparison group.	Paired t-tests indicated that between baseline and T2 there was a statistically significant decrease in wellbeing with a medium effect size. Change between T1 and T3 was not significant, however. Wellbeing remained slightly lower than general population norm across 12 months.
Key secondary outcome measures	ROPP, MLQ	n/a
Analyses	Parallel multiple mediation model	n/a
Significant associations	MLQ-Presence was a mediator of the relationship between ROPP-Total and WOLF-Total. ROPP-Total was positively related to MLQ-Presence, which was positively related to WOLF-Total scores.	n/a

WOLF - The Work-Related Flow Inventory; WEMWBS - Warwick-Edinburgh Mental Wellbeing Scale; ROPP - Recovery-Oriented Peer-Provider; MLQ - Meaning in Life Questionnaire..

Burnout

Data relating to burnout and stress can be found in table 5. Both longitudinal studies (Gillard et al., 2022, Park et al., 2016) observed a significant increase in scores of depersonalisation between baseline and time two (four or six months). This was maintained to 12 month follow-up in Gillard et al. (2022), but not in Park et al. (2016). In Park et al. (2016), emotional exhaustion also significantly increased between baseline and 6 months, again this was not maintained at 12 months.

Seven studies compared PSW samples with norms or controls. The majority of studies found PSWs have levels of burnout similar to comparison samples including Vocational Rehabilitation Specialists (Eisen et al., 2015, Park et al., 2016) and non-peer mental health workers (Scanlan et al., 2020, Weikel and Fisher, 2022). Hayes and Skeem (2022) were the only study to find a larger proportion of PSWs endorsed moderate to high levels of emotional exhaustion than a mental health staff norm, though the effect size was small. Two studies (Gillard et al., 2022, Ostrow et al., 2022a), found lower burnout scores and higher levels of personal achievement/efficacy in PSWs than norms from a sample of nurses and a comparison group of certified PSWs working in non-peer roles. PSWs working in peer-run organisations reported significantly lower depersonalisation scores than those in non-peer organisations in one study (Weikel and Fisher, 2022).

Only Hayes and Skeem (2022) reported on other aspects of stress, finding that their sample reported lower levels of general stress than a general adult population norm and lower levels of secondary traumatic stress than a social worker norm. A subgroup of their sample, currently experiencing clinically significant symptoms of a mental health difficulty, showed higher scores of emotional exhaustion, general stress and secondary traumatic stress than compared norms.

Table 5 - Burnout and Stress Outcomes

Study (author, year)	Abraham, 2022	Eisen, 2015	Park, 2016
Construct	Burnout	Burnout	Burnout
Measure	MBI-HSS	MBI-HSS	MBI-HSS
Descriptive data	EE n = 100, M = 16.88, SD = 11.46 (Range 0-54)	M (SD) Range 1-7 •EE 2.43 (1.22) •DP 1.50 (.804) •PA 6.40 (.635)	M (SD) T1: Baseline (n = 149) T2: 6 months (n = 125) T3: 12 months (n = 110) •EE T1: 12.9 (11.0); T2: 15.4 (11.7); T3: 13.6 (11.3) (Range 0-54) •DP T1: 2.5 (4.0); T2: 3.5 (4.7); T3: 3.1 (4.2) (Range 0-30) •PA T1: 43.2 (5.1); T2: 43.3 (5.0); T3: 43.8 (4.8) (Range 0-48)
Comparisons	None	No sig. diff. between groups	EE and DP scores were significantly higher at 6 months than baseline. No other sig. diffs. between time points. No sig. diff. between groups found.
Key secondary outcome measures	RAS	n/a	BASIS -24, GES
Analyses	Multiple Regression	n/a	Bivariate analyses Multivariable regression
Significant associations	Greater role clarity was predictive of lower EE.	n/a	Correlates of burnout at baseline: White participants reported higher EE and DP than non-white participants at baseline. More hours per week providing direct services was associated with lower DP and higher PA. Greater EE and DP were associated with higher psychiatric symptom severity. Greater PA was associated with lower psychiatric symptom severity. Greater baseline self-efficacy was associated with lower EE and DP and higher PA. Baseline predictors of burnout at 6 month follow-up: Being white predicted higher DP. Lower overall psychiatric symptom severity and lower general self-efficacy predicted higher PA. Baseline predictors of burnout at 12 months: Greater general self-efficacy predicted higher EE. Overall psychiatric symptom severity at baseline predicted higher DP.

Table 5 - Burnout and Stress Outcomes [Contd.]

Study (author, year)	**Gillard, 2022**	**Weikel, 2022**
Construct	Burnout	Burnout
Measure	MBI-HSS	MBI-HSS
Descriptive data	n, M (SD) T1: Baseline T2: 4 months T3: 12 months •EE T1: 32, 8.6 (9.27); T2: 20, 9.8 (7.84); T3: 21, 11.8 (9.72) (Range 0-54) •DP T1: 32, 3.0 (3.61); T2: 20, 4.4 (3.9); T3: 21, 4.7 (4.07) (Range 0-30) •PA T1: 23, 39.3 (7.34); T2: 19, 38.7 (6.9); T3: 19, 37.5 (11.2) (Range 0-48)	•EE 18.58 (11.64) (Range 0-54) •DP 3.00 (3.16) (Range 0-30) •PA 39.64 (7.42) (Range 0-48)
Comparisons	A significant increase in DP scores to T2, small- medium effect size, was maintained to T3. Scores indicate lower EE and DP and higher PA than norms.	T-tests showed no sig. diff. on EE, DP, or PA between peer workers and non-peer providers. Peer providers in peer-run organisations reported significantly lower levels of DP than those in other organisations.
Key secondary outcome measures	n/a	AWS, SCS-SF
Analyses	n/a	Bivariate analyses
Significant associations	n/a	Lower workload satisfaction, workplace control, worklife reward, workplace community and self-compassion were all associated with higher EE. intent to leave the mental health field was associated with higher EE.

Table 5 - Burnout and Stress Outcomes [Contd.]

Study (author, year)	**Hayes, 2022**	**Ostrow, 2022a**
Construct	Burnout	Burnout
Measure	MBI-HSS	MBI-GS
Descriptive data	•EE n =647 M = 18.69 SD = 11.90 (Range 0-54)	M (SD not reported) (Range 0-6) EX 2.06 CY 1.32 PE 5.13
Comparisons	A larger proportion of the peer support worker sample endorsed moderate to high levels of EE compared with nonpeer clinical staff norm. Peer specialists experiencing significant symptoms of a mental health difficulty showed higher levels of EE than non-peer clinical staff norm with a large effect size.	Participants in PS jobs reported lower EX and CY, and higher PE than those in other jobs. The prevalence of high EX did not differ by job type . High CY and low PE were significantly less common in peer services than other types of jobs. A higher proportion of those in PS jobs fit the "engaged" burnout profile (low EX, low CY, high PE) compared to those in other job types.
Key secondary outcome measures	Study questionnaire	AWS, GES
Analyses	Bivariate analyses	Multivariable regression Contingency Tables
Significant associations	Younger age showed a weak correlation with higher EE.	Older age and greater workplace community predicted lower EX. Job tenure > 1 year predicted higher EX. Older age, being black, greater worklife reward, workplace community, and workplace fairness predicted lower CY. Longer job tenure predicted higher CY. Age, better fit with workplace values, greater self-efficacy, and number of negative experiences at all jobs predicted higher PE. Participants classified as High EX , High CY or low PE were more likely than others to be currently looking for a new job.

Table 5 - Burnout and Stress Outcomes [Contd.]

Study (author, year)	**Scanlan, 2020**	**Hayes, 2022**
Construct	Burnout	General Stress
Measure	OLBI	PSS
Descriptive data	M (SD) (Range 1-4), Disengagement 2.17 (0.50), Exhaustion 2.44 (0.50)	n = 632 M = 13.97 SD = 6.72 (Range 0-40)
Comparisons	No significant difference in scores found between groups .	Lower levels of stress compared with a general adult population norm, with a small effect size. Peers without significant symptoms showed lower levels of stress than a general adult population norm, with a moderate effect size. Peers with significant symptoms showed higher levels than the general adult norm with a moderate effect size.
Key secondary outcome measures	Survey study, JDRQ	Study questionnaire
Analyses	Bivariate analyses	Bivariate analyses
Significant associations	Disengagement and Exhaustion were positively correlated with turnover intention and negatively correlated with satisfaction with supervision and professional development and opportunities for career progression. Disengagement was positively correlated with physical environment and physical workload and negatively correlated with cognitive demands. Exhaustion was positively correlated with emotional demands, physical environment, shift work, physical workload, recipient contact demands, work-home interference and workload. Disengagement and exhaustion were negatively correlated with feedback, rewards and recognition, social support, job control, participation, supervisor support and manager support. Disengagement was also negatively correlated with job security.	Younger age showed a weak correlation with higher scores of general stress.

Table 5 - Burnout and Stress Outcomes [Contd.]

Study (author, year)	**Hayes, 2022**
Construct	Secondary Traumatic Stress
Measure	STSS
Descriptive data	n = 616 M = 28.03 SD =10.70 (Range 17 to 85) n = 372 (60.4%) endorsed few or no symptoms, n = 152 (24.7%) mild symptoms and n = 92 (14.9%) clinically significant levels of secondary trauma symptoms.
Comparisons	Peer support worker sample endorsed lower levels of secondary STS compared with a social worker norm, with a small effect size. For those without significant symptoms this reached a moderate effect size. Participants experiencing significant symptoms showed higher levels of STS than the social worker norm with a large effect size.
Key secondary outcome measures	Study questionnaire
Analyses	Bivariate analyses
Significant associations	Younger age showed a weak correlation with higher scores on STSS. There was a weak relationship between those who worked in inpatient settings and lower STS.

MBI-HSS - Maslach Burnout Inventory Human Services Survey, EE - Emotional exhaustion, DP - Emotional exhaustion, PA - Personal Accomplishment; Sig. diff. – significant difference; RAS - Role Ambiguity Scale; BASIS -24 - Behaviour and Symptom Identification Scale; GES - General Self-Efficacy Scale; AWS - Areas of Work Life Scale; SCS-SF - Self-Compassion Scale; MBI-GS - MBI: General Survey, EX - Exhaustion, CY - Cynicism, PE – Professional Efficacy; OLBI - Oldenburg Burnout Inventory; JDRQ – Job demands and resources questionnaire; PSS - Perceived Stress Scale; STSS - Secondary Traumatic Stress Scale; STS – secondary traumatic stres

Role Satisfaction

Data on role satisfaction is presented in table 6. The only study to assess job satisfaction longitudinally (Gillard et al., 2022) observed a decrease in personal satisfaction and satisfaction with workload between baseline at 4-month follow-up, as well as a significant decrease in satisfaction with prospects and training across time points. In studies that compared PSWs with other groups, PSWs had comparable levels of job satisfaction to non-peer mental health clinicians (Scanlan et al., 2020) and higher levels than CPSs working in non-peer roles (Ostrow 2022b) and when compared to norms from health visitors, district nurses and practice nurses using visual inspection of mean scores (Gillard et al., 2022). The exception to this pattern is lower satisfaction with pay and prospects compared with health visitors (Gillard et al., 2022) and Vocational Rehabilitation Specialists (Chang et al., 2016).

Relationships with secondary outcomes

There was mixed evidence that perceived empowerment was associated with improved role or job satisfaction, with one study (Edwards and Solomon, 2023) showing a significant association but two studies (Abraham et al, 2022, Burke et al 2018) showing no association. Limited evidence for other associations provided by one study (Burke et al., 2018) found that empowerment was associated with improved perceived quality of life, fewer personal costs experienced in relation to work, and lower internalised stigma. The only association with wellbeing was the degree to which peer-workers used a recovery approach in their role related indirectly to their work-related wellbeing, mediated by perceived meaning in life (Bujanover et al., 2022).

Higher general self-efficacy predicted higher personal accomplishment/ professional efficacy in two studies (Park et al., 2016, Ostrow et al., 2022a). However, this relationship changed over time (Park et al., 2016) with lower self-efficacy at baseline predicting higher personal accomplishment at 6-months and higher self-efficacy at baseline predicting higher levels of emotional exhaustion at 12-month follow-up.

