Barriers and facilitators to peer support in Early Intervention in Psychosis Services

Catrin Coates

Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology

April 2025

Total word count: 17,773

THESIS PORTFOLIO: CANDIDATE DECLARATION

Title of degree programme	**Professional Doctorate in Clinical Psychology**
Candidate name	**Catrin Coates**
Registration number	
Initial date of registration	**September 2022**

Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed:  Date: 30/04/2025

Acknowledgements

I would like to thank those who took part in the research for giving their time and sharing their stories. Thank you to the peer staff who gave their input and feedback on the research design and executive summary. I have appreciated the help and guidance from Kim, my research supervisor, throughout this process. Thank you for all your help.

Table of Contents

Thesis abstract

The first paper is a systematic literature review and thematic synthesis of staff experiences working in Early Intervention in Psychosis (EIP) services in the United Kingdom. A total of ten studies were selected for review. These were appraised using the Mixed Methods Appraisal Tool. A thematic synthesis of the data was undertaken. The review found three key themes 'Staff experiences of working with clients', 'Staff experiences of working in an EIP team' and 'Staff experiences of clients' stigma'. Findings indicate that therapeutic relationships with clients, using a client-centred approach and working with clients' stigma were key to EIP staff experiences.

The second paper is an empirical study exploring the barriers and facilitators to peer support in EIP services. The study aimed to further understand the experiences of peer staff in EIP services by exploring the perceived barriers and facilitators to implementing peer support in these services. Eight participants with experience of delivering peer support in EIP services took part in semi-structured interviews. Reflexive thematic analysis was used to analyse the data. Two themes were developed: 'Three approaches in one service' and 'Organisational culture and perceptions of peer support'. The main barriers and facilitators found were organisational approaches, team culture and perceptions of peer support. Challenges implementing peer support in EIP services can lead to peer support not being fully and appropriately utilised. Clinical implications highlight the importance of EIP teams understanding peer support and its value, and for peer support to be delivered in line with its defining principles.

The third paper is an executive summary of the empirical study in the second paper. It is aimed at staff, services and stakeholders involved in the implementation and delivery of peer support in EIP services.

Paper 1: Literature review

Staff experiences of working in Early Intervention in Psychosis Services in the United Kingdom: A systematic review and thematic synthesis

Word count: 7,963

(Excluding title page, acknowledgements, footnotes, references and appendices)

This systematic literature review has been written in accordance with author guidelines for Early Intervention in Psychiatry (Appendix 4).

This paper broadly follows author guidelines for Early Intervention in Psychiatry, however further editing and formatting will be completed prior to submission to the journal.

Abstract

Aim

Research in Early Intervention in Psychosis (EIP) services has largely focussed on client outcomes. Less is known about the experiences of staff in EIP services, despite evidence suggesting factors including staff well-being, service provision, and the staff-client therapeutic relationship influence the experiences and outcomes of clients accessing EIP services. The aim of this study was to systematically review staff experiences of working in EIP services in the United Kingdom (UK).

Method

PsycInfo, EMBASE, MEDLINE, and CINAHL electronic databases were searched for English language, peer reviewed studies. Studies focusing on the experiences of staff working in EIP services in the UK were included. Quality appraisal of papers was conducted using the Mixed Methods Appraisal Tool. A thematic synthesis of the data was undertaken.

Results

Ten studies were included for review and synthesised into three analytical themes, developed from seven descriptive themes: (1) Staff experiences of working with clients (1.1. Therapeutic relationships, 1.2. Being client-centred, 1.3. Supporting recovery), (2) Staff experiences of working in an EIP team (2.1. Supportive teams, 2.2. Service pressures), (3) Staff experiences of clients' stigma (3.1. How clients experience stigma, 3.2. The impact of stigma, 3.3. Addressing stigma).

Conclusions

Therapeutic relationships with clients, using a client-centred approach and working with clients' stigma were key to EIP staff experiences. EIP staff benefit from a supportive, whole team approach, but service pressures can present challenges.

Implications for clinical practice and recommendations for future research are discussed.

Key words

Early intervention, experiences, psychosis, staff, systematic literature review, thematic synthesis.

Introduction

People who experience psychosis have symptoms including seeing or hearing things that others cannot (known as hallucinations) and having beliefs that others do not view as being true (known as delusions) (NHS, 2023). Experiencing symptoms of psychosis for the first time is commonly referred to as a First Episode of Psychosis (FEP) in clinical practice and literature (NHS, 2023). Bromley et al. (2015) describes that a FEP can be frightening and confusing, and that misconceptions and stereotypes associated with psychosis can increase people's distress.

Early Intervention in Psychosis (EIP) services have been established worldwide to specifically support people who are experiencing a FEP. In 1999, EIP services were introduced in the United Kingdom (UK) as part of the NHS framework (Department of Health, 1999; Joseph & Birchwood, 2005). EIP services aim to provide those accessing their services (clients) with timely assessment and treatment, intensive and assertive outreach, and a whole-team approach to their care (NHS England, 2023). EIP services offer psychological, pharmacological, social, occupational, and educational interventions, peer support, as well as support for families and carers (Neale & Kinnair, 2017; National Institute for Health and Care Excellence [NICE], 2014). These interventions aim to support people who have experienced a FEP to work towards the best recovery possible by increasing functioning, reducing symptoms and helping them 'live full, hopeful and productive lives' (NHS England, 2023, p. 16). Given the range of interventions provided by EIP services, teams are multidisciplinary. However, clients receiving support from an EIP service will have an allocated Care Coordinator who is the primary person in charge of their care, supporting them throughout their time in the service (NHS England, 2023).

Providing timely evidence-based treatments within EIP services has been found to improve outcomes for those who experience a FEP. These include improved engagement with services, quality of life, social and occupational functioning (e.g. employment), as well as reduced hospital re-admissions and use of crisis and inpatient services (Correll et al., 2018; Craig et al., 2004; Dodgson et al., 2008; Garety et al., 2006; NHS England, 2023).

Recent research has shifted its focus from outcomes of clients in EIP services to the experiences of clients accessing these services and their family members and/or carers. Loughlin et al. (2020) conducted a meta-synthesis of client and carer experiences of engaging with EIP services. Loughlin et al. (2020) found that a real, genuine relationship with a key EIP staff member was reported to be the most important factor for EIP clients and their carers, in which staff were perceived to take a ‘genuine, person-centred interest in their holistic well-being’ (Loughlin et al., 2020, p. 31). Loughlin et al. (2020) did not define ‘key EIP staff member’, but most studies in their review identified this as the primary staff member responsible for managing and facilitating the care of a client. Tindall et al. (2018) synthesised research on experiences of engagement in EIP services from the perspectives of clients and their caregivers, and found that the therapeutic relationship with an EIP staff member was ‘a significant factor for enabling service engagement’ (Tindall et al., 2018, p. 790). Areas such as clients feeling heard, being given time to talk, and collaboration with clients were reported to be the most important qualities in these key therapeutic relationships (Tindall et al., 2018).

Although research suggests that therapeutic relationships are important to clients in EIP services and a better therapeutic alliance with staff improves outcomes for clients with early psychosis (Goldsmith et al., 2015; Loughlin et al., 2020; Tindall et

al., 2018), it is unclear whether the therapeutic relationship holds particular importance for clients in EIP services when compared to clients in other services. Evidence has highlighted the significance of the therapeutic relationship for not only clients in EIP services, but also those who access services for prolonged/repeated episodes of psychosis or other mental health difficulties (Browne et al., 2019; Henderson et al., 2020; Hewitt & Coffey, 2005; Sweeney et al., 2014). Researching the experiences of staff in EIP services, and what it is like to work within and deliver EIP services, may help with understanding what influences the development of these key therapeutic relationships.

Research and subsequent guidance on NHS staff wellbeing has outlined the importance of considering wider impacts on NHS staff, such as workforce pressures, increased mental health needs of staff, and the cost-of-living crisis (Health and Social Care Committee, 2021; NHS Providers, 2022). Investigating EIP staff experiences could develop our understanding of how staff perceive their roles and deliver EIP services, particularly in light of the EIP service approach involving timely and intensive assessment and treatment (NHS England, 2023). Research suggests that mental health staff can perceive competing priorities and resource issues as negatively impacting the implementation of recovery-oriented practice (Gilburt et al., 2013; Le Boutillier et al., 2015).

There are no current peer reviewed studies evaluating the findings of the experiences of staff working within EIP services into a single review. This review therefore aims to synthesise the research findings in this area, and poses the research question: What are the experiences of staff working in EIP Services in the UK? In this review, ‘EIP staff’ are defined as staff members working within an EIP service’s multidisciplinary care team supporting clients accessing these services.