Table 6 - Role Satisfaction Outcomes

Study (author, year)	**Abraham, 2022**	**Edwards, 2023**
Measure	IJSS	PSS
Descriptive data	M (SD) (Range 1-4), Disengagement 2.17 (0.50), Exhaustion 2.44 (0.50)	n, M (SD) (Range 1-4) Job satisfaction (global) 318, 3.13 (0.05) General satisfaction 497, 3.46 (0.63) Pay satisfaction 346, 2.56 (0.77) Advancement and security satisfaction 503, 2.81 (0.82) Supervision satisfaction 501, 3.30 (0.80) Coworker satisfaction 491, 3.38 (0.56) Feelings on the job satisfaction 494, 3.18 (0.52)
Comparisons /Change across time	None	None
Key secondary outcome measures	AMQ, RSA	WPQ, SPOS, PES
Method of assessmen	Multiple regression	Hierarchical Multiple Regression
Significant associations	Greater mentoring from supervisors and a more recovery oriented workplace were significant predictors of higher Job Satisfaction.	Higher levels of perceived organisational support, job empowerment, coworker support , supervisor support, age, and being a CPS were significant predictors of higher overall job satisfaction. Higher levels of coworker support, job empowerment, perceived organisational support predicted higher general satisfaction. Higher levels of Job empowerment, perceived organisational support, age, being a CPS and having a hospital work setting predicted higher pay satisfaction. Higher levels of job empowerment, perceived organisational support, and having a Hospital work setting predicted higher advancement/security satisfaction. Higher ratings of coworker support, job empowerment, supervisor support, perceived organisational support, and age were predictive of higher supervision satisfaction. Having a supervisor with a peer background predicted lower supervision satisfaction scores. Coworker support was predictive of higher coworker satisfaction. Having a hospital work setting was predictive of lower scores of coworker satisfaction. Coworker support, job empowerment, perceived organisational support, and age predicted higher scores on the feelings about the job subscale.

Table 6 - Role Satisfaction Outcomes [Contd.]

Study (author, year)	**Grant, 2012**	**Mowbray, 2021**	**Wu, 2022**
Measure	IJSS	17-item IJSS	JSPDS
Descriptive data	Not reported	Overall job satisfaction M = 3.57 (only mean reported) (Range 1-5)	Not reported
Comparisons /Change across time	None	None	None
Key secondary outcome measures	SPOS, WIS	N/A	SPOS, W-BNSS, UWES, OCS
Method of assessment	Multiple regression	Multivariate regression	Serial Multiple Mediation Analysis
Significant associations	Higher perceived organisational support and workplace integration predicted overall job satisfaction.	Black/African American respondents reported significantly lower job satisfaction compared to white respondents. Respondents with a four-year college degree reported significantly lower job satisfaction compared to respondents with a less than high-school education.	Greater degrees of organisational support are associated with higher levels of job satisfaction. Autonomous motivation to work, work engagement, and affective commitment to the organisation mediated the effect of organisational support on job satisfaction.

Table 6 - Role Satisfaction Outcomes [Contd.]

Study (author, year)	**Burke, 2018**
Measure	EPPS
Descriptive data	n, M (SD) (Range 1-10), Satisfaction with training 142, 7.6 (2.5), Satisfaction with managerial supervision 129, 7.7 (2.5), Satisfaction with professional supervision 119, 7.6 (2.5), Satisfaction with pay 143, 6.4 (2.6), Perceived support for you in PS role 146, 6.9 (2.7), Satisfaction with career progression 145, 5.0 (3.0) Overall satisfaction with PS role 145, 7.3 (2.5) Perceived acceptance by team 82, 7.1 (2.4) Perceived value by team 82, 7.0 (2.6)
Comparisons /Change across time	None
Key secondary outcome measures	EPPS, MANSA
Method of assessment	Spearman's rank correlation
Significant associations	Overall satisfaction with PS role had a strong positive correlation with perceived support, moderately positively correlated with managerial supervision, career progression, perceived value by team, training, pay, and perceived acceptance by team. It showed a weak negative correlation with total personal costs experienced. Satisfaction with training showed a weak positive correlation with total personal benefits. Satisfaction with pay had a moderate negative correlation with total personal costs experienced. Perceived support for you in PS role had a weak positive correlation with Quality of Life and a weak negative correlation with total personal costs experienced. Satisfaction with career progression showed a moderate negative correlation with total personal costs experienced. Perceived acceptance by team showed a moderate positive correlation with Quality of Life. Perceived value by team showed a moderate positive correlation with Quality of Life.

Table 6 - Role Satisfaction Outcomes [Contd.]

Study (author, year)	**Gillard, 2022**	**Ostrow, 2022b**
Measure	MJS	BIAJS
Descriptive data	T1: Baseline T2: 4 months T3: 12 months, Descriptive n, Mean (SD) (Range 1-5), Personal Satisfaction T1 29, 4.3 (0.72); T2 17, 4.2 (0.51); T3 19, 4.2 (0.64), Workload T1 30, 3.9 (0.76); T2 17, 3.8 (0.62); T3 19, 3.8 (0.78), Professional Support T1 31, 4.5 (0.53); T2 17, 4.5 (0.58); T3 19, 4.4 (0.82), Training T1 29, 3.9 (0.74); T2 17, 3.8 (0.92); T3 19, 3.6 (0.86), Pay T1 30, 3.5 (1.14); 17, 3.4 (1.23); 20, 3.5 (1.10), Prospects T1 30, 3.5 (0.92); T2 17, 3.5 (1.00); T3 19, 3.1 (1.10), Standards of care T1 29, 4.0 (0.62); T2 17, 4.0 (0.65); T3 19, 3.9 (0.89), Overall Satisfaction T1 30, 3.9 (0.66); T2 17, 3.9 (0.60); T3 20, 3.7 (0.74)	Overall job satisfaction n= 305 M = 17.3 SD = 2.9 (Range 4-20)
Comparisons /Change across time	Job satisfaction mean scores were higher than the norms from UK health visitors, district nurses and practice nurses, with the exception of satisfaction with pay and prospects. Personal satisfaction (medium effect size) and satisfaction with workload (small effect size) decreased from T1-T2. Satisfaction with prospects and training decreased across time points with a small to medium effect size for both.	Those in peer services jobs indicated significantly greater job satisfaction than CPSs working in other types of jobs.
Key secondary outcome measures	n/a	n/a
Method of assessment	n/a	n/a
Significant associations	None	Associations with job satisfaction were not reported separately for those in peer services jobs.

Table 6 - Role Satisfaction Outcomes [Contd.]

Study (author, year)	**Chang, 2016, Eisen, 2015**	**Clossey, 2018**
Measure	JSI	Study questionnaire
Descriptive data	M (SD) (Range 1-5) Type of work 4.42 (1.00) Amount of work 4.20 (1.07) Pay 2.98 (1.37) Relationships with coworkers 4.23 (1.12) Quality of direct supervision 4.07 (1.33) Quality of senior managers 3.58 (1.36) Opportunities for promotion 2.44 (1.44) Working conditions 3.89 (1.31) Perceived customer satisfaction 4.22 (0.98) Amount of praise received 3.93 (1.24) Quality of your work 4.55 (0.75) Overall satisfaction 4.26 (0.94).	Not reported
Comparisons /Change across time	The PS group was significantly less satisfied with pay, quality of direct supervision, quality of senior managers, and Opportunities for promotion than the VRS group with a moderate effect size.	None
Key secondary outcome measures	Survey	Study Questionnaire
Method of assessment	Regression Analysis	Hierarchical Multiple Regression
Significant associations	Adjusting for sex, age and length of employment, white PSs had significantly lower levels of satisfaction in pay, and opportunities for promotion than non-white peers, non-white and white VRSs, and white and non-white comparison group employees.	Higer scores on Organisational Culture and Working alliance with peers subscales were predictive of higher job satisfaction.

Table 6 - Role Satisfaction Outcomes [Contd.]

Study (author, year)	**Cronise, 2016**	**Kuhn, 2015**	**Scanlan, 2020**
Measure	Modified PSPECS Single item	Single item	Single item
Descriptive data	Overall job satisfaction: M = 4.24, SD = 1.02 (Range 1-5)	Overall job satisfaction n = 16, M = 4.29 SD = 0.79 (range 1-5)	Overall job satisfaction M = 7.25 SD = 2.08 (Range 1-10)
Comparisons /Change across time	None	None	No sig. diff. between peer workers and non-peer mental health clinicians.
Key secondary outcome measures	Study survey	Study survey	OLBI, Study survey, JDRQ
Method of assessment	Stepwise Multiple Regression	Multiple regression	Bivariate analyses
Significant associations	Higher ratings on the following items were associated with higher ratings of overall job satisfaction: Responsibility in the job reflects level of training and lived experience, Feeling respected by supervisors and colleagues, Feeling respected by peers who receive the service, Perception of having sufficient training to do the job, Working in community settings and/or peer run programs, Taking more hours of training to qualify as peer support provider, Perception that their peer support skills are used.	When controlling for time since training and having a job description only supervisor's understanding of peer specialist job role significantly predicted job satisfaction.	Job satisfaction was negatively associated with scores of turnover intention, disengagement and exhaustion. It was positively associated with satisfaction with supervision and professional development, and opportunities for career progression. In relation to Job demands it was significantly negatively associated with physical environment, physical workload, shift work and time pressure. Job satisfaction was positively associated with all Job Resources constructs; Job control, job security, rewards and recognition, social support, supervisor support, manager support, feedback, and participation.

AMQ - Alleman mentoring questionnaire revised; RSA - Recovery Self-Assessment Revised (Provider Version); WPQ - Work Practice Questionnaire; SPOS - Survey of Perceived Organizational Support; WIS - Workplace Integration Scale; W-BNSS - Work-related Basic Need Satisfaction Scale; UWES - Utrecht Work Engagement Scale; OCS - Affective, Normative and Continuance Employee-Organizational Commitment Scale; MANSA - Manchester Short Assessment of Quality of Life; JDRQ - Job Demands and Resources Questionnaire; VRS - Vocational Rehabilitation Specialist.

In relation to participant characteristics, findings from two studies (Park et al., 2016, Ostrow et al., 2022a) suggest that white participants may be more likely to report depersonalisation and emotional exhaustion, although in Park's study this difference did not remain at 12 months. Several studies found an association with higher age associated with lower exhaustion and higher personal efficacy. One study (Ostrow et al., 2022a) provided limited evidence that longer job tenure was associated with both higher exhaustion and cynicism levels.

Several aspects of the workplace predicted dimensions of burnout. Workplace community showed an inverse relationship with emotional exhaustion and cynicism in two studies (Ostrow et al., 2022a, Weikel & Fisher, 2022) . Single studies provided limited evidence that greater worklife reward, and workplace fairness predicted lower cynicism, while a better fit with workplace values was predictive of greater professional efficacy (Ostrow et al., 2022a) and greater role clarity predictive of lower emotional exhaustion (Abraham et al., 2022). There was reasonable evidence that participants with higher emotional exhaustion/ exhaustion were more likely to be looking for a new job or considering leaving the mental health field (Ostrow et al., 2022a, Scanlan et al., 2020, Weikel and Fisher, 2022).

Several papers assessed the relationship between general organisational variables and PSW role satisfaction. Three studies (Edwards and Solomon, 2023, Grant et al., 2012, Wu et al., 2023) found that higher levels of perceived organisational support, predicted higher levels of job satisfaction. There is single study evidence (Wu et al., 2023) that this relationship was mediated by autonomous motivation to work, work engagement, and affective commitment to the organisation. Various aspects of the supervisory relationship were significant predictors of greater job satisfaction including mentoring from supervisors (Abraham et al., 2022), feeling respected by supervisors (Cronise et al., 2016) and supervisor's understanding of the peer role (Kuhn et al., 2015). Evidence of general supervisor support as a predictor of job satisfaction was mixed with one study (Edwards and Solomon, 2023) finding an association and another finding none (Kuhn et al., 2015).

Four studies found that fit between the workplace and skills and values more specific to peer work were associated with improved job satisfaction, including a recovery oriented workplace (Abraham et al., 2022), organisational culture (Clossey, 2018), working in a peer run organisation, and having the opportunity to use peer support skills (Cronise et al.,2016). Two studies found aspects of the relationship with peers accessing the service also predicted greater job satisfaction (Clossey et al., 2018, Cronise et al., 2016).

Risk of Bias

Results of the analysis of methodological quality and risk of bias in the studies using the JBI Critical Appraisal Tool for Analytical Cross-sectional Studies are displayed in table 7. Agreement between raters was 89.6% (κ = 0.67) indicating substantial agreement. Overall, the evidence base suffers from several potential sources of bias. Frequently commented upon in studies were the variety of job titles, work tasks and settings that could potentially come under the umbrella of the PSW category, making it difficult to establish whether study participants have comparable roles. The clear statement of inclusion and exclusion criteria was absent from 25% of studies. While details of the study settings themselves were often reported, contextual details of PSWs' working environments or organisational factors related to the work they were undertaking such as availability of supervision, contact with other PSWs, and approach to peer work were frequently not reported. A notable exception to this was Gillard et al. (2022) which provided detailed information on participants, organisational context and intervention, and took a mixed method approach that allowed quantitative findings to be interpreted in the context of PSW experience.

There were clear issues with measurement across studies. All studies used self-report measures. Commonly, studies employed novel, unvalidated measures or adapted existing measures without validating the new version. There does not yet appear to be consensus around gold standard measures appropriate for use in a PSW population. Contrastingly, some studies such as Hayes et al. (2022) were rigorous in their use of validated measures, assessed internal consistency, and limited their analysis and reporting accordingly. Three studies used statistical methods that required a larger sample size than was available to them to sufficiently power the analyses. Two studies acknowledged that this limited the generalisability of their studies, however this was not noted in a third study. In contrast, other studies with smaller sample sizes made the decision to limit their analyses to those that could be sufficiently powered and as such were more limited in the conclusions that they could draw. Neither study that employed a longitudinal design used a control group, though in both cases efforts were made to compare with carefully chosen reference samples. Issues with loss to follow-up were found, meaning that those participants who completed all stages of the study may have experienced fewer negative impacts of the PSW role than those who did not.

Assessment of risk of bias was further informed by reference to the Appraisal tool for Cross Sectional Studies (AXIS) (Downes et al., 2016). This prompted further reflection on aspects of bias not explicitly accounted for by the JBI tool. Studies relied heavily on non-randomised convenience samples. While some studies used clear sampling frames, others were noted to be difficult to establish, meaning response rates were not reported. As such it is possible that the participants in these studies are not representative of PSWs in general and may in particular miss out on those who experience more of the negative impacts of peer work and as such either leave their roles or choose not to participate in surveys. The degree of involvement of peer researchers or those with lived experience in study or measure design is a major strength of the emerging evidence base, which may add to the relevance, appropriateness or ecological validity of measures used.

Table 7 - Risk Of Bias

Study identifier (Author, Year)	Were the criteria for inclusion in the sample clearly defined?	Were the study subjects and setting described in detail?	Was the exposure measured in a valid and reliable way?	Were objective, standard criteria used to define mental health peer workers?	Were confounding factors identified?	Were strategies to deal with confounding factors stated?	Were the outcomes measured in a valid and reliable way?	Was appropriate statistical analysis used?	Was follow up complete, and if not, were the reasons to loss to follow up described and explored?	Were strategies to address incomplete follow up utilized?
Abraham, 2022	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	n/a	n/a
Brooks, 2021	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	n/a	n/a
Bujanover, 2022	🟥	🟩	🟩	🟥	🟩	🟩	🟩	🟩	n/a	n/a
Burke, 2018	🟩	🟩	🟥	🟩	🟥	🟥	🟥	🟩	n/a	n/a
Chang, 2016	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	n/a	n/a
Clossey, 2018	🟥	🟩	🟥	🟥	🟩	🟩	🟥	🟩	n/a	n/a
Cronise, 2016	🟥	🟩	🟥	🟥	🟩	🟩	🟥	🟩	n/a	n/a
Edwards, 2023	🟩	🟩	🟨	🟥	🟩	🟩	🟩	🟩	n/a	n/a
Eisen, 2015	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	n/a	n/a
Gillard, 2022	🟩	🟩	🟩	🟩	🟥	🟥	🟩	🟩	🟥	🟩
Grant, 2012	🟩	🟥	🟥	🟩	🟩	🟩	🟩	🟥	n/a	n/a
Hayes, 2022	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	n/a	n/a
Kuhn, 2015	🟩	🟥	🟥	🟩	🟩	🟩	🟥	🟨	n/a	n/a
Mowbray, 2021	🟥	🟩	🟩	🟩	🟩	🟩	🟥	🟩	n/a	n/a
Ostrow, 2022a	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	n/a	n/a
Ostrow, 2022b	🟩	🟩	🟥	🟩	🟩	🟩	🟩	🟩	n/a	n/a
Park, 2016	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟨
Scanlan, 2020	🟩	🟩	🟩	🟩	🟥	🟥	🟥	🟨	n/a	n/a
Weikel, 2022	🟥	🟩	🟩	🟥	🟩	🟩	🟩	🟩	n/a	n/a
Wu, 2022	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	n/a	n/a

Legend: Green – Yes; Yellow – Unclear; Red – No.

Discussion

This review aimed to examine mental health PSWs' experiences of delivering peer support in relation to their personal recovery and wellbeing, burnout and work-related stress, and role satisfaction. A further aim of the review was to identify any variables that were associated with these outcomes. The review combined a body of work describing 16 cohorts of PSWs across 20 studies with a total of 3,425 participants. The vast majority of studies took a cross-sectional descriptive or analytical approach. The studies explored a broad range of outcome domains using 18 measures for the primary outcomes of interest. This, along with variation in how measures were scored, meant that there were significant methodological challenges in directly comparing the results of the included studies and synthesising the evidence. Notwithstanding these methodological challenges, this review provides a snapshot of the primary PSW outcomes, as well as signalling the individual, relational and organisational factors that may be associated with these.

Many more studies addressed areas of job satisfaction and burnout, with relatively fewer examining PSW wellbeing or personal recovery variables. Several studies looked at the clinical recovery of participants but not from a wider recovery approach perspective which is more congruent with the stated ethos of employing organisations and the PSW role. This may suggest that areas of research are being determined by organisational, rather than PSW interests.

The sample of PSWs included in this review had relatively high levels of job satisfaction and all but one study found that levels of burnout were either not significantly different or lower than comparisons. Overall, these findings suggest that PSWs are experiencing similar impacts of their work to their non-peer colleagues. One study's findings (Hayes and Skeem, 2022) indicate that PSWs experiencing clinically significant symptoms of a mental health difficulty may be at higher risk burnout, secondary traumatic stress and general stress than PSWs who are not. There is also early indication that it may be important to take account of individual differences in self-efficacy, as those with higher self-efficacy initially may be more likely to experience emotional exhaustion later in their role. These findings warrant further research to see whether findings are replicated in other samples and to explore what might be done to limit these risks.

Findings from the two longitudinal studies provide an indication that the impact of the work may change over time; Gillard et al.'s (2022) qualitative findings suggest outcomes of interest may fluctuate with an initial period of adaptation to the demands of the role leading to a dip in indicators of wellbeing and burnout. Simmons et al.'s, (2020) longitudinal qualitative study of youth mental health PSWs provides further context that with experience and support to navigate this challenge, participants reported benefits to their confidence, recovery and help-seeking. The finding from a third cross-sectional study (Ostrow et al., 2022a) that job tenure above a year is associated with higher levels of burnout suggests that in some circumstances burnout may increase over time rather than recovering. As such these dips may represent a natural process of adaption to a role, however organisational culture and supports may be essential to ensuring that the dip is resolved. Job satisfaction with prospects and training were both found to be significantly lower than baseline at 12 months follow-up, indicating that pay and prospects for training and career progression could be an area that requires particular attention from employers and supervisors, however currently this is based on evidence from only one study.

The variety of different roles presented in the studies, measures used, range of secondary outcomes assessed in combination with the methodological limitations of the studies included in this review substantially limit possibilities to draw reliable conclusions from synthesising the data. As such, in order to usefully organise the findings relating to variables associated with the primary outcomes of interest of the present review the authors looked to existing relevant theory. Bronfenbrenner's Bioecological theory (Bronfenbrenner and Morris, 2007) was chosen for this purpose as concepts of person, process, context and time allow systematic consideration of the interaction between individual and contextual factors but also take an explicitly lifelong developmental stance that chimes with both a recovery perspective and the idea of individual and system adaptation to the PSW role over time.

Proximal processes, bidirectional processes between a person and another individual or aspect in their microsystem or immediate environment, such as relationships with supported peers and supervisory relationships were particularly associated with job satisfaction. Consistent with the helper therapy principle, helping roles were found to confer greater meaning. This echoes qualitative research (Watson, 2019) which emphasises the reciprocal nature of the role. It also highlights the importance of appropriate organisational supports and investment in peer worker development in relation to job satisfaction.

At the microsystem or immediate work environment level, there are indications that perceived fit between the PSW's expectations and workplace community, workplace reward, workplace fairness, workplace values and role clarity are associated with facets of burnout. Organisational support, specifically the feeling of being valued as an individual and one's wellbeing being valued as well as organisational culture, recovery orientation, being able to use peer support skills and peer run organisations being associated with greater job satisfaction. This suggests again that the fit between PSW skills, training and the wider organisation is potentially of great importance. Contrastingly, Burke et al.'s (2018) finding of no significant differences in PSW personal recovery according to type of organisation, experience of receiving peer support and negative experiences working in a mental health team may indicate that PSW experiences are similar in health service and non-health service peer roles. Of note this is based on chi-square and t-test analyses from one study, which used a more stringent alpha level to determine significance than some studies included in this review ($p < .01$). Organisations should therefore consider how they embed a recovery approach and the principles of peer support at different levels of the organisation, such that it is clearly part of organisational culture.

Notably, significant associations with variables at the exo- and macro-system levels require further assessment to examine how the approach interacts with, is embedded and received at a higher organisational, policy, and social level and how this in turn affects PSWs and peers.

Limitations

The present review has several limitations. Key stakeholders were not included in the design or conduct of the review, as such key contextual or explanatory factors may have been missed. Grey literature was omitted which could add insight particularly around the experience of PSWs in charity, community or peer-run organisations. Included studies were primarily from the USA and UK with many parts of the world not being represented and it is therefore limited in its generalisability, especially with regard to countries with differing models of health care or understandings of mental health difficulties.

A broad range of primary outcomes of interest were included in the review that may overlap conceptually in the way that they are variously used in the included studies. As such, there may be a need to seek consensus across researchers in peer support roles to agree a common set of outcomes to measure PSW experiences of the effects of delivering peer work on PSWs. Given the exploratory nature of analyses in the selected studies, a decision was made to prioritise multivariate level analyses over bivariate analyses. This may mean that evidence from some higher quality studies has been given less weight than that from less rigorous studies which inappropriately conducted multivariate analyses without adequate sample size or power.

Finally, a limitation of the review was the use of the chosen critical appraisal tool. While the JBI Cross-Sectional Analytical Studies tool is a robust, rigorously developed and widely used tool for critical appraisal and synthesis of cross-sectional evidence to aid clinical decision-making in healthcare, it is designed primarily to assess studies of aetiology and risk and as such may not capture all possible sources of bias in the included studies, with sampling bias notably not being directly addressed in this tool but rather in the JBI prevalence studies tool. Further, the adaptation of the JBI tool to include follow-up questions for longitudinal studies was intended to allow for uniform comparison across papers, however this may have limited the analysis of the two longitudinal studies included in the review. We noted supplementary methodological limitations in this review drawing upon the AXIS tool, however this was not systematically applied.

Conclusions

Existing quantitative evidence on PSW personal recovery and wellbeing, stress and burnout and job satisfaction has high levels of heterogeneity, and lacks clarity around role definitions, peer work approaches, and essential contextual information. This along with the methodological issues mentioned make it difficult to draw meaningful conclusions about the impact of delivering peer work on peer workers themselves. The evidence base addressing PSW wellbeing and personal recovery requires to be expanded, with Gillard et al.'s (2022) study providing an example of how this might be achieved using mixed method longitudinal designs. Study designs that allow inference of causation or development of individuals, organisations and systems are currently lacking. Given that peer work roles are increasingly a core part of mental health provision, it is essential that we understand how peer workers experience this and how roles can be strengthened and developed in mental health services.