Method

Search strategy

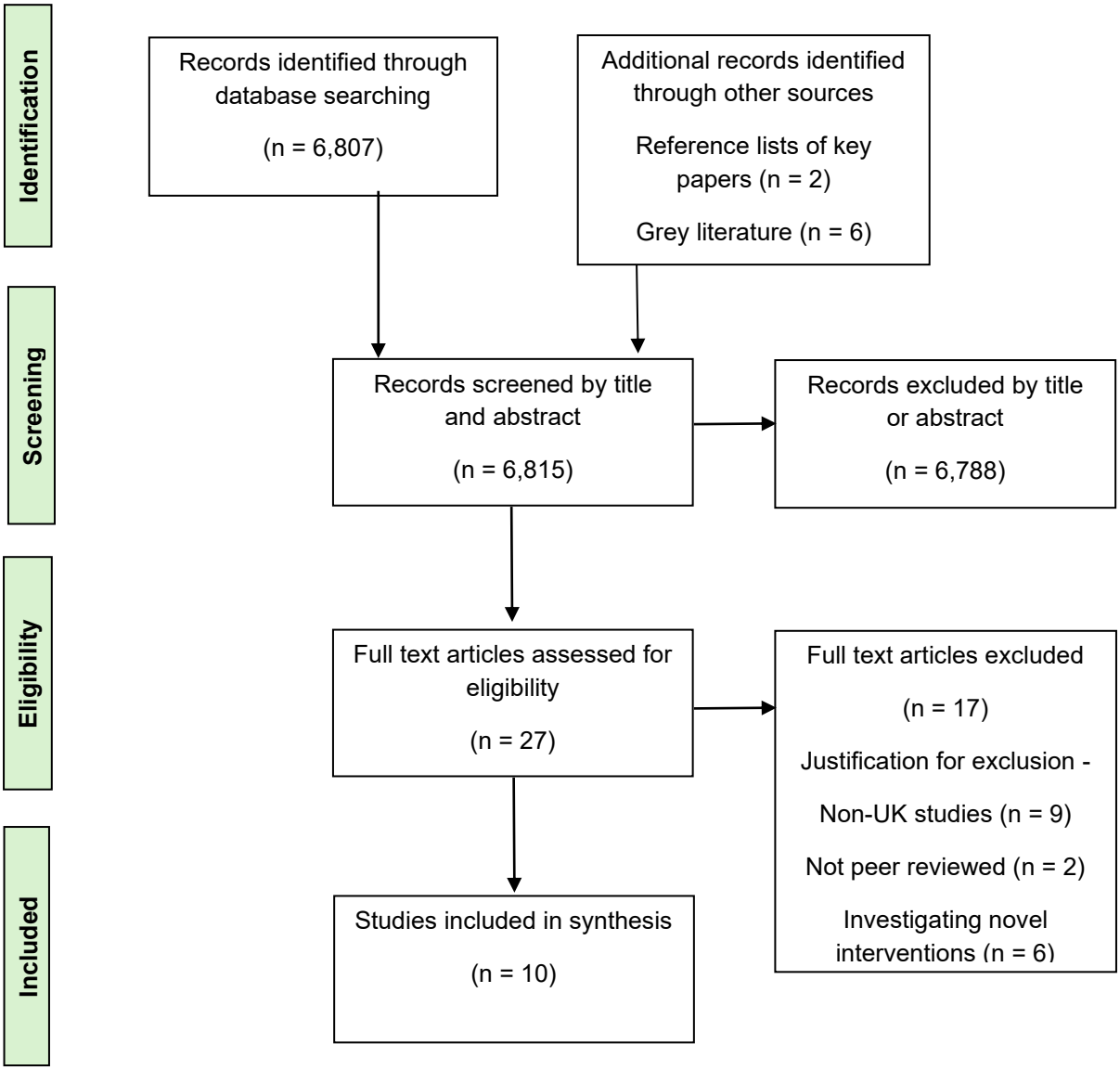
A systematic approach was used to identify potential papers, appraise the quality of selected papers, and analyse and synthesise data, with the aim of developing an understanding of the experiences of staff working in EIP services in the UK.

A search was carried out in April 2024 using the electronic databases PsycInfo, EMBASE, MEDLINE, and CINAHL. Search terms were used with the Boolean operators ‘AND’ and ‘OR’. The search terms used were ((('early intervention'[Title]) OR ('psychosis'[Title]) AND ('staff' OR 'professionals' OR 'clinician' OR 'practitioner')). Terms were entered for searching with limits of ‘Peer Reviewed Journals’ and ‘English Language’. Figure 1 shows the flow of studies through the different phases of the systematic search.

Database searches produced 6,807 published articles. Two articles were identified for potential inclusion through the reference lists of relevant journal articles. A search of grey literature using Google Scholar found six additional studies for potential inclusion. Papers were reviewed by title and abstract, and then full articles. In all, 6,815 article title and abstracts were screened, of which 27 were retrieved for full-text examination. 10 articles met the full inclusion criteria. All searches revealed that no similar systematic review had previously been published.

Figure 1

Screening process for studies to be included in the review, including number of studies (n) at each stage.



Eligibility criteria

This review sought studies reporting data on the experiences of staff working in EIP services in the UK. Studies were eligible for inclusion in the review if:

- They were quantitative, qualitative or mixed methods studies, which had been peer reviewed and published in full.
- They had participants who were staff working in EIP services in the UK.

- They included information on the experiences of EIP staff on working in EIP services in the UK.
- They were available in English language.

Studies were excluded if:

- They were not peer reviewed or published in full.
- They were not available in English language.
- They investigated new or novel aspects of care not outlined in current guidelines for EIP services (NHS England, 2023; Royal College of Psychiatrists, 2025) to ensure the focus was on staff experiences of how EIP services were currently being delivered.
- They investigated experiences of other groups (e.g. EIP clients) in addition to EIP staff, but it was not possible to identify staff perspectives specifically.

Data extraction

Key information from included studies was extracted and recorded (see Figure 2). Data was extracted from the ‘results’ or ‘findings’ sections of these studies for the thematic synthesis of the evidence.

Quality assessment

A quality assessment was undertaken using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). The MMAT was designed to appraise qualitative, quantitative and mixed methods studies. It is an effective screening tool for conducting systematic mixed studies reviews (Pace et al., 2012) and is commonly used for such reviews. The MMAT has two parts: (1) Questions asking whether or not it is an empirical study, and therefore suitable for further appraisal using the tool, and (2) Different categories of questions specific to the type of study being appraised, where the appraiser chooses the relevant category of appraisal questions

for the studies they are appraising (Hong et al., 2018). For each category, there is a set criteria that the reviewer either rates as ‘yes, no or can’t tell’. Hong et al. (2018) do not recommend providing an overall score for studies which have been rated, but advise reviewers to report these in more detail e.g. a narrative report. Papers in this review have been critically appraised as recommended by Hong et al. (2018). Appendices 1 and 2 outline the guidance used to undertake the quality appraisal of studies using the MMAT (Hong et al., 2018). Appendix 3 demonstrates the quality appraisal process for each study.

Data synthesis

A thematic synthesis was applied to the ‘results’ or ‘findings’ sections of included studies and followed Thomas and Harden’s (2008) framework for thematic synthesis of qualitative research in systematic reviews. Although not all studies included were qualitative, thematic synthesis has been recommended for synthesising studies with quantitative, qualitative and mixed methodology (Dixon-Woods et al., 2005). This framework has also been used in previous literature reviews (Navas et al., 2022; Subasinghe, et al., 2023).

Thomas and Harden’s (2008) framework provides a structured guide to conducting a thematic synthesis through the development of descriptive and analytical themes. There are three stages to thematic synthesis: (1) line-by-line coding of text, (2) developing descriptive themes, and (3) generating analytical themes. The development of descriptive themes through thematic synthesis is inductive and close to the original findings of studies, in line with our aim to review staff experiences of working in EIP services in the UK. This framework also outlines the process for the development of analytical themes, where reviewers ‘go beyond’ the findings of studies to ‘generate new interpretive constructs, explanations or

hypotheses' (Thomas & Harden, 2008, p. 1). These describe all of the descriptive themes and must therefore be sufficiently novel and new (Thomas & Harden, 2008). Thomas and Harden (2008) describe how analytical themes are developed by examining the descriptive synthesis in the context of an external theoretical framework i.e. the review question.

Results

Systematic review

Included studies

Ten studies were included in the review. Figure 2 provides an overview of included studies. Seven studies investigated EIP staff experiences of delivering routine care in EIP services e.g. risk assessment, peer support, transition from the service. Three of these studies also aimed to explore EIP staff perspectives on ways that these aspects of routine care could be developed and improved, although this topic also arose in many of the other studies. For example, Lonsdale and Webber (2021) aimed to identify what information EIP staff find useful when facilitating crisis planning, and whether and how these crisis plans can be improved. Three studies investigated EIP staff experiences of other aspects of their work in EIP services, which were not intervention-specific e.g. client recovery, boundaries with clients, essential elements of EIP services.

Figure 2

Overview of reviewed studies

Authors, year of publication	Aim	Design and analysis	Participant number and type	Key findings/ themes
Whiting et al. (2024)	Examine current approaches, attitudes and challenges to assessing violence risk in EIP services.	Semi-structured interviews. Clinical vignettes given to participants to prompt discussion. Thematic analysis using constant comparative method.	30 total: 18 EIP staff 12 EIP clients and carers	Themes: (1) Current practice and focus of violence risk assessment and management e.g. timing, content, responding (2) Challenges and barriers to assessing violence risk e.g. stigma, non-disclosure, time-pressure (3) General attitudes to violence risk e.g. clinical importance, service remit.
Bone et al. (2023)	Explore how care coordinators in EIP services develop their understanding and practice around navigating boundaries.	Semi-structured interviews. Grounded theory.	13 EIP Care Coordinators	A concentric model emerged, defining different layers of influence impacting care coordinators' navigation of boundaries. Model included higher governing levels, factors and challenges specific to EIP service culture, client characteristics and individual care coordinator decision-making processes. Care coordinators adopted a flexible, case-by-case approach in response to challenges.

Nguyen et al. (2021)	1. Investigate key elements of peer support in EIP services, and 2. How Peer Support Worker's might best be recruited and supported in their work.	Semi-structured interviews. Thematic analysis.	7 EIP Peer Support Workers	Themes: (1) Benefits of peer support (2) Ideal requirements for Peer Support Workers (3) Effectively delivering peer support (4) Working alongside peers.
Lonsdale and Webber, (2021)	1. Identify what information practitioners find useful when facilitating crisis planning in EIP services, and 2. Whether and how these crisis plans can be improved.	Mixed methods. Survey rating usefulness of items on current crisis plan template and interviews. Non-parametric tests and thematic analysis.	82 total: 70 survey 12 interviews, EIP staff	Survey: Items rated as most useful: (1) Early warning signs (2) Triggers (3) Treatments which have been helpful in the past. No significant differences found in response between factors e.g. professional groups, demographics. Themes from interviews: (1) Personalisation (2) Self-management (3) Collaboration (4) Barriers.
Stefanidou et al. (2021)	1. Investigate the views of Mental Health Practitioners about the context and causes of loneliness in people with early psychosis, and 2. Explore potential interventions.	Semi-structured interviews. Thematic analysis.	20 EIP Mental Health Practitioners	Themes: (1) How loneliness manifests itself (2) Reasons why EIP clients are lonely and its effects on them (3) Potential ways of alleviating loneliness among EIP clients.