Nonetheless, there are some areas of relative clarity. Overall PSWs have good job satisfaction, with pay, training and progression all areas that could be worked on to improve this and potentially reduce rates of job turnover. Burnout levels among PSWs are comparable to or lower than those in the wider mental health workforce, suggesting that PSWs are not more susceptible to burnout than traditional mental health colleagues. These rates are significantly higher than general population norms and rates of burnout increase and job satisfaction appear to decrease the longer that PSWs are in their roles. It could therefore be hypothesised that factors within the design of mental health services themselves need to be considered to identify areas that could be modified in order to reduce burnout across all mental health workers. At an organisational level, workplace community, organisational culture, recovery orientation and being in true peer work roles are candidate areas for further research to establish which aspects might lead to lower emotional exhaustion and greater job satisfaction. Recovery models may play an important part in this, however it is clear from the evidence presented that while peer work roles are a vital part of the recovery approach, the introduction of such roles in otherwise unchanged services is not sufficient.

These findings have implications for wider mental health workforce wellbeing, an area currently being developed in Scotland through the Mental Health and Wellbeing Workforce Action Plan, 2023-2025 (The Scottish Goverment, 2023). Rather than centring on individual worker vulnerability, it is essential that routine service delivery takes place in organisational contexts and cultures that are conducive to workforce wellbeing as a whole.

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Chapter 2

A Message in a Bottle

A Grounded Theory Study of Peer Supported Development of Advance Statements

Prepared in accordance with the author requirements for
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Plain Language Summary

Background

Advance Statements allow a person with a serious mental health difficulty to record preferences for treatment in case they are unable to make decisions about their care in future. In Scotland, by law medical professionals must consider the preferences in an Advance Statement. However, very few people who might need an Advance Statement have one.

Research suggests that more people make and Advance Statement when they have individual help to complete it. Medical professionals are often unable to dedicate enough time to Advance Statements, so it has been suggested that peer workers may be well placed to provide this support, due to their first-hand experience of mental health difficulties and their skills in supporting relationships between patients and medical professionals. A fuller understanding of why and how peer support workers make it more possible for individuals to develop advance statements is needed. This study sought to learn from peer worker experience, and build theory to explain why and how peer support enables others to overcome the difficulties that people may otherwise face developing advance statements alone.

Methods

Peer workers with experience of supporting people with mental health difficulties, aged 18 or over and resident in Scotland were invited to participate via Twitter and peer support organisations. Participants who were in hospital or currently experiencing a mental health crisis could not participate. The study used constructivist grounded theory methods, which involved collecting and analysing data at the same time. This learning informs the next stage of the study and further data is gathered to test out any theories that are generated. Data was collected through individual online interviews with peer workers that lasted 60-90 minutes.

Main Findings and Conclusions

The study resulted in a map of the activities peer support workers engage in to support others to develop Advance Statements. The way peer workers helped people was characterised by three processes: Creating Safety; Balancing Power; and Transforming and Repurposing. Each of these processes rely on established peer work values. The study found that it was important to think about the work environment and how organisations might support peer workers to do this work. It concludes that this approach is important to ensure that people are supported to make decisions about their care and that it also applies to introducing peer support in mental health services more generally.

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Abstract

Advance Statements are an essential supported decision-making facility in mental health services, enacted when a person lacks capacity to make decisions about their care. Nonetheless, few people take advantage of them in practice. Peer supported facilitation has been identified as having potential to increase Advance Statement uptake by overcoming modifiable barriers to their development. Constructivist grounded theory analysis was used to explore how nine peer support workers approached Advance Statement development in Scotland. An activity map derived from the analysis is presented along with three themes that characterise the peer supported facilitation process: Creating Safety; Balancing Power; and Transforming and Repurposing. Recognising Advance Statement development as a complex intervention, context at the individual, organisation and macro level is integrated with these findings to create tentative theories about how peer support might increase uptake and the conditions that might influence this outcome. The study's findings have implications for the successful implementation of supported decision making and peer support roles across mental health services.

Background

If a person’s capacity to make informed decisions in their best interests is significantly impaired, the Mental Health (Care and Treatment) (Scotland) Act 2003 ("Mental Health Act 2003," 2003) allows treatment to be given without their consent under a compulsory treatment order or section. A review of the implementation of the United Nations Convention on the Rights of Persons with Disabilities 2006 (UNCRPD) in the United Kingdom (UK) (Committee on the Rights of Persons with Disabilities, 2017) raised concerns that UK legislation relies too heavily on substituted decision making and fails to fully recognise the rights of disabled people to individualised supported decision making to exercise their legal capacity (Article12(3))("UNCRPD," 2006). The Scottish Mental Health Law review (Scott, 2022), tasked with proposing how to better realise human rights in mental health legislation, names supported decision making as its “lynchpin” stating that “It should not be the case that the clinician’s view on what is best for the person receiving care and treatment is the most important factor”. In Scotland, the Advance Statement (AS) is one available supported decision-making tool, which allows a person, at a time when a professional considers them to have capacity to make informed choices, to state preferences and proscriptions for treatment in writing ("Mental Health Act 2003," 2003; Scottish Executive, 2005). If the person’s decision-making later becomes significantly impaired and they are treated under the Act, clinicians are legally required to consider the wishes in the statement and justify any decision to override these ("Mental Health Act 2003," 2003; Mental Welfare Commission, 2017b).

Advance statements have shown some promise in reducing the use of coercion into care. Two meta-analyses of randomised controlled trials (RCTs) have found that AS significantly reduced the risk of compulsory psychiatric admission (de Jong et al., 2016;

Molyneaux et al., 2019). De Jong et al. (2016) found that, of the four interventions their review identified which aim to reduce compulsory admission, only AS showed a significant effect. The pooled results of four RCTs found that AS reduced the risk by 23% (RR, 0.77; 95% CI, 0.60-0.98; I2 = 2.2%), whereas no reduction was seen for Community Treatment Orders, compliance enhancement, or integrated treatment. It has been noted that this potential for AS to reduce coercion in mental health services may be of particular benefit to Black, Asian and minority ethnic patients, given inequalities in involuntary admission rates (Ariyo et al., 2021; Babatunde et al., 2023; Jankovic et al., 2020). In their meta-analysis of five RCTs on crisis planning, Molyneaux et al. (2019) also found a 25% reduction in compulsory admissions for those receiving crisis planning interventions compared to those who did not (RR = 0.75, 95% CI 0.61-0.93, *P* = 0.008). However, there was no evidence that such interventions reduce voluntary admissions and they conclude that these results may be due to patients and clinicians being more willing to consider voluntary admission in the event of a crisis. It is also important to note that while some advance care planning processes explicitly include reflection on past illness and signs of possible relapse, others such as the Scottish Advance Statement need not do so and are only considered by clinicians if someone is deemed not to have capacity. As such, the mechanisms theorised to lead to reduced compulsory admissions may differ between advance care planning tools.

Examined individually, these RCTs paint a more nuanced picture, with no statistically significant reduction in compulsory admissions in three of the studies included in Molyneaux et al. (2019). Thornicroft et al. (2013) aimed to replicate findings from an earlier RCT with 160 participants (Henderson et al., 2004) which found that use of Joint Crisis Plans (JCPs) formulated by a patient, care coordinator, psychiatrist and project worker significantly reduced compulsory admissions over a 15 month period. Thornicroft et al. (2013) conducted a larger trial with 569 participants across 64 mental health teams and found no significant difference in admissions. An embedded qualitative study (Farrelly et al., 2015; Thornicroft et al., 2013) led the authors to conclude that mental health teams were not adequately prepared to deliver the intervention, and clinicians felt ambivalent about it. Staff did not dedicate time exclusively to developing the JCP, patients were unable to distinguish the JCP appointment from treatment as usual and JCPs were not adhered to in subsequent crises. Thornicroft et al. (2013) note that Henderson et al.'s (2004) trial had been conducted with clinicians who had a particular interest in JCPs whereas clinicians in routine practice may have been less engaged.

Many patients who are aware of advanced decision making tools generally support the principle (Braun et al., 2023; Mental Welfare Commission, 2017a) . However, despite strengthened legal and administrative processes introduced in the Mental Health (Scotland) Act 2015 ("Mental Health (Scotland) Act 2015," 2015), it is widely acknowledged that the current system does not function as intended (Scott, 2022). Uptake remains low, with only 706 individuals recorded as having an AS registered with the Mental Welfare Commission for Scotland (MWC) in February 2021 (Ross et al., 2021). The MWC reports that of the 4,721 people who received compulsory treatment in Scotland between 2017 and 2020, only 6.6% had an AS and of these 36.9% had their AS overridden. This suggests that the existence of AS in itself is not sufficient to allow a person to exercise their rights and further supports may be required.

Prior research into Advance Care Planning (ACP) has indicated candidate reasons for this disparity at different stages of development and enactment. Potential users of ACP may mistrust that their wishes will be acted on, be reluctant to revisit experiences of coercion into care, lack knowledge about AS (Foy et al., 2007), lack power to assert their wishes (Farrelly et al., 2016), have concerns about provoking resentment in staff (Amering et al., 2005), or differ in how active they wish to be in decisions about their treatment (Backlar et al., 2001;

Davidson et al., 2015; Mental Welfare Commission, 2019). Clinicians may feel ambivalent about AS, lack the time and knowledge to support their development, misjudge the patient's ability to take such decisions (Davidson et al., 2015), or prioritise risk management over patient wishes (Glasgow, 2020).

Most people require supports to complete an AS. Davidson et al. (2015) suggests that there is a considerable process from understanding to enacting supported decision making. This involves weighing risks and benefits, gathering resources and information, and a role shift to becoming a collaborative actor, in addition to the practical development of the document itself (Amering et al., 2005). Two systematic reviews, one looking at Psychiatric Advance Directives (PAD) from the patient perspective (Braun et al., 2023) and one considering PADs as complex multistage interventions (Nicaise et al., 2013) found indications that facilitated PADs may result in better outcomes in terms of uptake, completion and working alliance. A recent rapid evidence review suggested that completion rates improve with individual facilitation to 50-61% among interested participants (Jankovic et al., 2020). A Cochrane review comparing two randomised controlled trials also tentatively suggested an intensive intervention process developing a JCP was more beneficial, particularly in improving patient-clinician relationship, than a low intensity intervention (Campbell & Kisely, 2009).

It has been proposed that peer worker facilitation may tackle some of the determinants of the uptake and effectiveness of AS (Backlar et al., 2001; Lasalvia et al., 2023). There is some indication that, when properly supported, implementation of peer worker roles can lead to wider system change, with services taking a more respectful and collaborative approach to patient care (Bradstreet, 2006; McLean et al., 2009). Trusted relationships, role-modelling and acting as a bridge to engagement between communities and services have been identified as candidate mechanisms of change in peer work (Gillard et al., 2015). One study of a manualized peer facilitated PAD intervention in Assertive Community Treatment teams found that, in comparison with a clinician facilitated intervention, rates of PAD completion and PAD quality were not significantly different with 50% of the intent to treat sample completing a PAD (Easter et al., 2017). A companion paper to the study found that peer and clinician PADs were rated by an expert as similar in quality and feasibility, and peer facilitated PADS were more likely to be prescriptive than proscriptive (Belden et al., 2022). Tinland et al. (2022) conducted an RCT across sites in France which compared a Peer Worker Facilitated PAD intervention with controls who received information only. They found that at 12-month follow-up PAD completion was higher in the peer work intervention group (54.6%) than controls (7.1%). While there was no effect on overall rates of admission, there were significantly fewer compulsory admissions in the PW group (27%) than in the control group (39.9%) (risk difference -0.13, 95% CI -0.22 to -0.04, $P = .007$). The PW group also reported fewer symptoms, greater empowerment and higher recovery scores than controls. An economic evaluation of the study found the PW intervention was both more cost effective and less expensive than usual care (Loubière et al., 2023).

Between 2015 and 2016, Greater Glasgow Mental Health Network (GGMHN) piloted a Peer Promotion of Advance Statements project (Greater Glasgow Mental Health Network, 2016). The project recruited five peer support volunteers who delivered 33 AS drafting sessions, resulting in 15 completed AS. Those who made an AS reported feeling ‘empowered’ by the process, PSWs bridged the relationship between the peer and mental health professionals, addressing concerns about the process on both sides and creating a context for open dialogue. The project also informed the development of MWC resources on AS and engaged in outreach and awareness raising work with service users, carers, third sector organisations and mental health professionals with the aim of embedding AS as a local priority. Such a project implemented more widely could potentially increase uptake and effectiveness of AS. To date, however, there is no programme theory underpinning the proposed intervention, which relied significantly on individual worker expertise.

The number of modifiable, interacting components and possible outcomes involved in such an intervention categorise it as complex (Henderson et al., 2004; Nicaise et al., 2013; Thornicroft et al., 2013). Programme theory articulates the multiple elements, interactions and mechanisms of an intervention, creating a shared model for stakeholders of how the intervention leads to intended or unintended outcomes and under what circumstances (Skivington et al., 2021). Examining how existing evidence and theory fit within delivery context may increase intervention success, reduce unintended harm and decrease research wastage, as well as providing insight into the feasibility of delivering the intervention in other contexts (Bleijenberg et al., 2018). Effective evaluations can then be designed to test theorised mechanisms of change, which in turn leads to the updating of the programme theory and refining of the intervention (Skivington et al., 2021)

Study aims

Influenced by human rights based approaches to and questions of social justice in healthcare, the study aimed to construct a grounded theory of peer support to enhance uptake of AS. The overarching area of inquiry considered how peer support workers in Scotland address identified barriers as they support service users to enact their human rights through the development of AS, focusing on:

i. The key components of a peer support intervention around the development of AS.
ii. The mechanisms theorised to lead to increased likelihood of developing an AS.

iii. The key features of the context this peer support is delivered in and how they impact on the AS development process.

iv. The impact of the peer support intervention on the context in which it is delivered.

Method

Design

The study used a constructivist grounded theory methodology (Charmaz, 2014). Starting from the above broad area of inquiry, the research took a retrospective interview approach. Charmaz situates constructivist grounded theory within a pragmatist tradition, sharing a commitment to social justice as enacted process and an interest in how people solve problems in daily life (Charmaz, 2017). Data are understood to be co-constructed by participants and researchers (Thornberg, 2012). This approach locates the research and researcher in historical, social and structural context and explicitly considers the power and collective ideology which underpins the analysis (Charmaz, 2017). Constructivist grounded theory therefore provides an appropriate lens to address the process of enacting AS in context and to generate new theory with explanatory power (Urquhart, 2019).

Sampling and recruitment

As grounded theory samples the phenomenon of interest (Morse & Clark, 2019), purposive sampling was used to recruit participants based in Scotland with experience of offering peer supported ACP to people with mental health difficulties. Experience of developing AS was not required. Excluded from participation in the study were those under 18, not resident in Scotland, currently experiencing a mental health crisis, or not currently living in the community. Those seen by the researcher in a clinical capacity were not invited to take part due to the risk of perceived obligation to participate.

Consistent with theoretical sampling, a provisional lower and upper limit of 6-12 participants was proposed (Braun & Clarke, 2021) drawing on Malterud's principle of information power (Malterud et al., 2016) and pragmatic considerations of available researcher time for the project. Information power is proposed as an alternative to theoretical saturation and suggests that sample size is determined according to the quality of data gathered, the specificity of the sample, the applicability of established theory, the breadth of the study aim and the desired generalisability of cases.

Participants were recruited through Twitter and relevant Third Sector Organisations to reach participants with a broad range of contexts and experiences. Most participants reviewed study documents, provided initial consent to participate, and gave personal details and accessibility requirements online using Qualtrics. One participant reviewed information and gave consent via video call using an interpreter. Participants were contacted via email or text message to arrange an interview and had the opportunity to ask questions. Consent was reviewed at the start of each interview. Participants were reimbursed according to NIHR guidelines (National Institute for Health and Care Research, 2022) at a rate of £25 per interview which was delivered by bank transfer or voucher according to participant preference. Participants were able to decline reimbursement and participate on a voluntary basis.

Participants

Eleven participants were recruited. Two left the study prior to interview, one due to ill health and another who no longer wished to be interviewed. A decision was taken to limit the personal data reported for each participant due to purposive sampling focusing on participant experience in advance care planning rather than aiming for representative sampling. Participant PSW experience is outlined in table 1 below.

Table 1

Participant PSW Experience

Variable		n = 9
PSW role type	Paid	8
	Unpaid	0
	Both	1
	Missing	0
Years' experience as PSW	0-2	2
	3-5	3
	6-9	3
	10+	0
	Missing	1

Procedure

The primary data generated was intensive interview data. Intensive interviewing (Charmaz, 2014, p. 56-8) allows for the in-depth exploration of participants' perspectives, interpretations and first-hand experiences of routine activities. In order to achieve this, open questions were used and unanticipated areas of inquiry or implicit views were followed up within interviews, encouraging participants to do most of the talking. An interview guide (Appendix 8) was developed with broad open questions, key topic areas, and possible prompts (Charmaz , 2006, p. 26). The guide explicitly allowed for flexibility as the theory developed and the possibility of participants guiding the direction of the conversation (Birks & Mills, 2015, p.57). Interviews lasted 60-90 minutes and took place online via Microsoft Teams, with one participant using an interpreter. Interviews were recorded and auto transcribed using Microsoft Teams software and corrected in Microsoft Word. Participants were allocated a unique identifier and identifying information removed. Transcripts were coded by hand and codes and memos developed using Microsoft Notebooks. As interviews and coding progressed, theoretical sampling was used as part of an iterative process of analysis to purposefully select participants to provide contradictory or confirmatory data following theory development (Morse & Clark, 2019). These decisions were taken in discussion with the Chief Investigator.

Analysis

Guided by a constructivist grounded theory approach, analysis was abductive and iterative (Birks & Mills, 2015; Charmaz, 2017). Grounded theory analysis privileges the experience of participants but is informed by the researcher's prior knowledge, existing theory and research (Thornberg, 2012). Memo writing and regular research supervision during this process allowed the researchers' context, power structures and ideology to be scrutinised as they shaped their findings (Charmaz, 2017). Discussions following interviews informed the approach and areas of inquiry of future interviews. Each interview was coded line-by-line using gerunds, a memo was then written for each participant and discussed moving towards focussed coding. Constant comparison was used in categorizing data, with memos and diagramming employed to capture and expand on patterns researchers identified in the data. Theoretical sampling was used to identify interviews that might confirm or disconfirm emerging theories.

Ethical approval

Ethical approval (ref. 200210208) was granted by the University of Glasgow College of Medical, Veterinary & Life Sciences ethics committee.

Transparency and reflexivity

The principal investigator is a doctoral researcher and Trainee Clinical Psychologist employed by an NHS health board. They were previously a support worker in a third sector organisation and have an interest in human rights. The researchers anticipated that the clinical role might create a difficult power dynamic for some participants that might inhibit their responses, particularly those who may have previously been subject to compulsory care. Following interviews the researchers discussed their positionality. The interviewer was aware of being initiated through clinical training and practice to viewing mental health difficulties through the lens of the medical model and reflected on an assumption that as a researcher there was a professional requirement to remain neutral in interviews. This assumption of neutrality runs in direct opposition to the Constructivist Grounded Theory stance. The interviewer reflected on the experience of interviews with experienced PSWs skilled at managing power imbalances and promoting equality and mutuality and the feeling of being initiated into this approach. As interviews went on, the interviewer adopted a more conversational stance of "showing their workings", sharing more about their motivation and wondering aloud with interviewees about areas of uncertainty or contrast. In so doing it was hoped to be more transparent in the construction of meaning and to create space for participants to modify or disagree with what the interviewer was interpreting from their encounter.

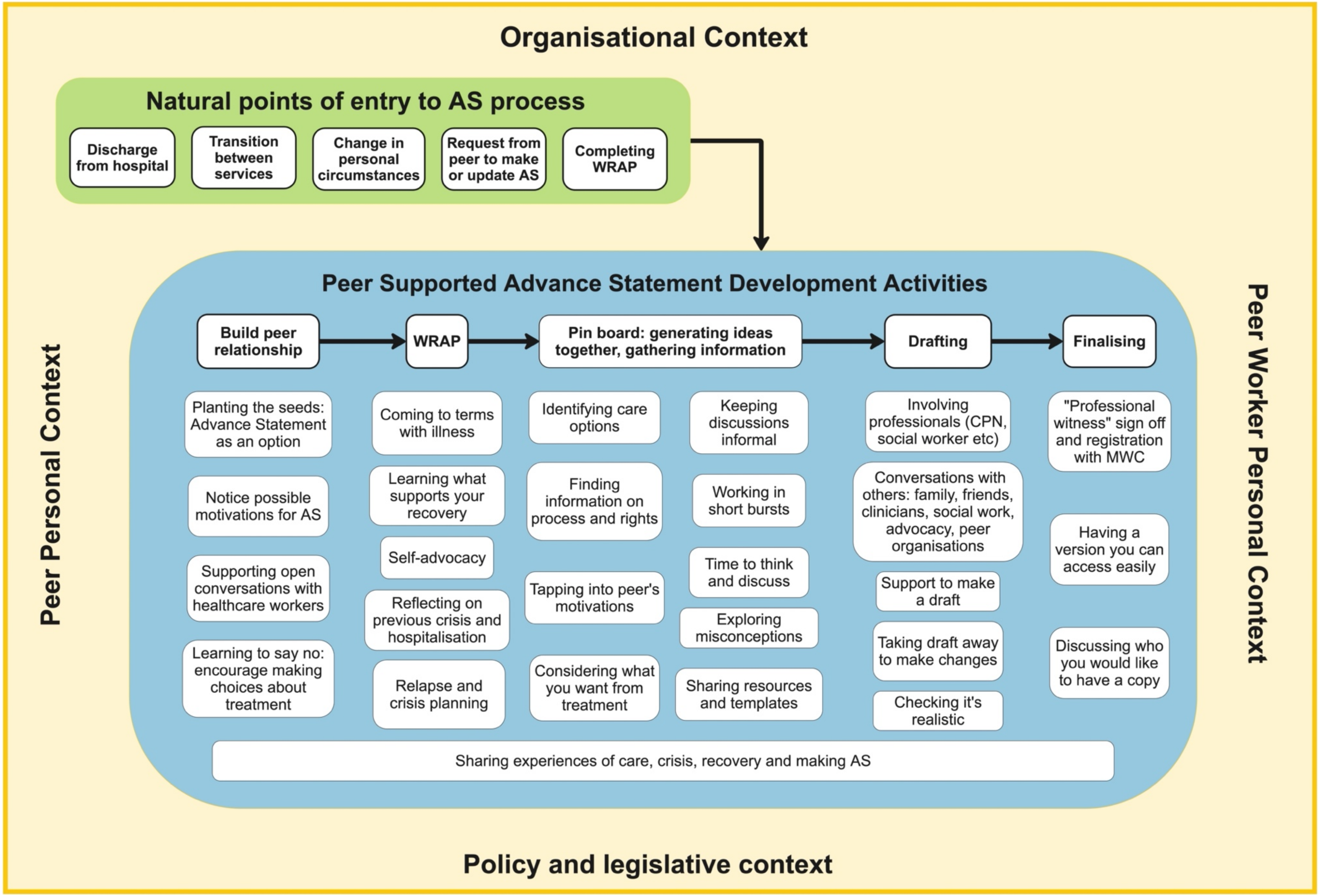
Results

An activity map is presented in figure 1 and described below. This outlines the key practical components, processes and contexts participants reported to be part of peer supported AS development. This is primarily descriptive in nature, drawing on informational data from all participants. Given the nature of the data described, direct quotations are not routinely provided. The results of theoretical analysis are then presented below.

Activity Mapping

Participants described a range of activities and processes they engaged in with peers. None described this as a service-driven or structured intervention. Their levels of involvement ranged from signposting to other workers or agencies, to working with peers to develop or revise AS. Development was tailored to the needs and motivations of the individuals, the PSW's own level of experience with AS, and the contexts of the services and local area they were within.

Figure 1 Activity Mapping Diagram



Points of entry

Points of entry into the development or revision of an AS were times of change or transition. These included discharge from hospital, transitions between services, changes in personal circumstances such as pregnancy, or changes around symptoms, diagnosis, or treatment.