Bogen-Johnston et al. (2020)	Investigate how EIP service practitioners work with clients who hear voices.	Semi-structured interviews. Template analysis.	10 EIP staff	Novel themes: (1) Starting a conversation about voices (2) Continuing the conversation about voices.
Woodward et al. (2019)	Explore staff views of the barriers and facilitators to transition from EIP services.	Individual interviews. Template analysis.	18 EIP staff	Themes: (1) Delayed discharge: nowhere to go (2) Collaboration between agencies (3) Therapeutic relationships (4) Empowering service users: involvement and preparation.
White et al. (2017)	Explore the impact of peer support on an EIP team.	Focus group. Thematic analysis.	6 EIP staff	Themes: (1) The value of peer support (2) The peer support role
Morton et al. (2010)	Find out if staff and clients perceive a new EIP service as promoting resilience and, in turn, recovery.	Questionnaire. Participants given items from recovery questionnaire and rated how much the service promoted these areas. Spearman's rank.	40 total: 7 EIP staff 28 EIP clients	The analysis found a strong positive agreement that the service promoted resilience. There was one significant difference between staff and client responses, as staff responded to the question about the service having 'appropriate service provision' by giving significantly lower scores on this item than clients.
Marshall et al. (2004)	Identify the essential elements of a new EIP service.	Delphi study. Unspecified test of statistical significance.	21 EIP expert clinicians	High degree of consensus found on the importance of 90% of elements related to UK guidance. Statements rated as essential with most consensus were: (1) EIP services should deal with people in their first episode of psychosis (2) EIP services should

		be composed of staff whose sole or main responsibility is to the EIP service (3) EIP service should have at least one member trained in Cognitive Behavioural Therapy.

Methods

There were seven qualitative studies, two quantitative studies and one mixed methods study (Lonsdale & Webber, 2021) included in this review.

Six qualitative studies collected data using individual interviews and one (White et al., 2017) used a focus group. Of the studies that conducted individual interviews, five used a semi-structured interview approach and one of these (Whiting et al., 2024) gave participants clinical vignettes to prompt discussion during interviews. Woodward et al. (2019) did not specify the structure or approach used in participant interviews. Five qualitative studies used thematic analysis. Whiting et al. (2024) used thematic analysis using a constant comparative method. Bone et al. (2023) used grounded theory and Bogen-Johnston et al. (2020) used template analysis. The qualitative components of the mixed methods study (Lonsdale & Webber, 2021) were analysed using thematic analysis.

The two quantitative studies and the quantitative component of the mixed methods study (Lonsdale & Webber, 2021) involved participants rating/ranking items. These included rating how much participant's EIP service promoted aspects of recovery (Morton et al., 2010), ranking the usefulness of aspects of crisis plans (Lonsdale & Webber, 2021), and rating the importance of aspects of UK guidance for EIP services (Marshall et al., 2004).

Participants and study sites

Sample sizes for qualitative studies ranged between six and 20 (M = 13), and for quantitative studies between seven and 21 (M = 14). Lonsdale et al.'s (2021) mixed methods study had 70 participants complete the survey and 12 participate in interviews. Studies recruited participants from within one to 11 EIP services, however not all studies reported this information. All studies were conducted in the UK: Five in

the South of England, one in the North West of England (Woodward et al., 2019) and four did not report the location of the EIP services that participants were recruited from.

In regard to participants, seven studies recruited EIP staff members from any discipline/role. Bone et al. (2023) recruited Care Coordinators, Nguyen et al. (2021) recruited Peer Support Workers and Marshall et al. (2004) recruited 'expert clinicians'. Morton et al. (2010) collected data from EIP service clients and staff, and Whiting et al. (2023) collected data from clients, carers and staff.

Quality appraisal

Details of the quality appraisal process undertaken are outlined in Appendix 3. Nine studies met all criteria for validity and reliability in their respective MMAT appraisal categories outlined in Appendix 1 (Hong et al., 2018).

On the qualitative screening questions, Whiting at al. (2024) did not meet criteria for the question 'Is the qualitative approach appropriate to answer the research question?', as the study did not adequately explain the justification for their chosen method of analysis. The study reported using thematic analysis informed by the constant comparative method to analyse semi-structured interview transcripts. The rationale for this method of analysis was unclear, so the study was marked down in this area (see Appendix 3).

Thematic synthesis

The main findings from included studies were developed from eight descriptive themes then synthesised into three analytical themes (see Figure 3). Quotes and citations from the papers are included to illustrate these themes.

Figure 3

Table of analytical and descriptive themes

Analytical themes	Descriptive themes
1. Staff experiences of working with clients	1.1 Therapeutic relationships 1.2 Being client-centred 1.3 Supporting recovery
2. Staff experiences of working in an EIP team	2.1 Supportive teams 2.2 Service pressures
3. Staff experiences of clients' stigma	3.1 How clients experience stigma 3.2 The impact of stigma 3.3 Addressing stigma

Synthesis of findings

Analytical theme 1: Staff experiences of working with clients.

1.1. Therapeutic relationships.

In nine studies, EIP staff spoke about the importance of their therapeutic relationship with clients, indicating that these relationships are central to EIP staff experiences. Bone et al. (2023) described that EIP staff authentically relating with clients helped develop therapeutic relationships: 'Bringing aspects of their real selves into the relationship invited clients to reciprocate' (Bone et al. 2023, p. 387). Stronger therapeutic relationships were perceived to improve clients' engagement with services (Bone et al., 2023) and help clients have safe, non-judgmental conversations about experiences of psychosis: 'Service users were able to express

their experiences in a safe relationship. Having open, non-judgemental conversations about voice hearing' (Bogen-Johnston et al., 2020, p. 612).

1.2. Being client-centred.

Being client-centred was something EIP staff believed was helpful for clients, as highlighted by eight studies in this review. Being client-centred involved EIP staff being flexible and adapting their approach to meet individual clients' needs. EIP staff used client-centred approaches when setting boundaries with clients (Bone et al., 2023), having conversations about voice hearing (Bogen-Johnston et al., 2020) and risk of violence (Whiting et al., 2024). Lonsdale and Webber (2021) found EIP staff felt it was important to develop personalised crisis plans for individual clients: "You can't do a plan for everyone, it needs to be for them" (Lonsdale & Webber, 2021, p. 1941). The process of making personalised crisis plans was seen to have benefits including empowering clients and helping them feel listened to by EIP staff (Lonsdale & Webber, 2021).

1.3. Supporting recovery.

Seven studies described EIP staff experiences of supporting clients in their recovery. EIP staff spoke about how recovery could include different factors, such as clients feeling more able to manage symptoms or experiences of psychosis: "To help [clients] kind of manage certainly their distress around voices" (Bogen-Johnston et al., 2020, p. 612). Clients having safe and stable housing and engaging more with activities that were important to them were also seen to be key aspects of recovery: "We've been able to support them [clients] with housing and, employment and, getting their driving licence back" (Bone et al., 2023, p. 387).

EIP staff were found to have experiences of empowering clients and providing hope to support them in their recovery. Woodward et al. (2019) described how EIP

staff reminded clients of the positive progress they had made in order to provide continued hope and empowerment: “It was just instilling, or reminding her [client] of how far she'd come” (Woodward et al., 2019, p. 918).

Nguyen et al. (2021) explored the experiences of EIP peer staff, who have their own lived experience of psychosis and go on to work in EIP services in a peer staff role. Nguyen et al. (2021) found that peer staff experienced the positive impact of their role in providing client with a ‘symbol of hope’ for recovery following a FEP: “You’re [peer staff member] able to get up in the morning and come to work, and all those things speak volumes without actually me having to say anything. And I think that really offers people hope.” (Nguyen et al., 2021, p. 198).

Analytical theme 2: Staff experiences of working in an EIP team.

2.1. Supportive teams.

EIP staff spoke about their experience of working within an EIP team in seven studies. EIP staff were found to benefit from a supportive, whole-team approach, which involved staff supporting and advising each other when needed. White et al. (2017) highlighted ‘the importance of encouraging supportive relationships, and open communication, within the team’ (White et al., 2017, p. 106). Bone et al. (2023) found that EIP staff use their team as a resource to check out questions or concerns about staff-client boundaries: “you take it to the team . . . “ooh how, how do I manage this?” (Bone et al., 2023, p. 388).

2.2. Service pressures.

In many studies, EIP staff shared their experiences of service pressures such as resource issues and time constraints. EIP staff perceived that service pressures led to them being less able to adhere to the EIP approach and be flexible to meet clients’ needs. Morton et al. (2010) found that EIP staff perceived that resource issues,

including low staffing levels and mix of skills, limited their ability to ‘provide high intensity support, access to social workers and occupational therapists, and access to medical colleagues at a time of crisis.’ (Morton et al., 2010, p. 91).

Woodward et al. (2019) found that EIP staff can experience challenges transferring clients from EIP services to other mental health services, such as Community Mental Health Teams (CMHTs), and believed that this was due to the service pressures in other teams. EIP staff shared their experiences of working with clients in EIP services for longer than the commissioned three years due to these challenges: ‘When they're [clients] due to be referred on there isn't the availability, certainly in CMHT, so we're finding that we can have people up to five-six years’ (Woodward et al., 2019, p. 916).