Timing

In addition to the requirement for peers to have capacity to complete the AS, participants thought about their readiness to do so. Several participants felt that it was beneficial for peers to complete the Wellness Recovery Action Plan (WRAP) prior to completing an AS. Participants felt it important that someone was able to come to terms with having been unwell, to learn what supports their recovery and communication, and to reflect on previous crises. Additionally, participants spoke about recovery needs that peers would prioritise above the AS. Several participants mentioned the necessity of building a peer relationship prior to AS development. Equally, PSWs cautioned against waiting so long that the AS had to be rushed prior to discharge from a service, or the opportunity of completing the AS with a trusted professional was missed.

Participants reported that it was helpful for peers to receive information about creating AS early in their care, however many saw little evidence of AS being used or promoted. If PSWs were not directly approached by peers for support or information around AS, some participants said they would suggest it when they noticed a particular motivation or need that could be met through an AS. Some PSWs also explored peers’ misconceptions and misgivings around AS.

Completing the Advance Statement

When ready, PSWs shared information and resources for discussion, as well as examples from their own AS where they had one. One participant described this being like a "post-it board" (Participant 2), generating ideas together. PSWs explored what peers want from their treatment, what their options might be, and who else they wanted to involve. Participants referred to existing pieces of work completed during recovery, such as the WRAP, to complete the AS. They also drew on their existing knowledge of the person, being able to remember things that they had enjoyed or mentioned as useful in the past, as well as information gained through Multidisciplinary Team discussions or less formal discussions with colleagues. Participants described making AS more approachable by using informal settings where possible, being engaged in another activity such as getting a coffee, and working in short bursts over several sessions. Participants made time for people to reflect or make changes to drafts between meetings.

Involving others

PSWs varied in their level of involvement in AS development. Several mentioned other organisations such as independent advocacy or a third sector organisation known to have expertise in this area. Some attended appointments alongside peers to support them to access these services. One participant said the key consideration for them was the relationship the peer had with the worker who completed the AS, it was sometimes more appropriate for the peer to work on the AS with a key worker or social worker they had a good relationship with. Others involved the professional witness to the AS, a requirement for registration with the Mental Welfare Commission (MWC). One participant involved this person early in discussions to facilitate finalising the document. This included social workers, key workers, and psychiatrists. Either the peer wrote the AS themselves, or PSWs or another professional wrote a draft for the peer to take away and amend. Depending on their context

PSWs reported different experiences of gaining input from professionals, with some reporting this to be easy and others finding it extremely difficult to get AS prioritised due to the urgency and level of risk involved in the professional witness' routine work.

Peer Supported Advance Statements in context

A contrast was noted in how comfortable PSWs were in completing AS and whether it was a priority for participants. Features in the context of the intervention impacted on this, particularly PSW perceptions of how valued AS were in their place of work. A lack of visibility of AS caused anxiety about how they might be received by senior clinicians, and reinforced the perception that AS might not be respected. Some participants noted that no training on AS was provided, while training on other topics was promoted or compulsory. They commented that AS were not visible in clinical record keeping systems, spoken about by staff, or asked about at hospital admission. Participants referred to their own experiences of care, having not been asked about or provided with information about AS. Conversely, several peers mentioned training or talks they had valued from the Mental Welfare Commission and GGMHN, which explained AS, provided examples, and advised how to improve the quality of AS. Such training appeared to increase participants' confidence in supporting others with AS.

Through and in addition to the activities described above, PSWs created the conditions they perceived as facilitative for peers to develop AS in different contexts, while preserving peer values and relationships. These processes and the contexts that influence them are explored in more depth under the themes and subthemes outlined in table 2 and described below.

Table 2

Themes and subthemes

Theme	Subthemes
Creating Safety	
Balancing Power	Advance Statement as an empowerment tool
Transforming and Repurposing	A Message in a Bottle Translating Flexibility

Creating Safety

A guiding principle in PSWs approach to supporting development of AS is creating psychological safety. While there was often a perceived long-term benefit to having an AS, there were also costs involved for the peer. In particular, this involved an awareness that to create an AS, peers were required both to think back to and reflect on what were potentially extremely difficult experiences of illness and treatment, and to tolerate the possibility that this could happen again in the future:

> *But that crisis stuff is actually really important for learning, and that's why if I'm working with somebody, I would make sure that they are in the right place to do it. You know, you know, if we need to take a break and things, we'll take a break and things. And if they can do the first part of WRAP but not the crisis part, then they may not be ready to do things like make an advance statement because you need to be able to process some of that hurt and pain to know what will be helpful for avoiding that again. (Participant 3)*

While the empowerment potential of AS resonated strongly with participants, this part of the process was more challenging and at times felt to clash with PSWs usual way of working which focussed primarily on the present moment and on hope:

> *I think as well some people are quite easily triggered thinking back to how things were when they were in hospital. And I think sometimes it puts them in a weird position of having to think about times when they were restrained or IMed or whatever, which aren't really things that … those are topics of conversation that I try not get people to focus on (Yeah, exactly) usually. (Participant 5)*

Some participants spoke about being approached by a clinician to do an AS creating a sense that they expected you to become unwell again, compared to completing an AS with a peer as a tool that can be used if the need should arise. The PSW approach found ways to support people to tolerate the possibility of becoming unwell again in future. One PSW spoke about how they might do this in a way that embodied peer values:

> *Um I I suppose it really sort of obvious example might be like symptoms versus experiences. (Mm-hmm.) That's probably fairly that's probably a fairly natural one. And and and I suppose… Umm... I suppose another part is about sort of attribution or bias. (Mm-hmm.) Um… so for, for, for example. Umm… If if somebody has um, I don't know, if, if somebody maybe has, like you know, a recurring episode of psychosis or something like that, am I attributing it to the previous diagnosis or am I attributing it to the sort of the the bigger picture of you know what, what was going on in their life at the time and what what was going on in their life in the, you know, six months to a year that led up to it, that might have been stressful?*
>
> *(Yeah. OK. That makes a lot of sense. So it it changes the starting point that you're coming from almost when you're talking to somebody?)*
>
> *Yeah. Yeah, it does. Yeah. Yeah. And, and I I think, I think as well it changes a little bit the the degree of ... I hate to use the word inevitability, but yeah... What's a better word? It's not inevitable, but the… degree of power and influence that somebody has to stay well.*
>
> *(Mmm. Yeah, absolutely. So having that wider context.)*
>
> *Yeah, it's a bit more hopeful, I think! For want of a better word. (Participant 2)*

PSWs were able to provide containment through this process by sharing their own AS where relevant, or modelling their ability to tolerate the possibility that, while they did not expect to, they could also become unwell again in future. Participants found that by sharing some of the things they had found most difficult in past periods of hospitalization, they allowed people to speak openly about their own experiences without fear of consequences or being judged:

> *Um so I think like creating that sort of space where you know you're not gonna be judged is really easy to do when you're a person who also has lots of things that they've done that could have been heavily judged and you can kinda talk about those things and be like, " I did this and that was wild." And then people are like, "Well, I did this and that was wild!" Like, that actually could be quite important information… (Participant 5)*

This was also a reason that most PSWs felt it important that the AS was completed in the context of an existing peer relationship, as trust made it easier for people to disclose more difficult information. This was also important in the context of using a trusted sign language interpreter to help the individual to relax:

> *And again, that's part of the communication as well, because your interpreter that works well with you, that you, you're confident in their ability to interpret for you, you relax and you're able to express more. If you're uptight, you don't know the interpreter's getting you, you don't know, you're getting, you have to explain so much more. You have to work so much harder. So I think for part of an advance statement that's imperative that they use the interpreter of choice that they have that rapport, trust in that interpreter to know that they can actually relax enough. (Participant 4)*

The importance of trust was placed not only in the peer relationship but in the responsibility PSWs felt to ensure that AS did not create false expectations for treatment:

> *And what I don't want is the, you know advance statements to become these tools where things are contested and trust breaks down because they've said things that are completely unrealistic. Mind you, they probably the capacity assessment would pick that up, but even then, um, that risks conflict between the patient and their team because they wouldn't sign off. (Participant 3)*

Peers recognized that even considering AS could be overwhelming and difficult for some people due to the current impact of mental health difficulties making it challenging to consider more than the present moment. PSWs described preparing people by acknowledging the difficulty of the conversation, offering breaks, and making time after work on the AS to talk about something lighter. One PSW explained that practically they had found that peers were more likely to manage to complete the AS when it was spread in small chunks over several sessions in the course of their routine work. It was also notable that AS were seen as a way of reducing someone's sense of uncertainty about the future and giving a greater sense of control:

> *And I think it makes you feel a little bit more in control (yeah), especially when you know when your mental health takes a turn, everything does feel so out of control. At least you can go, "Right, I know if that happens again, I've got that one thing which I have had control of and that should be, um yeah, taken care of." (Participant 8).*

This was evident in PSWs emphasizing that the peer should be able to easily access their AS themselves should they need it, including in an appropriate translation where required, rather than relying on it being easily available in clinical systems: "That's just one example of the barriers within the language itself, and to make sure that we have that appropriate translation in place that we can provide at that crucial moment." (Participant 4)

Balancing Power

Throughout the interviews participants described their perceptions of power and the ways that it is organized hierarchically in the medical system. Hospitals viewed as organized "more like an army" (Participant 7) with strict discipline, making it difficult for people to connect as humans. Both patients and staff were described as feeling unable to challenge doctors, not necessarily because of the attitude of the doctor themselves but from a perspective of "Doctor's right," (Participant 1) felt to be a hangover from the old system of asylums still pervading services. This imbalance in power was perceived to affect patient relationships with clinicians, acting as a barrier to supported decision making. As one participant put it:

> *Erm, I think sometimes the whole power dynamic, and it still goes back to this whole thing you know, "They could lock me up, if I say the slightest thing. They could have me put away." And it's like, "Well, actually, no they can't. It's not that easy to do that." Erm. And that kind of stuff. Erm, I think that, not having that threat, not having that power dynamic helps. (Participant 1)*

PSWs perceived themselves as able to have a more open and balanced conversation with peers around what they would like from their care, as well as gently challenging people's perceptions around how they are expected to interact with clinicians.

Advance Statement as an empowerment tool

Some peer support workers viewed the development of AS as a process of empowerment, rather than an outcome. Through the process of experiencing an equal relationship and having open discussions, the peer is invited to become aware of the things they want and to recognise their agency by harnessing their existing power and engaging in more open conversations with professionals. In this way, PSWs bridge the gap between the rights that someone has available to them in the system and the person's ability to avail themselves of these rights.

To do this PSWs must challenge the perception that "It's the clinician that has the, em, knowledge and experience. Umm… And we should therefore listen, and do what we're told." (Participant 1). PSWs recognised the difficulties peers might have in engaging in an equal conversation with their doctor or clinician about treatment: "They don't think I can say, yeah, I can…I can choose like well maybe I don't want this treatment. Maybe I don't want, maybe I don't want things to do in this way" (Participant 7). Equally, PSWs supported people to overcome barriers to expressing their wishes that may come from past life experiences where they have not been able to safely have a voice, or the impact of the illness itself meaning that thinking about one's own needs might be a trigger for self-critical thoughts.

In this sense, the process of developing an advance statement is perceived by some as beneficial in engaging in treatment decisions, regardless of the final outcome:

> *Em, but also so that people can see that they have a choice and they don't just have to have things done to them. It's very much an empowerment tool. And it doesn't always result in people going on and developing an advance statement…erm…but it plants the seeds and it gets that idea that, "You know what, I've got choice here." (Participant 1)*

One peer support worker felt that this process of crisis and care planning also gave the peer and themselves a sense of control over the person's illness, "So it it does feel quite empowering for us both to kinda go "We can do something here. Like don't worry about if you become unwell again." (Participant 6).

Two people mentioned working in contexts where AS were valued and enquired about, meaning that PSWs felt their work in supporting their development and driving innovation in this area was also valued. By contrast, other PSWs described conditions that made them less confident about supporting peers to develop an AS. For some this came down to AS not appearing to be valued in the system they worked in:

> *Like all these types of courses, things like on Learn Pro. Do you see one of the advance statements? I don't think so! Do you ever get emails out to go "Come learn about advance statements?" No. Right, so, that then makes me think these advance statements are a waste of time like. (Yeah.) It doesn't add to my confidence in them at all." (Participant 6)*

While some PSWs felt that encouraging patient rights could be seen as "rocking the boat" or "putting your head above the parapet" (Participant 9). Indirect communication shaped PSWs perceptions that AS might be unwelcome, for instance overhearing how colleagues spoke about their patients, or did not engage with peer work services:

> *There is kind of, not a level of contempt, but, but there is a wee bit of kinda, not suspicious, but something like that where they sort of keep you at a bit of a distance. But then again, I do hear them interacting with their patients on the phone and I… well... they keep, they have a bit of contempt for them. So I'm just sort of like someone that they would consider another service user or a patient, you know. (Participant 9)*

This led to some participants feeling that discussing or promoting patient rights could potentially jeopardise their relationship with colleagues and appear that they were questioning their expertise or undermining relationships between clinicians and patients. Importantly, PSWs occupy both the patient and the provider position and some participants felt less confident about whether peers developing AS might be seen as problematic by clinicians and impact negatively on their care:

> *And you do wonder as well, like, you know, obviously I've been a patient myself, so you wonder, what do the professionals think about advance statements? So if I... what if I was to raise that with my psychiatrist, let's say, if a patient was thinking that way? What are they going to say? Are they going to laugh it off? Are they going to think that I'm going to be problematic for them? Do they give it any sort of credibility? Is it going to be a problem, that kind of thing? (Participant 9)*

While ambivalence remained around whether AS would be enacted in practice, several participants felt that a comprehensive or meaningful AS, combined with other tools like the WRAP, made it more likely overall that a person's wishes would be acted on, or a better informed decision about their treatment would be taken on their behalf. Participants were often guided by a clear vision that they wanted to make use of the difficult experiences that they had had to support others, driven by both the positive and negative experiences of care they had experienced themselves. As one participant put it, "We were like, "Hey, this actually really didn't work for us and was terrible." So there is also a kind of faction who were like "We're gonna, you know, overhaul it from within."" (Participant 5)

Transforming and repurposing

Participants varied in the extent to which they perceived AS as likely to be useful or respected in relation to its explicit purpose of stating wishes for treatment under the circumstances of compulsory admission. Some who had less trust that AS would be respected by professionals were less likely to encourage peers to invest time in developing an AS:

> *So I think, I feel like it doesn't hold much… (Yeah.) much grounds. Although doctors are supposed to consider it, a lot of them are... I'm gonna say so institutionalised that they know what's right. They know what's best. That worked for that person, therefore, it doesn't matter what that statement says, this is going to work for this person too, and that's that. (Yeah.) Like the decision's made before the person's even in the bed, that kind of thing. (Participant 6)*

Other PSWs found ways to transform or repurpose the AS to make it more accessible or useful to the peers they work with.

A Message in a Bottle

Participants spoke about using the AS to communicate things they felt were most important for an unknown clinician to know for them to make the best possible decisions about someone's treatment and create the conditions for their recovery. As one participant put it:

> *I sometimes think of it as a little bit like a… a message in a bottle. You don't necessarily know the person that's gonna pick it up. So… So… So, sometimes you have to, you have to sort of, umm… you have to think to tell… people like really obvious things. (Participant 2)*

Routinely, participants placed their focus on the accompanying personal statement rather than the AS itself to provide information about the person as an individual, seen as vital to supported decision making:

> *And the power of a personal statement as well because you know I I really, from my own experience, feel that, you know, if a clinician doesn't know you, if they've got nothing to go on, they may well make decisions that they wouldn't have made had they got a bit more context about, you know, who you are and what your baseline is and what you like to do. (Participant 3)*

Participants acknowledged a difference between the medical focus of the AS and the things that they perceive to matter when they think about being hospitalised:

> *But for me it was really important that I was breastfeeding because some… for me it was the one thing that was keeping me alive, it… you know what I mean? So I was like, "it's really important that I do this and if there's medication that I can have while I'm breastfeeding then that is really important to me." And fair enough if it comes down to the point that the medication is not working for me and I have to go on to something else, then that's the option I have to take. But this is the first thing that I expressed that I want, that if it's safe then that's what I want. And so, yeah, so that's something that's in my advance statement that's really important for me." (Participant 8)*

In this way, the thread of the recovery perspective, as distinct from an absence of symptoms, runs through the PSW approach to the AS:

> *And so, I really like the approach. The approach of seeing the person as a whole. (Yeah.) Um and the meaning of… of recovery like that… so I… I like the recovery is not only through medication but involves more things. Yes, seeing the person as a whole in different aspects and… and how recovery, sometimes, it could mean not that you are totally like physically, maybe you're still experiencing the symptoms but how, despite of the symptoms, you kind of still have a meaningful life. So, I really like that aspect of the practical things, like how you can be in life experiencing mental health difficulties" (Participant 7)*

Participants widened the medical focus of treatment: "Em, a lot of people don't realise that it's not just medication or ECT that you can put in them that actually you can request all sorts of different therapeutic treatments because treatment, they don't realize what treatment means under the Mental Health Act. " (Participant 3) They also considered important practicalities such as communication needs, or example setting preferences for who to speak to if a person is unable to verbalise how they are feeling, thinking about how someone with autism might prefer to receive written information, or the importance of providing a trusted interpreter.

Translating

PSWs spoke about bridging a gap between the formal language used by medical and legislative systems and the day-to-day language peers would naturally use to describe their experiences. “We have a medical sign that's been there. It's been explained this is schizophrenic. But for deaf people, they don't understand that's what this means. They understand that they have their ghosts or that they have their friends, you know, up there. It's so difficult and complex." (Participant 4). In so doing, PSWs translate jargon-heavy information, through their own experience, into colloquial language that can be more easily related to peers’ own experience. In turn, through the AS, PSWs engage in a process of translation to render peers’ wishes more likely to be accepted by the medical system as rational and treatment compliant:

> *And so, yeah, I think the more you can get people to actually verbalise what it is they need out of treatment, and the more that you can get them to do that in a way that's not gonna be perceived as, like, treatment resistant or those kind of like “ohh you just don't like the system, so we're not gonna listen to you” kind of vibe. I… I think the more that you can do that in, like, a… a measured, formal way when people are well, the better chance you have of it being listened to further down the line if people are less well. (Participant 5)*

One person described this as being like a ‘negotiator’. By creating a space that people can ‘vent’ in their own words, they allow the peer to open up in a way they would not be able to with their clinician. The PSW then has “the tricky way of trying to phrase it in a way that isn't offensive, to put it across.” (Participant 1).

In the wider system, PSWs resisted the way that people with mental health difficulties are spoken about by others by coming from the perspective of a shared identity, and refocused on people's strengths. This resistance was clear in the language participants chose to describe peers, refusing to collude with the language used in the medical system and focusing on the experience of the person themselves:

> *And they're all people that I visit out in the community, apart from some of them are kind of frequent… What everyone else would describe as 'revolving door' patients, but I'm not gonna do that [laughs]. So I also see people on the ward when they need to be. (Participant 5)*

Flexibility

Peers contrasted the way that they approached the AS with those of non-peer colleagues:

> *The official stuff, there's like hundreds of pages of just kind of bumpf about like "we don't have to take this into account, but we will try, and…." But that's that's stuff I've not found very useful to just, like, hand people. Cause I did an advance statement with a key worker once where they just took, like, that and, like, all of those pieces of paper and were like, "Right, today we're gonna dedicate an hour to going through this." And I was like, "I would say no to that and I work on the team. (Participant 5)*

Rather than a single, paper-based exercise, many PSWs gradually introduced the AS conversationally over a period of time. The ability to work slowly and patiently with people to build a relationship over a flexible period was seen as a privilege and a vital resource it was recognised many medical professionals did not have available to them:

> *You know, I've even, you know will take them to the shops and chat with them on the way to the shops and, you know, if I initially get a, "Oh, I'm not so sure about that." I might give it time and then revisit it, but I've got the time and the patience to be able*

> *to do that, (Yeah.) whereas you know some of the other staff, they're much more pushed if a patient doesn't say yes in a in a single session. (Participant 3)*

This flexibility around timeframes meant that PSW interventions were driven by the pace and needs of the person, rather than fitting what could be done into a timeframe that prioritized system demands. Repurposing existing work that had been done during someone's recovery, including the WRAP, staying well in psychology, and interest checklists in occupational therapy reduced the burden on the person to write a statement from scratch. There was recognition that drafting a meaningful AS is an iterative process, with peers given time and space to make changes to drafts, to speak to other people about it, and to reflect on other things they may wish to include.

Discussion

This study aimed to understand how peer support workers in Scotland address identified barriers in their support of others developing AS. Intensive interviews with participants with a range of different levels of experience of advance care planning and AS, both personally and as peer workers in a variety of settings, provide previously unavailable information from the peer worker perspective on how AS are developed and the factors that influence this in their routine practice. These accounts inform our understanding of how, why and under what circumstances peer involvement might increase uptake of AS in Scotland.

Using grounded theory methodology an activity map was created, and three key processes were identified that characterise peer workers' approach to supporting the development of AS: Creating Safety; Balancing Power; and Transforming and Repurposing. Each of these processes are underpinned by established peer work values that influence way that peer workers approach advance statement development. Peer workers use their skills in supporting others to recognise and "harness" their own power and agency, focussing on AS as a hopeful process rather than suggesting that relapse is inevitable, identifying what would be meaningful motivation for peers to consider developing an AS, using the peer relationship to build trust and psychological safety, sharing their own experiences to destigmatise, and modelling tolerating the possibility of a future compulsory admission while in recovery.

Each of these activities and processes are influenced by contexts that determine whether a peer work intervention might increase uptake of AS. Using Ebenso and colleagues' (Ebenso et al., 2019) approach to integrating context, these can be understood to influence mechanisms of change and in turn affect project outcomes at the individual, organisation and macro levels. Based on the findings of the study we can create tentative theories about how PSWs might increase the uptake of AS and the conditions that might influence this.

An example of this process is shown in the context, mechanism, outcome matrix displayed in table 3.

Table 3
Example Context, Mechanism, Outcome Matrix

	Contexts	Mechanisms	Outcomes
Individual level	Peers fear relapse and avoid planning for it	PSWs provide containment, model tolerating this fear and approaching AS as a safety net	Peers are better able to tolerate completing AS
		Peers are given multiple opportunities to complete AS when they are ready to do so	Peers do not miss opportunity to complete AS with support
		PSWs understand personal costs of developing AS as well as potential benefits	PSWs have realistic conversations with peers and address ambivalence. PSWs offer ways to make AS development more manageable.
	Peers feel fear or shame around past episodes of illness and avoid recalling them	PSWs share their own experiences and destigmatise periods of illness	Peers are able to reflect on past periods of illness and consider what they would want in future
		Completion of WRAP when ready allows peers to make sense of this	Peers know what supports their recovery and make high quality AS
	Some peers are not convinced AS are useful or effective	PSWs add credibility to the AS process using experience	Peers feel creating an AS is worthwhile
		PSWs tap into individual motivations for the completion of AS	Peers are motivated to complete AS
	Some PSWs do not feel confident completing AS	Appropriate training and supervision is provided	PSWs are confident in their knowledge and know who to turn to with questions.
		PSWs have access to other PSWs to share knowledge, expertise and problem solve	PSWs are less isolated and more confident in overcoming barriers to AS development.
	Some PSWs are not convinced AS are effective	PSWs see AS being appropriately enacted in routine practice	PSWs are more likely to initiate AS development

Table 3

Example Context, Mechanism, Outcome Matrix

	Contexts	Mechanisms	Outcomes
Individual level [Contd.]	Peers are daunted by making an AS	PSWs provide information and collaboratively generate ideas based on their knowledge of the person	AS development is appropriately scaffolded and more manageable leading to higher rates of completion
		PSW discusses AS in a casual setting and/or while engaging in another activity.	
	Peer motivation and cognition may be affected by illness	PSW facilitate using existing work	
		PSW provides options for support to draft AS	
		PSW structures AS development in short bursts across multiple sessions.	
	PSW negative experience of interactions with clinicians make them less certain AS will be welcome or respected	PSWs are respected and valued in/by clinical teams and have good relationships	PSWs more confident in encouraging AS development

	Contexts	Mechanisms	Outcomes
Organisation level	Overstretched healthcare professionals prioritise risk over AS making it difficult to access professional witnesses or advice	PSWs have more time to develop and prioritise AS and act as a bridge to professionals	Peers receive the support they require to complete AS
	Staff are not confident developing or enacting AS	Training on AS is embedded at every level	All staff understand AS, and are more likely to use them appropriately. PSW feel confident supporting AS development.
	As are not spoken about or promoted in NHS services	Managers take responsibility for routinely enquiring about AS	PSW are confident AS are a valued priority for all staff
	Organisation has a culture of valuing patient voices	AS are more likely to be valued and appropriately considered where enacted	PSW feel confident that AS development will be well received and feel safe in supporting peers to do so.
	Organisation is recovery focussed and values peer work	PSWs experience positive relationships with clinical staff and can access clinician input for AS where required.	PSWs are confident peers have received appropriate advice on AS. AS are more likely to be clinically appropriate. AS can be appropriately witnessed when completed.
Macro level	Mental Welfare Commission monitor promotion, update and overrides of AS	Mental health service staff are held accountable for appropriate use of AS.	This information is acted on within services. PSW confidence in AS is increased.
	Mental Health Law Review Findings are acted upon	Supported decision making is viewed as essential	AS are the norm where a person's ability to make decisions about care is significantly impaired.
	Scottish Government Mental Health and Wellbeing Strategy	The value of peer support is championed across mental health services. PSW job security is improved.	PSWs are available to support peers to develop AS. Valuable PSW knowledge is not lost to role turnover.