EIP staff in Woodward et al.’s (2019) study shared that these challenges were frustrating for EIP staff and clients, and ‘resulted in higher caseloads within EIPS, reducing care coordinators' capacity to offer intensive interventions’ (Woodward et al., 2019, p. 916).

Analytical theme 3: Staff experiences of clients’ stigma.

The definition of stigma used in this review is; when the process of ‘labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them’ (Link & Phelan, 2001, p. 377).

3.1. How clients experience stigma.

In nine studies, EIP staff spoke about their experience of noticing clients’ stigma, including internal and external stigma.

EIP staff recognised clients’ internal stigma, but each named this differently e.g. internalisation of mental illness stigma (Stefanidou et al., 2021), self-stigmatisation (Nguyen et al., 2021). Internal stigma was used to define the same phenomenon

reported across many studies in this review; the internalisation of negative stereotypes and prejudices (Jahn et al., 2020).

The different types of external stigma that EIP clients' experience were reported by EIP staff e.g. stigma from those close to them (e.g. family), from communities, and from the media. Studies found that, from EIP staff experiences, they viewed external stigma and stereotypes often came from a lack of awareness and compassion from communities and the media about mental health difficulties and/or experiences of psychosis e.g. "He [client] feels quite judged by his community" (Stefanidou et al., 2021, p. 6), "the stereotype that's in the media that people with psychosis are dangerous." (Whiting et al., 2024, Appendix 3, p. 3).

3.2. The impact of stigma

Many studies found that EIP staff experiences involve noticing the impact of clients' stigma on how clients feel about themselves and view themselves. EIP staff reported that clients' stigma can lead to clients feeling ashamed and self-conscious about their psychotic experiences (Nguyen et al., 2021), anxious and afraid of talking about experiences of psychosis (e.g. hearing voices) (Bogen-Johnston et al., 2020), and feeling lonely, worthless and having low self-esteem (Stefanidou et al., 2021).

EIP staff perceived that clients' stigma can lead to clients being more isolated and withdrawn, and negatively impact recovery (Bogen-Johnston et al., 2020; Stefanidou et al., 2021). For example, Bogen-Johnston et al. (2020) found that EIP staff recognised that clients with internal stigma about voice-hearing felt anxious and afraid of talking about this, and these clients were therefore less likely to talk about their experiences of hearing voices:

> [Clients] who kind of are more open to kind of talking about the experience do better? I think for those who don't engage in that kind of work, I find that the kind

of anxiety and fearfulness maintains itself more (Bogen-Johnston et al., 2020, p. 612).

3.3. Addressing stigma

In many studies, EIP staff spoke about their experiences of addressing clients' stigma. Most studies reported on staff experiences of working directly with clients' stigma in EIP services, including talking about stigmatised topics with clients to challenge and reduce the stigma around these e.g. risk of violence (Whiting et al., 2024), voice hearing (Bogen-Johnston et al., 2020). White et al. (2017) and Nguyen et al. (2021) highlighted that having peer staff within EIP services can address and reduce a clients' stigma, as the sharing of lived experience of psychosis can help 'alleviate the pessimistic narratives and assumptions of chronic disabilities which could be associated with psychosis' (Nguyen et al., 2021, p. 198).

Discussion

Therapeutic relationships and client-centred approaches

Our findings demonstrate that therapeutic relationships with clients are a key aspect of EIP staff experiences, reflecting findings in previous research which suggest these therapeutic relationships are also an important factor for clients in EIP services (Loughlin et al., 2020; Tindall et al., 2018), and a better therapeutic alliance with staff improves outcomes for clients with early psychosis (Goldsmith et al., 2015).

Another important aspect of EIP staff experiences was being flexible and adapting their approach to meet individual clients' support needs. This finding is consistent with evidence suggesting that clients who have experienced a FEP benefit from an individualised, person-centred approach due to the significant changes and reconstruction of their identities following a FEP (Causier et al., 2024; Harris et al., 2022; Loughlin et al., 2020; Wood & Alsawy, 2018). Harris et al. (2022) and Loughlin

et al. (2020) highlight the importance of viewing psychosis in the context of a client's wider life-narrative. Causier et al. (2024) reviewed barriers to help-seeking in those who have experienced a FEP and found that clients consistently report valuing individualised support. These findings are in line with that of our review, which found that EIP staff recognise the benefits of providing a client-centred approach. However, it remains unclear whether these aspects hold particular importance for staff and clients in EIP services, as evidence also suggests the significance of therapeutic relationships and being client-centred for people accessing other mental health services and the staff supporting them (Browne et al., 2019; Henderson et al., 2020; Hewitt & Coffey, 2005; Sweeney et al., 2014).

The EIP service approach centres on timely assessment and treatment, intensive and assertive outreach, and supporting clients who have experienced a FEP for three years (NHS England, 2023). This approach aims to allow EIP staff, including Care Coordinators (the allocated member of staff managing a client's care), to implement a client-centred, flexible and assertive approach with clients (NHS England, 2023). The findings of this review demonstrated the ways in which therapeutic relationships and client-centred approaches may be of particular importance for EIP staff, which could be due to the approach and ethos of EIP services and guidance on client interventions within EIP services.

Supporting clients' recovery

This review found that EIP staff have experiences of supporting clients with different aspects of recovery, including support to engage with meaningful activities and to manage symptoms/experiences of psychosis, and practical support (e.g. housing). Research exploring the views of EIP clients about recovery are similar to that of the perspectives of EIP staff found in this review. Clients in EIP services have

reported recovery should be client-centred and holistic, including social and functional recovery (engaging with meaningful occupation and relationships) and reduction and management of symptoms/experiences of psychosis (Bertolote & Mcgorry, 2005; Hansen et al., 2019; Lam et al., 2011; Vaingankar et al., 2020; Windell et al., 2012).

Our findings highlight that empowering clients and providing hope were the most important factors for EIP staff when supporting clients in their recovery. Vaingankar et al. (2020) explored perspectives of those who have experienced a FEP on recovery, and found empowerment through a sense of personal agency (e.g. taking ownership over their physical health) and having a hopeful, positive perspective were seen as important factors in recovery from a FEP (Vaingankar et al., 2020).

Morton et al. (2017) was the only paper in this review exploring EIP staff perspectives on recovery specifically. Morton et al. (2017) investigated EIP staff and client perspectives of how much a new EIP service promoted resilience, and in turn recovery, and found that the EIP service was seen to be adequately promoting the resilience and recovery of clients.

Our findings regarding EIP staff experiences of supporting recovery are consistent with NHS guidance on the ethos and approach of EIP services, which recommend providing holistic and recovery-focused support, including social and occupational interventions (Neale & Kinnair, 2017), and have a strong ethos of hope (NHS England, 2023).

Other mental health services (e.g. CMHTs) within the NHS use similar models of recovery, suggesting other staff experiences in this area may be similar to that of EIP staff. However, this would warrant further exploration given that research exploring mental health staff perspectives of recovery in psychosis generally have had

conflicting findings regarding staff optimism for client recovery and models of recovery (Hampson et al., 2018; Marwaha et al., 2009; Morera et al., 2017). For example, Marwaha et al. (2009) explored the attitudes of clinicians in CMHTs in the UK and found that, although staff viewed it as being part of their role to support clients in finding employment, they did not feel confident doing this and perceived that around two thirds of their clients would be unable to work. It would be of interest for future research to explore mental health staff perspectives of recovery across EIP and other services, and potential mediators for this e.g. staffs' levels of confidence in supporting clients' recovery, adequacy of staff training, clients' length of time in services, service model.

Supportive team approaches

EIP staff described positive experiences of using the team as a resource including getting support and advice from colleagues within the team, reflecting findings of other research in this area. O'Connell et al. (2021) explored the barriers and facilitators to the implementation of early psychosis services across a number of countries with a range of demographics. Organisational support facilitated effective implementation of EIP services (O'Connell et al., 2021). O'Connell et al. (2021) found that factors such as staff receiving supportive leadership and positive work environments were beneficial in creating EIP teams which staff perceive to be supportive.

Staff in other mental health teams, not just EIP teams, have been found to benefit from similar team approaches e.g. positive work environments, fostering a culture of trust and psychological safety, having positive relationships at work (Coates & Howe, 2015; O'Connor et al., 2018). Previous research also highlights team approaches that mental health staff find beneficial which were not in our review, such as staff

autonomy, receiving clinical supervision and staff recognition (Coates & Howe., 2015; O'Connor et al., 2018). There has been no current research investigating the experiences of EIP staff relating to team approaches, and the potential impacts of these on EIP staff, teams and clients.

Service pressures

EIP staff experiences were found to be impacted by service pressures e.g. resource issues. This supports findings of other UK-based research, such as Gilburt et al. (2013) who found that staff in mental health services perceive that resource issues affect their ability to provide recovery-oriented approaches, as this often requires working more intensively with clients over longer periods of time. NHS guidance also highlights the importance of considering the impact of workforce pressures on staff (Health and Social Care Committee, 2021; NHS Providers, 2022).

Previous reviews have found that limited resources and inadequate funding can be barriers to the development and adequate implementation of EIP services in the UK and in similar mental health services internationally (Causier et al., 2023; Csillag et al. 2016; O'Connell et al. 2021). Le Boutillier et al. (2015) found that when competing priorities arise for mental health staff, it can affect recovery-oriented practice, supporting our findings that service pressures can negatively impact the experience of EIP staff and client care. These findings are also supported by a report by the British Medical Association on the views of mental health staff, which found that 52% of respondents said they were too busy to provide the care they would like to and 44% said that their workload was unmanageable (British Medical Association, 2019).

Stigma

Studies indicated EIP staff recognise clients' internal and external stigma. No studies in this review focussed specifically on stigma despite our findings suggesting it is an important aspect of EIP staff experience, and consistent findings regarding the impact of stigma in those who have experienced a FEP (e.g. DeLuca & Yanos, 2023; Firmin et al., 2019; Franz et al., 2010; Gronholm et al., 2017; Ho et al., 2018; Hussain et al., 2024; Kinson et al., 2018; Kular et al., 2019; Vyas et al., 2021).

Internal stigma

The term 'internal stigma' was used in this review to define the phenomenon reported across many studies; the internalisation of negative stereotypes and prejudices (Jahn et al., 2020). Internal stigma is often experienced by those with FEP (Firmin et al., 2019; Gronholm et al., 2017; Ho et al., 2018; Hussain et al., 2024), as reported by EIP staff in the studies reviewed.

In many studies, EIP staff spoke about their experiences of noticing clients' internal stigma, but each named this differently e.g. self-stigmatisation (Nguyen et al., 2021). Firmin et al. (2019) found that levels of internalised stigma were higher in those with prolonged psychosis (42%) compared to those with early psychosis (25%), suggesting that internal stigma continues and potentially increases for those who experience psychosis for prolonged periods. There has been much research highlighting the prominence of internal stigma in people who experience psychosis generally (Eliasson et al., 2021; Sum et al., 2024) and other mental health difficulties (Alonso et al., 2019; Dubreucq et al., 2021), suggesting that internal stigma impacts many people with mental health difficulties and not solely those who experience a FEP.

External stigma

This review found that EIP staff perceive that clients' experience external stigma from those close to them (e.g. family), from communities, and from the media. This reflects findings of previous research focussing on EIP services, which highlight the impact of stigma on people who are accessing these services, including stigma from carers and family members (Franz et al., 2010; Kinson et al., 2018; Vyas et al., 2021). Some studies in this review found that EIP staff perceive stigma to be a societal problem influenced by factors such as the media and a lack of public awareness about mental health problems e.g. Whiting et al. (2024). Maletta and Vass (2023) found that mental health difficulties, such as psychosis, continue to be portrayed negatively by the UK media, supporting our findings.

The impact of stigma

This review found that EIP staff experiences involved noticing how stigma affects clients' mental health and well-being, including having a detrimental impact on the recovery of clients. EIP staff reported that stigma had led to clients in EIP services becoming more isolated, withdrawn socially and be less likely to open up (e.g. talk to staff about hearing voices). This reflects findings of other research that increased stigma in those with FEP can lead to social isolation, withdrawal and clients not disclosing their experiences (DeLuca & Yanos, 2023; Gronholm et al., 2017). Previous research has also suggested that mental health staff have an awareness of the stigma experienced by the clients they work with and the impacts this can have (Dobransky, 2019; O'Reilly et al., 2019; Paananen et al., 2020).

Addressing stigma

EIP staff were found to have experiences of seeking to challenge and reduce clients' stigma. This included EIP staff talking about stigmatised topics with clients,

and being conscious of how they speak to clients to avoid feeding into stigmatising narratives. Having peer staff within EIP services was also seen as beneficial in addressing clients' stigma (Nguyen et al., 2021; White et al., 2017).

Our findings support research regarding the benefits of peer support for destigmatising mental health difficulties (Burke et al., 2019; Ochocka et al., 2006; Repper & Carter, 2011; Simmons et al., 2020), and the importance of those who have experienced psychosis to be able to have safe, non-stigmatising conversations about their mental health (Klauber et al., 2024).

There are no current studies investigating how EIP staff seek to address clients' stigma through informal conversations with clients. Dobransky (2019) explored mental health staffs' approaches to stigma management when working with clients in mental health care generally. Dobransky (2019) found that staff had two main approaches: (1) Normalising, involving encouraging and supporting clients to acknowledge and disclose their mental health difficulties, and (2) Brokering/buffering, where staff take an active role to protect clients from potential external stigma by advocating for them. Our findings regarding EIP staff experiences suggest that EIP staff take on more of the 'normalising' role when talking to clients, as studies found that EIP staff seek to challenge and reduce clients' stigma by talking about stigmatised topics with them (Bogen-Johnston et al., 2020; Whiting et al., 2024), and involving peer staff to normalise experiencing FEP and offer perspectives of hope and recovery (Nguyen et al., 2021; White et al., 2017).

NHS guidance on the delivery of EIP services does not outline specific interventions or offer guidance for staff on facilitating conversations to address, reduce or challenge clients' stigma. However, evidence suggests that some of the interventions already offered by EIP services could potentially help address and

reduce clients' stigma, despite these not being designed to address stigma specifically. These include peer support (Nguyen et al., 2021), family therapy and the use of client-centred approaches (Vyas et al., 2021). Some small-scale studies have suggested the potential benefits of interventions designed to address stigma specifically, including therapeutic groups (Best et al., 2018; McCay et al. 2006) and Cognitive Therapy (Morrison et al., 2016).

Peer support

Nguyen et al. (2021) and White et al. (2017) found that having peer support staff in the team, who have their own lived experience of psychosis, can act as a 'bridge' between non-peer staff and clients. Peer staff, usually called 'Peer Support Workers', are people who work within mental health teams and have lived experience of mental health difficulties, drawing on this lived experience to provide support, hope and encouragement to clients (Health Education England, 2020).

Our findings suggest that some of the barriers to developing therapeutic relationships and alliances (e.g. power imbalances and stigma) could be reduced by offering peer support in EIP services. This supports previous research suggesting peer support has benefits for people with mental health difficulties including improving confidence and hope, and challenging mental health stigma (Burke et al., 2019; Ochocka et al., 2006; Simmons et al., 2020). Peer support has also been associated with a decrease in stigmatisation, symptom distress, as well as levels of depression and psychosis (Davidson et al., 2012; Repper & Carter, 2010).

Strengths and limitations

Strengths

Papers included in this review were mostly of good quality. Most studies reviewed were qualitative in their methodology, allowing this review to gather rich data about

EIP staff experiences. Synthesis of findings mostly reflect that of previous research in this area, including studies from other countries, and have a number of clinical implications and recommendations for future research, which will be discussed below.

Limitations

All studies included were conducted in the UK, with five based in the South of England and one in the North West of England. Four studies did not report the location of the EIP services that participants were recruited from. A possible limitation is that we cannot know whether the findings captured the experiences of EIP staff from a range of locations within the UK, and this may limit the generalisability of our findings to the UK as a whole. Our findings may therefore more accurately reflect experiences of EIP staff in the South of England.

No studies explored the experiences of EIP staff in aspects of their role that did not directly involve experiences of working with clients e.g. staff well-being, training, supervision. This likely led to the findings of this review being focussed primarily of EIP staff experiences of working with clients and may mean that other aspects of their experience were not captured in this review such as staff experiences of receiving training and supervision in EIP services.

One of the papers reviewed, Whiting et al. (2024), did not meet all criteria for validity and reliability on the MMAT quality appraisal (see Appendix 3). Whiting et al. (2024) used thematic analysis informed by the constant comparative method and did not adequately explain the justification for choosing this method. Potential issues with the quality of this study are a limitation of the review overall.

Clinical implications

Training and support for EIP staff on developing therapeutic relationships and navigating barriers to this may be beneficial e.g. boundaries and self-disclosure (Nguyen et al., 2021). The evaluation of staff-client therapeutic relationships may also be beneficial for EIP services, as stronger therapeutic relationships have been found to improve clients' engagement with services (Bone et al., 2023) and facilitate safe, non-judgmental conversations about experiences of psychosis (Bogen-Johnston et al., 2020). EIP services would benefit from seeking to identify and address clients' stigma, including offering peer support to improve hope, motivation and challenge pessimistic views about psychosis through the mutual sharing of lived experiences of FEP (Nguyen et al., 2021). Resource issues, such as low staffing levels and increased workload due to high client caseloads, and their impact on EIP staff and clients, warrants further attention in research and policy development (Morton et al., 2010; Woodward et al., 2019).

Future research

Ways in which EIP staff can further develop and maintain key therapeutic relationships with clients would be beneficial to explore further, as well as methods of evaluating EIP staff-client therapeutic relationships. It may be beneficial to conduct further research into how resource issues may impact the delivery of EIP services and the way in which EIP staff implement the EIP service approach.

Future research is needed to explore the specific benefits and optimal delivery of peer support in EIP services from the perspectives of clients and EIP staff, including peer staff. Further research into EIP staff experiences of working with clients' stigma would be beneficial. Insights into how EIP staff can discuss, address and reduce

clients' stigma would be of particular interest, as well as potential challenges and limitations to this.

Conclusion

This paper aimed to systematically review and provide a thematic synthesis of staff experiences of working in EIP services in the UK. The therapeutic relationship with clients, being client-centred and working with clients' stigma were key to EIP staff experiences. EIP staff benefit from a supportive whole team approach, but service pressures can negatively affect their work with clients. Implications for clinical practice include that EIP services would benefit from seeking to identify and address clients' stigma and providing peer support may be beneficial for this. Recommendations for future research include exploring how EIP staff can further develop and maintain therapeutic relationships with clients, the optimal delivery of peer support in EIP services, and EIP staff experiences of working with clients' stigma.