The CMO matrix demonstrates how the skilful work done by PSWs in creating the conditions for peers to successfully develop AS is dependent on contextual factors at the individual, organisational and macro levels based on data collected from the PSW perspective.

Several issues raised by PSWs in this study reflect findings from Gumley et al. (2021) Foucauldian Discourse Analysis of interviews with Mental Health Staff in a Scottish Health Board. Power is similarly experienced in a health system with a clearly delineated hierarchical structure. Like PSWs, nurses report concerns about AS being perceived by psychiatrists as a challenge to their decision making. Our findings that PSWs perceive AS not to be valued by those higher up in the organisation and that for some staff members there is a misconception that an AS is a wishlist but that ultimately the psychiatrist knows best are triangulated in existing qualitative research on shared decision making tools with patients and staff (Gumley et al. 2021, Farrelly et al 2015a). This appears to represent a state of gridlock within the system whereby it is accepted that AS completion and implementation remain an optional extra. It is clear that while PSW support to develop AS would be beneficial in increasing the uptake of AS and importantly improving peers' experiences of developing AS, this alone is not sufficient and would require input and adaptations at different levels of the system for successful implementation.

Our findings raise some important areas for consideration in relation to implementation. One of the benefits of the JCP approach highlighted by (Farrelly et al, 2015b) was the perceived improvement, when successfully implemented, in the relationship between patient and clinician. It is notable that in our study the process of improving patient and clinician engagement was dependent on the peer relationship over time and based on the process of empowerment. As clinicians could potentially have no involvement in the AS development process itself, or limited involvement as a witness, this should not be anticipated to have the same effect on patient-clinician relationships. In a related point, the importance of PSWs being able to be flexible with time was noted as a key advantage of PSW facilitation of AS development. Loubière et al.'s (2023) finding that a peer supported PAD intervention was cost-effective even when allowing for as many sessions as needed to complete the PAD is of note, however it must be cautioned that the value of PSW involvement is not as a more cost effective version of routine delivery but in the fundamental qualities of the peer work approach which should be preserved in any intervention (Gillard, 2019).

Limitations

Participants provided a wealth of valuable data in interviews and it was not possible to present some issues in the depth that would be required to do them justice. Of particular note are important data relating to wider barriers to and inequities in mental health care, shared decision making and access to basic human rights faced by deaf patients. This is an area that requires further attention and which may also apply to speakers of other languages. This study is limited to the perspective of PSWs. As such it does not include perspectives from other important stakeholders such as people accessing peer work services, their families, independent advocates, social workers or other mental health service professionals. The small sample size provides rich data, however it is not representative and therefore limits generalisability. Data on ethnicity, religion, sexuality and economic background were not collected and as such the study may miss voices from otherwise marginalised groups. This study looks specifically at a Scottish context and may not generalise to other countries' health care systems or understandings of mental health difficulties.

Implications for practice

The importance of both supported decision making (Scott, 2022) and peer support roles in mental health services (The Scottish Goverment, 2023) have been highlighted as important parts of the drive to improve Scotland's mental health system. This study provides information not only about how PSWs might improve uptake of the AS, an essential supported decision making tool, but the contexts that influence this outcome. In interviews, participants expressed a wish to learn from each other how they approach this work, and it is hoped that this paper will begin that process. More sustainably PSWs involved in AS development will require the opportunity to routinely share their expertise and learn from each other.

Many of the findings from this study also apply to the wider aims of the Scottish government mental health and wellbeing strategy and delivery plan, which sets out to "champion the value of peer support across a range of settings (The Scottish Goverment, 2023)." In particular, PSWs are a vital part of a more recovery-oriented service but their introduction alone is not sufficient to change organisational culture and priorities. Key contexts and mechanisms must be addressed to make adaptations at all levels of the system, which requires the expertise of and investment in PSWs, inclusion of all mental health staff, and leadership of those in senior positions.

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Appendices

Systematic Review

Major Research Project

Appendix 1: PRISMA Reporting Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p.1
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p.2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p.4-8
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p.8
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p.10
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p.9
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Appendix 2
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p.10-12
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p.12
Data items	10a	List and define all p for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	p.12
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p.12
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p.12-13
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	p.12

Section and Topic	Item #	Checklist item	Location where item is reported
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	p.10-11
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	p.12-13
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	p.12-13
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	p.12-13
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	n/a
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	n/a
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	n/a
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	n/a
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p.13-14
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	p.13-14
Study characteristics	17	Cite each included study and present its characteristics.	p.15-16
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p.53
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	p.32,34,36,43
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	p.28-30
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	n/a
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	n/a

Section and Topic	Item #	Checklist item	Location where item is reported
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	n/a
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.54
	23b	Discuss any limitations of the evidence included in the review.	p.57
	23c	Discuss any limitations of the review processes used.	p.57
	23d	Discuss implications of the results for practice, policy, and future research.	p.59
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p.9
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p.9
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	p.9
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	n/a
Competing interests	26	Declare any competing interests of review authors.	n/a
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	n/a

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Appendix 2: Example Search Strategy

Database: Embase <1974 to 2023 September 18>

Search Strategy:

1 peer provide*.tw. (143)
2 peer support*.tw. (9896)
3 peer specialist*.tw. (194)
4 peer work*.tw. (352)
5 consumer provide*.tw. (127)
6 consumer survivor*.tw. (53)
7 peer recovery.tw. (165)
8 expert* by experience.tw. (282)
9 (peer adj2 deliver*).tw. (708)
10 (consumer adj2 employ*).tw. (115)
11 or/1-10 (11518)
12 mental health/ (208267)
13 mental health.tw. (264499)
14 mental disease/ (277951)
15 mental illness*.tw. (51914)
16 mental disorder*.tw. (62606)
17 psychiatric diagnosis/ (21387)
18 psychiatric.tw. (304377)
19 eating disorder/ (31093)
20 eating disorder*.tw. (32253)
21 automutilation/ (24555)
22 (self adj (injur* or mutilat* or harm*)).tw. (19849)
23 suicidal behavior/ (19829)
24 suicidal ideation/ (31766)
25 suicide attempt/ or suicide/ (96690)
26 suicid*.tw. (122101)
27 mood disorder/ (53336)
28 mood disorder*.tw. (31903)
29 affective disorder*.tw. (24680)
30 bipolar disorder/ (66676)
31 bipolar.tw. (107861)
32 depression/ (485187)
33 depressi*.tw. (661845)
34 psychosis/ (106746)
35 psychosis.tw. (66193)
36 psychotic.tw. (60106)

37 schizophrenia/ (195726)
38 schizophreni*.tw. (184327)
39 or/12-38 (1726996)
40 (personal* adj (benefi* or cost* or challeng* or impact*)).tw. (2747)
41 mental health recovery/ (735)
42 psychosocial rehabilitation/ (2013)
43 recovery.tw. (723764)
44 connect*.tw. (624261)
45 empower*.tw. (51091)
46 empowerment/ (13242)
47 hope*.tw. (158183)
48 hope/ (12906)
49 optimis*.tw. (101773)
50 optimism/ (6672)
51 identit*.tw. (204394)
52 meaning*.tw. (237156)
53 Recovery Assessment Scale.mp. (147)
54 Questionnaire about the Process of Recovery.mp. (42)
55 Mental Health Recovery Measure.mp. (37)
56 Recovery Style Questionnaire.mp. (15)
57 Maryland Assessment of Recovery.mp. (20)
58 Recovery Attitudes Questionnaire.mp. (19)
59 Stages of Recovery Scale.mp. (2)
60 Stages of Recovery Instrument.mp. (24)
61 burnout/ (26252)
62 burnout.tw. (24651)
63 Maslach Burnout Inventory/ (1605)
64 Maslach Burnout Inventory.mp. (4818)
65 mental stress/ (99376)
66 stress*.tw. (1330035)
67 wellbeing/ (85633)
68 wellbeing.tw. (42985)
69 well-being.tw. (135935)
70 ((job or role) adj satisfaction).tw. (13335)
71 job satisfaction/ (35877)
72 or/40-71 (3480589)
73 11 and 39 and 72 (2189)
74 limit 73 to english language (2152)

Appendix 3: COREQ Checklist

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	79
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	79
Occupation	3	What was their occupation at the time of the study?	79
Gender	4	Was the researcher male or female?	n/a
Experience and training	5	What experience or training did the researcher have?	79
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	n/a
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	79
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	79
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	78
Participant selection			

Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	75
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	76
Sample size	12	How many participants were in the study?	76
Non-participation	13	How many people refused to participate or dropped out? Reasons?	76
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	78
Presence of nonparticipants	15	Was anyone else present besides the participants and researchers?	78
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	77
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	78
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	n/a
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	78
Field notes	20	Were field notes made during and/or after the inter view or focus group?	78
Duration	21	What was the duration of the inter views or focus group?	78
Data saturation	22	Was data saturation discussed?	76
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	n/a
Topic	**Item No.**	**Guide Questions/Description**	**Reported on Page No.**

Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	78
Description of the coding tree	25	Did authors provide a description of the coding tree?	n/a
Derivation of themes	26	Were themes identified in advance or derived from the data?	78
Software	27	What software, if applicable, was used to manage the data?	78
Participant checking	28	Did participants provide feedback on the findings?	n/a
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	85
Data and findings consistent	30	Was there consistency between the data presented and the findings?	103
Clarity of major themes	31	Were major themes clearly presented in the findings?	85
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	103

Appendix 4: Approved MRP Proposal

Available online: https://osf.io/gznbq

Appendix 5: University of Glasgow MVLS Ethics Committee Approval Letter

University of Glasgow

Professor Andrew Gumley

MVLS College Ethics Committee

A Grounded Theory Study of Peer Supported Development of Advance Statements for People with Severe and Enduring Mental Illness

200210208

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. We are happy therefore to approve the project, subject to the following conditions

- Project end date as stipulated in original application.
- The data should be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research: (http://www.gla.ac.uk/media/media_227599_en.pdf)
- The research should be carried out only on the sites, and/or groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- For projects requiring the use of an online questionnaire, the University has an Online Surveys account for research. To request access, see the University's application procedure at https://www.gla.ac.uk/research/strategy/ourpolicies/useofonlinesurveystoolforresearch/.
- You should submit a short end of study report within 3 months of completion.

Yours sincerely

Terry Quinn
FWSO, FESO, MD, FRCP, BSc (hons), MBChB (hons)
Reader / Honorary Consultant

Appendix 6: Participant information Sheet

Available online: https://osf.io/n248u

Appendix 7: Consent Form

Available online: https://osf.io/wc7xk

Appendix 8: Topic Guide

Available online: https://osf.io/pmk6s