References

Alonso, M., Guillén, A. I., & Muñoz, M. (2019). Interventions to Reduce Internalized Stigma in individuals with Mental Illness: A Systematic Review. *The Spanish Journal of Psychology*, *22*, E27–E27. https://doi.org/10.1017/sjp.2019.9

Bertolote, J., & Mcgorry, P. (2005). Early intervention and recovery for young people with early psychosis: consensus statement. *British Journal of Psychiatry*, *187*(48), 116–s119. https://doi.org/10.1192/bjp.187.48.s116

Best, M. W., Grossman, M., Milanovic, M., Renaud, S., & Bowie, C. R. (2018). Be outspoken and overcome stigmatizing thoughts (BOOST): A group treatment for internalized stigma in first-episode psychosis. *Psychosis*, *10*(3), 187-197. https://doi.org/10.1080/17522439.2018.1472630

Bogen-Johnston, L., deVisser, R., Strauss, C., & Hayward, M. (2020). A qualitative study exploring how Practitioners within Early Intervention in Psychosis Services engage with Service Users' experiences of voice hearing? *Journal of Psychiatric and Mental Health Nursing*, *27*(5), 607–615. https://doi.org/10.1111/jpm.12612

Bone, A., Terry, R., & Whitfield, R. (2023). "It's a dent, not a break": an exploration of how care co-ordinators understand and navigate boundaries in early intervention in psychosis services. *Psychosis*, *15*(4), 381-393. https://doi.org/10.1080/17522439.2022.2108489

British Medical Association. (2019). *Measuring progress: Commitments to support and expand the mental health workforce in England.* https://www.bma.org.uk/media/2405/bma-measuring-progress-of-commitments-for-mental-health-workforce-jan-2020.pdf?_gl=1*1gxadpp*_up*MQ..*_ga*MTE4ODk0OTE1MS4xNzA5NjU0OTc5*_ga_F8G3Q36DDR*MTcwOTY1NDk3OC4xLjAuMTcwOTY1NDk3OC4wLjAuMA.

Bromley, S., Choi, M. A., & Faruqui, S. (2015, April). *First episode psychosis: An information guide*. Centre for Addition and Mental Health. https://drmiarademeyer.co.za/wp-content/uploads/2022/05/first-episode-psychosis.pdf

Browne, J., Nagendra, A., Kurtz, M., Berry, K., & Penn, D. L. (2019). The relationship between the therapeutic alliance and client variables in individual treatment for schizophrenia spectrum disorders and early psychosis: Narrative review. *Clinical Psychology Review*, *71*, 51–62. https://doi.org/10.1016/j.cpr.2019.05.002

Burke, E., Pyle, M., Machin, K., Varese, F., & Morrison, A. P. (2019). The Effects of Peer Support on Empowerment, Self-Efficacy, and Internalized Stigma: A Narrative Synthesis and Meta-Analysis. *Stigma and Health*, *4*(3), 337–356. https://doi.org/10.1037/sah0000148

Causier, C., Waite, F., Sivarajah, N., & Knight, M. T. D. (2024). Structural barriers to help-seeking in first-episode psychosis: A systematic review and thematic synthesis. *Early Intervention in Psychiatry*, *18*(5), 293–311. https://doi.org/10.1111/eip.13497

Coates, D., & Howe, D. (2015). Combatting staff burnout in mental health: Key managerial and leadership tasks that are fundamental to staff wellbeing and retention. *Asia Pacific Journal of Health Management*, *10*(2), 24-32. https://search.informit.org/doi/10.3316/ielapa.445686169940617

Correll, C. U., Galling, B., Pawar, A., Krivko, A., Bonetto, C., Ruggeri, M., Craig, T. J., Nordentoft, M., Robinson, D. G., & Kane, J. M. (2018). Comparison of early intervention services vs treatment as usual for early-phase psychosis: a systematic review, meta-analysis, and meta-regression. *JAMA psychiatry*, *75*(6), 555-565. https://doi.org/10.1001/jamapsychiatry.2018.0623

Craig, T. K., Garety, P., Power, P., Rahaman, N., Colbert, S., Fornells-Ambrojo, M., & Dunn, G. (2004). The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. *British Medical Journal*, *329*(7474), 1067. https://doi.org/10.1136/bmj.38246.594873.7C

Csillag, C., Nordentoft, M., Mizuno, M., Jones, P. B., Killackey, E., Taylor, M., Chen, E., Kane, J., & McDaid, D. (2016). Early intervention services in psychosis: from evidence to wide implementation. *Early Intervention in Psychiatry*, *10*(6), 540–546. https://doi.org/10.1111/eip.12279

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

DeLuca, J. S., & Yanos, P. T. (2023). Targeting Internalized Stigma in First-Episode Psychosis Services: Treatment Strategies from an Intersectional Perspective. *Journal of Health Service Psychology (Online)*, *49*(2), 101–111. https://doi.org/10.1007/s42843-023-00084-x

Department of Health. (1999, September). *A national service framework for mental health. Modern Standards and Service Models.* Department of Health. https://assets.publishing.service.gov.uk/media/5a7a050040f0b66eab99926f/National_Service_Framework_for_Mental_Health.pdf

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research & Policy*, *10*(1), 45–53. http://www.jstor.org/stable/26749970

Dobransky, K. M. (2019). Breaking down walls, building bridges: Professional stigma management in mental health care. *Society and Mental Health*, *9*(2), 228-242. https://doi.org/10.1177/2156869317750705

Dodgson, G., Crebbin, K., Pickering, C., Mitford, E., Brabban, A., & Paxton, R. (2008). Early intervention in psychosis service and psychiatric admissions. *Psychiatric Bulletin of the Royal College of Psychiatrists*, *32*(11), 413–416. https://doi.org/10.1192/pb.bp.107.017442

Dubreucq, J., Plasse, J., & Franck, N. (2021). Self-stigma in serious mental illness: A systematic review of frequency, correlates, and consequences. *Schizophrenia Bulletin*, *47*(5), 1261-1287. https://doi.org/10.1093/schbul/sbaa181

Eliasson, E. T., McNamee, L., Swanson, L., Lawrie, S. M., & Schwannauer, M. (2021). Unpacking stigma: Meta-analyses of correlates and moderators of personal stigma in psychosis. *Clinical Psychology Review*, *89*, 102077–102077. https://doi.org/10.1016/j.cpr.2021.102077

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review*, *28*(7), 1167–1187. https://doi.org/10.1016/j.cpr.2008.04.002

Firmin, R. L., Lysaker, P. H., Luther, L., Yanos, P. T., Leonhardt, B., Breier, A., & Vohs, J. L. (2019). Internalized stigma in adults with early phase versus prolonged psychosis. *Early Intervention in Psychiatry*, *13*(4), 745-751. https://doi.org/10.1111/eip.12553

Franz, L., Carter, T., Leiner, A. S., Bergner, E., Thompson, N. J., & Compton, M. T. (2010). Stigma and treatment delay in first-episode psychosis: a grounded theory study. *Early Intervention in Psychiatry*, *4*(1), 47–56. https://doi.org/10.1111/j.1751-7893.2009.00155.x

Garety, P. A., Craig, T.K. J., Dunn, G., Fornells-Ambrojo, M., Colbert, S., Rahman, N., Read, J., & Power, P. (2006). Specialised care for early psychosis: symptoms, social functioning and patient satisfaction: Randomised controlled trial. *British Journal of Psychiatry*, *188*(1), 37–45. https://doi.org/10.1192/bjp.bp.104.007286

Gilburt, H., Slade, M., Bird, V., Oduola, S., & Craig, T. K. J. (2013). Promoting recovery-oriented practice in mental health services: A quasi-experimental mixed-methods study. *BMC Psychiatry*, *13*(1), 167–167. https://doi.org/10.1186/1471-244X-13-167

Goldsmith, L. P., Lewis, S. W., Dunn, G., & Bentall, R. P. (2015). Psychological treatments for early psychosis can be beneficial or harmful, depending on the therapeutic alliance: an instrumental variable analysis. *Psychological Medicine*, *45*(11), 2365–2373. https://doi.org/10.1017/S003329171500032X

Gronholm, P. C., Thornicroft, G., Laurens, K. R., & Evans-Lacko, S. (2017). Mental health-related stigma and pathways to care for people at risk of psychotic disorders or experiencing first-episode psychosis: a systematic review. *Psychological Medicine*, *47*(11), 1867–1879. https://doi.org/10.1017/S0033291717000344

Hampson, M. E., Watt, B., & Hicks, R. (2018). Perspectives on Recovery in Psychosis. *Journal of Recovery in Mental Health*, *2*(1), 53-67. https://jps.library.utoronto.ca/index.php/rmh/article/view/31912

Hansen, H., Stige, S. H., Davidson, L., Løberg, E. M., & Veseth, M. (2019). “Needing different things from different people”–a qualitative exploration of recovery in first episode psychosis. *Social Work in Mental Health*, *18*(1), 75-95. https://doi.org/10.1080/15332985.2019.1679324

Harris, O., Lawes, A., Andrews, C., & Jacobsen, P. (2022). Kintsugi—Identity change and reconstruction following an episode of psychosis: A systematic review and thematic synthesis. *Early Intervention in Psychiatry*, *16*(7), 689–714. https://doi.org/10.1111/eip.13216

Health and Social Care Committee. (2021, June 8). *Workforce burnout and resilience in the NHS and social care: Second Report of Session 2021–22.* House of Commons. https://committees.parliament.uk/publications/6158/documents/68766/default/

Health Education England. (2020, October). *The Competence Framework for Mental Health Peer Support Workers. Part 1: Supporting document.* https://www.hee.nhs.uk/sites/default/files/documents/The%20Competence%20Framework%20for%20MH%20PSWs%20-%20Part%201%20-%20Supporting%20document_0.pdf

Henderson, P., Fisher, N. R., Ball, J., & Sellwood, W. (2020). Mental health practitioner experiences of engaging with service users in community mental health settings: A systematic review and thematic synthesis of qualitative evidence. *Journal of Psychiatric and Mental Health Nursing*, *27*(6), 807–820. https://doi.org/10.1111/jpm.12628

Hewitt, J., & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: literature review. *Journal of Advanced Nursing*, *52*(5), 561–570. https://doi.org/10.1111/j.1365-2648.2005.03623.x

Ho, R. W. H., Chang, W. C., Kwong, V. W. Y., Lau, E. S. K., Chan, G. H. K., Jim, O. T. T., Hui, C. L. M., Chan, S. K. W., Lee, E. H. M., & Chen, E. Y. H. (2018). Prediction of self-stigma in early psychosis: 3-year follow-up of the randomized-controlled

trial on extended early intervention. *Schizophrenia Research*, *195*, 463-468. https://doi.org/10.1016/j.schres.2017.09.004

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M.-P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M.-C., Vedel, I., & Pluye, P. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. *Education for Information*, *34*(4), 285–291. https://doi.org/10.3233/EFI-180221

Hussain, S., Yanos, P. T., Wiesepape, C. N., Samost, D. R., Myers, E. J., Munson, M. R., Lysaker, P. H., & Leonhardt, B. L. (2024). The Experience of Stigma and Treatment-Seeking Among Youth and Family Members Receiving First Episode Psychosis Services. *Stigma and Health*. https://doi.org/10.1037/sah0000507

Jahn, D. R., Leith, J., Muralidharan, A., Brown, C. H., Drapalski, A. L., Hack, S., & Lucksted, A. (2020). The Influence of Experiences of Stigma on Recovery: Mediating Roles of Internalized Stigma, Self-Esteem, and Self-Efficacy. *Psychiatric Rehabilitation Journal*, *43*(2), 97–105. https://doi.org/10.1037/prj0000377

Joseph, R., & Birchwood, M. (2005). The national policy reforms for mental health services and the story of early intervention services in the United Kingdom. *Journal of Psychiatry & Neuroscience*, *30*(5), 362–365. https://www.jpn.ca/content/30/5/362.short

Kinson, R. M., Hon, C., Lee, H., Abdin, E. B., & Verma, S. (2018). Stigma and discrimination in individuals with first episode psychosis; one year after first contact with psychiatric services. *Psychiatry Research*, *270*, 298–305. https://doi.org/10.1016/j.psychres.2018.09.044

Klauber, D. G., Christensen, S. H., Fink-Jensen, A., & Pagsberg, A. K. (2024). I Didn't Want the Psychotic Thing to Get Out to Anyone at All: Adolescents with Early Onset Psychosis Managing Stigma. *Culture, Medicine, and Psychiatry*, *48*(3), 569-590. https://doi.org/10.1007/s11013-024-09859-3

Kular, A., Perry, B. I., Brown, L., Gajwani, R., Jasini, R., Islam, Z., Birchwood, M., & Singh, S. P. (2019). Stigma and access to care in first-episode psychosis. *Early Intervention in Psychiatry*, *13*(5), 1208–1213. https://doi.org/10.1111/eip.12756

Lam, M. M., Pearson, V., Ng, R. M., Chiu, C. P., Law, C. W., & Chen, E. Y. (2011). What does recovery from psychosis mean? Perceptions of young first-episode patients. *International Journal of Social Psychiatry*, *57*(6), 580-587. https://doi.org/10.1177/0020764010374418

Le Boutillier, C., Chevalier, A., Lawrence, V., Leamy, M., Bird, V. J., Macpherson, R., Williams, J., & Slade, M. (2015). Staff understanding of recovery-orientated mental health practice: A systematic review and narrative synthesis. *Implementation Science*, *10*(1), 87–87. https://doi.org/10.1186/s13012-015-0275-4

Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, *27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Lonsdale, N., & Webber, M. (2021). Practitioner opinions of crisis plans within early intervention in psychosis services: A mixed methods study. *Health & Social Care in the Community*, *29*(6), 1936–1947. https://doi.org/10.1111/hsc.13308

Loughlin, M., Bucci, S., Brooks, J., & Berry, K. (2020). Service users' and carers' experiences of engaging with early intervention services: A meta-synthesis review. *Early Intervention in Psychiatry*, *14*(1), 26–36. https://doi.org/10.1111/eip.12803

Maletta, R. M., & Vass, V. (2023). A 20-year review comparing the use of 'schizophrenia' and 'psychosis' in UK newspapers from 2000 to 2019: Implications

for stigma reduction. *Schizophrenia Research*, *251*, 66–73. https://doi.org/10.1016/j.schres.2022.12.012

Marshall, M., Lockwood, A., Lewis, S., & Fiander, M. (2004). Essential elements of an early intervention service for psychosis: The opinions of expert clinicians. *BMC Psychiatry*, *4*(1), 17–17. https://doi.org/10.1186/1471-244X-4-17

Marwaha, S., Balachandra, S., & Johnson, S. (2009). Clinicians' attitudes to the employment of people with psychosis. *Social Psychiatry and Psychiatric Epidemiology, 44*(5), 349–360. https://doi.org/10.1007/s00127-008-0447-5

McCay, E., Beanlands, H., Zipursky, R., Roy, P., Leszcz, M., Landeen, J., Ryan. K., Conrad, G., Romano, D., Francis, D., Hunt, J., Constantini, L., & Chan, E. (2007). A randomised controlled trial of a group intervention to reduce engulfment and self-stigmatisation in first episode schizophrenia. *Australian e-journal for the Advancement of Mental Health*, *6*(3), 212-220. https://doi.org/10.5172/jamh.6.3.212

Morera, T., Pratt, D., & Bucci, S. (2017). Staff views about psychosocial aspects of recovery in psychosis: A systematic review. *Psychology and Psychotherapy*, *90*(1), 1–24. https://doi.org/10.1111/papt.12092

Morrison, A. P., Burke, E., Murphy, E., Pyle, M., Bowe, S., Varese, F., Dunn, G., Chapman, N., Hutton, P., Welford, M., & Wood, L. J. (2016). Cognitive Therapy for Internalised Stigma in People Experiencing Psychosis: A pilot randomised controlled trial. *Psychiatry Research*, *240*, 96–102. https://doi.org/10.1016/j.psychres.2016.04.024

Morton, A., Fairhurst, A., & Ryan, R. (2010). Promoting recovery: service user and staff perceptions of resilience provided by a new Early Intervention in Psychosis

service. *Early Intervention in Psychiatry*, *4*(1), 89–92. https://doi.org/10.1111/j.1751-7893.2009.00151.x

Navas, C., Wells, L., Bartels, S. A., & Walker, M. (2022). Patient and Provider Perspectives on Emergency Department Care Experiences among People with Mental Health Concerns. *Healthcare*, *10*(7), 1297. https://doi.org/10.3390/healthcare10071297

Neale, A., & Kinnair, D. (2017). Early intervention in psychosis services. *British Journal of General Practice*, *67*(661), 370-371. https://doi.org/10.3399/bjgp17X692069

Nguyen, J., Goldsmith, L., Rains, L. S., & Gillard, S. (2021). Peer support in early intervention in psychosis: a qualitative research study. *Journal of Mental Health*, *31*(2), 196–202. https://doi.org/10.1080/09638237.2021.1922647

NHS. (2023, September 5). *Overview – Psychosis.* Mental Health Conditions. https://www.nhs.uk/mental-health/conditions/psychosis/overview/

NHS England. (2023, February 16). *Implementing the early intervention in psychosis access and waiting time standard.* https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf

NHS Providers. (2022, September). *Rising living costs – the impact on NHS, staff and patients.* https://nhsproviders.org/media/694201/nhs-providers-cost-of-living-survey-briefing-september-2022.pdf

National Institute for Health and Care Excellence. (2014, February 1). *Psychosis and Schizophrenia in Adults: Prevention and Management.* https://www.nice.org.uk/guidance/cg178/resources/psychosis-and-schizophrenia-in-adults-pdf-248578083781

O'Connell, N., O'Connor, K., McGrath, D., Vagge, L., Mockler, D., Jennings, R., & Darker, C. D. (2021). Early Intervention in Psychosis services: A systematic review and narrative synthesis of the barriers and facilitators to implementation. *European Psychiatry*, *65*(1), e2–e2. https://doi.org/10.1192/j.eurpsy.2021.2260

O'Connor, K., Neff, D. M., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, *53*, 74-99. https://doi.org/10.1016/j.eurpsy.2018.06.003

O'Reilly, C. L., Paul, D., McCahon, R., Shankar, S., Rosen, A., & Ramzy, T. (2019). Stigma and discrimination in individuals with severe and persistent mental illness in an assertive community treatment team: Perceptions of families and healthcare professionals. *International Journal of Social Psychiatry*, *65*(7-8), 570-579. https://doi.org/10.1177/0020764019867358

Ochocka, J., Nelson, G., Janzen, R., & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 3-A qualitative study of impacts of participation on new members. *Journal of Community Psychology*, *34*(3), 273–283. https://doi.org/10.1002/jcop.20099

Paananen, J., Lindholm, C., Stevanovic, M., & Weiste, E. (2020). Tensions and paradoxes of stigma: Discussing stigma in mental health rehabilitation. *International Journal of Environmental Research and Public Health*, *17*(16), 1–18. https://doi.org/10.3390/ijerph17165943

Pace, R., Pluye, P., Bartlett, G., Macaulay, A. C., Salsberg, J., Jagosh, J., & Seller, R. (2012). Testing the reliability and efficiency of the pilot Mixed Methods Appraisal Tool (MMAT) for systematic mixed studies review. *International Journal of Nursing Studies*, *49*(1), 47–53. https://doi.org/10.1016/j.ijnurstu.2011.07.002

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*(4), 392–411. https://doi.org/10.3109/09638237.2011.583947

Royal College of Psychiatrists. (2025, April 1). *Quality Standards for Early Intervention in Psychosis Services (Third Edition).* https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/early-intervention-in-psychosis-teams-(eipn)/eipn-3rd-edition-standards---april-2025.pdf?sfvrsn=25c71a3d_3

Simmons, M. B., Grace, D., Fava, N. J., Coates, D., Dimopoulos-Bick, T., Batchelor, S., Howe, D., & Montague, A. E. (2020). The Experiences of Youth Mental Health Peer Workers over Time: A Qualitative Study with Longitudinal Analysis. *Community Mental Health Journal*, *56*(5), 906–914. https://doi.org/10.1007/s10597-020-00554-2

Stefanidou, T., Wang, J., Morant, N., Lloyd-Evans, B., & Johnson, S. (2021). Loneliness in early psychosis: a qualitative study exploring the views of mental health practitioners in early intervention services. *BMC Psychiatry*, *21*(1), 134–134. https://doi.org/10.1186/s12888-021-03138-w

Subasinghe, A., Hart, L. M., Radeka, A., Paxton, S. J., & Morgan, A. (2023). Young people's help-giving actions towards a peer with a mental health problem: A systematic review and narrative synthesis. *Early Intervention in Psychiatry*, *17*(4), 337–353. https://doi.org/10.1111/eip.13354

Sum, M. Y., Wong, C. T. W., Chu, S. T., Li, A., Lee, A. H. T., Chen, E. Y. H., & Chan, S. K. W. (2024). Systematic review and meta-analysis of internalised stigma and stigma resistance in patients with psychosis: The impact of individualism-

collectivism culture and other individual factors. International Journal of Social Psychiatry, 70(4), 639-652. https://doi.org/10.1177/00207640231216924

Sweeney, A., Fahmy, S., Nolan, F., Morant, N., Fox, Z., Lloyd-Evans, B., Osborn, D., Burgess, E., Gilburt, H., McCabe, R., Slade, M., & Johnson, S. (2014). The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: A cross-sectional study. *PloS One*, *9*(7), e100153–e100153. https://doi.org/10.1371/journal.pone.0100153

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(1), 45–45. https://doi.org/10.1186/1471-2288-8-45

Tindall, R. M., Simmons, M. B., Allott, K., & Hamilton, B. E. (2018). Essential ingredients of engagement when working alongside people after their first episode of psychosis: A qualitative meta-synthesis. *Early intervention in psychiatry*, *12*(5), 784–795. https://doi.org/10.1111/eip.12566

Vaingankar, J. A., Cetty, L., Subramaniam, M., Lee, Y. Y., Chong, S. A., Lee, H., & Verma, S. (2020). Recovery in psychosis: perspectives of clients with first episode psychosis. *Ann Acad Med Singap*, *49*(4), 186-198. https://pubmed.ncbi.nlm.nih.gov/32296807/

Vyas, A., Wood, L., & McPherson, S. (2021). A qualitative exploration of stigma experiences of second-generation British South-Asian people using an early intervention in psychosis service. *Psychosis*, *13*(4), 302-314. https://doi.org/10.1080/17522439.2021.1897654

White, H., Price, L., & Barker, T. (2017). Exploring the impact of peer support in early intervention in psychosis. *Mental Health and Social Inclusion*, *21*(2), 102–109. https://doi.org/10.1108/MHSI-12-2016-0036

Whiting, D., Glogowska, M., Fazel, S., & Lennox, B. (2024). Approaches and challenges to assessing risk of violence in first episode psychosis: A qualitative interview study of clinicians, patients and carers. *Early Intervention in Psychiatry*, *18*(8), 624–632. https://doi.org/10.1111/eip.13502

Windell, D., Norman, R., & Malla, A. K. (2012). The personal meaning of recovery among individuals treated for a first episode of psychosis. *Psychiatric Services*, *63*(6), 548-553. https://doi.org/10.1176/appi.ps.201100424

Wood, L., & Alsawy, S. (2018). Recovery in Psychosis from a Service User Perspective: A Systematic Review and Thematic Synthesis of Current Qualitative Evidence. *Community Mental Health Journal*, *54*(6), 793–804. https://doi.org/10.1007/s10597-017-0185-9

Woodward, S., Bucci, S., Edge, D., & Berry, K. (2019). Barriers and facilitators to "moving on" from early intervention in psychosis services. *Early intervention in psychiatry*, *13*(4), 914-921. https://doi.org/10.1111/eip.12708

Appendices

Appendix 1

MMAT guidelines

From Hong et al. (2018). Legend corresponds to the categories outlined in the MMAT appraisal table in Appendix 3.

1. Qualitative studies	Methodological quality criteria
"Qualitative research is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (Creswell, 2013b, p. 3). Common qualitative research approaches include (this list if not exhaustive): **Ethnography** The aim of the study is to describe and interpret the shared cultural behaviour of a group of individuals. **Phenomenology** The study focuses on the subjective experiences and interpretations of a phenomenon encountered by individuals. **Narrative research** The study analyzes life experiences of an individual or a group. **Grounded theory** Generation of theory from data in the process of conducting research (data collection occurs first).	1.1. Is the qualitative approach appropriate to answer the research question? Explanations The qualitative approach used in a study (see non-exhaustive list on the left side of this table) should be appropriate for the research question and problem. For example, the use of a grounded theory approach should address the development of a theory and ethnography should study human cultures and societies. This criterion was considered important to add in the MMAT since there is only one category of criteria for qualitative studies (compared to three for quantitative studies).
	1.2. Are the qualitative data collection methods adequate to address the research question? Explanations This criterion is related to data collection method, including data sources (e.g., archives, documents), used to address the research question. To judge this criterion, consider whether the method of data collection (e.g., in depth interviews and/or group interviews, and/or observations) and the form of the data (e.g., tape recording, video material, diary, photo, and/or field notes) are adequate. Also, clear justifications are needed when data collection methods are modified during the study.
	1.3. Are the findings adequately derived from the data? Explanations This criterion is related to the data analysis used. Several data analysis methods have been developed and their use depends on the research question and qualitative approach. For example, open, axial and selective coding is often associated with grounded theory, and within- and cross-case analysis is often seen in case study.

Case study In-depth exploration and/or explanation of issues intrinsic to a particular case. A case can be anything from a decision-making process, to a person, an organization, or a country. **Qualitative description** There is no specific methodology, but a qualitative data collection and analysis, e.g., in-depth interviews or focus groups, and hybrid thematic analysis (inductive and deductive). Key references: Creswell (2013a); Sandelowski (2010); Schwandt (2015)	1.4. Is the interpretation of results sufficiently substantiated by data? Explanations The interpretation of results should be supported by the data collected. For example, the quotes provided to justify the themes should be adequate.
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation? Explanations There should be clear links between data sources, collection, analysis and interpretation.
2. Quantitative randomized controlled trials	**Methodological quality criteria**
Randomized controlled clinical trial: A clinical study in which individual participants are allocated to intervention or control groups by randomization (intervention assigned by researchers). Key references: Higgins and Green (2008); Higgins et al. (2016); Oxford Centre for Evidence-based Medicine (2016); Porta et al. (2014)	2.1. Is randomization appropriately performed? Explanations In a randomized controlled trial, the allocation of a participant (or a data collection unit, e.g., a school) into the intervention or control group is based solely on chance. Researchers should describe how the randomization schedule was generated. A simple statement such as 'we randomly allocated' or 'using a randomized design' is insufficient to judge if randomization was appropriately performed. Also, assignment that is predictable such as using odd and even record numbers or dates is not appropriate. At minimum, a simple allocation (or unrestricted allocation) should be performed by following a predetermined plan/sequence. It is usually achieved by referring to a published list of random numbers, or to a list of random assignments generated by a computer. Also, restricted allocation can be performed such as blocked randomization (to ensure particular allocation ratios to the intervention groups), stratified randomization (randomization performed separately within strata), or minimization (to make small groups closely similar with respect to several characteristics). Another important characteristic to judge if randomization was appropriately performed is allocation concealment that protects assignment sequence until allocation. Researchers and participants should be unaware of the assignment sequence up to the point of allocation. Several strategies can be used to ensure allocation concealment such relying on a central randomization by a third party, or the use of sequentially numbered, opaque, sealed envelopes (Higgins et al., 2016).

	2.2. Are the groups comparable at baseline? Explanations Baseline imbalance between groups suggests that there are problems with the randomization. Indicators from baseline imbalance include: “(1) unusually large differences between intervention group sizes; (2) a substantial excess in statistically significant differences in baseline characteristics than would be expected by chance alone; (3) imbalance in key prognostic factors (or baseline measures of outcome variables) that are unlikely to be due to chance; (4) excessive similarity in baseline characteristics that is not compatible with chance; (5) surprising absence of one or more key characteristics that would be expected to be reported” (Higgins et al., 2016, p. 10).
	2.3. Are there complete outcome data? Explanations Almost all the participants contributed to almost all measures. There is no absolute and standard cut-off value for acceptable complete outcome data. Agree among your team what is considered complete outcome data in your field and apply this uniformly across all the included studies. For instance, in the literature, acceptable complete data value ranged from 80% (Thomas et al., 2004; Zaza et al., 2000) to 95% (Higgins et al., 2016). Similarly, different acceptable withdrawal/dropouts rates have been suggested: 5% (de Vet et al., 1997; MacLehose et al., 2000), 20% (Sindhu et al., 1997; Van Tulder et al., 2003) and 30% for a follow-up of more than one year (Viswanathan and Berkman, 2012).
	2.4. Are outcome assessors blinded to the intervention provided? Explanations Outcome assessors should be unaware of who is receiving which interventions. The assessors can be the participants if using participant reported outcome (e.g., pain), the intervention provider (e.g., clinical exam), or other persons not involved in the intervention (Higgins et al., 2016).
	2.5 Did the participants adhere to the assigned intervention? Explanations To judge this criterion, consider the proportion of participants who continued with their assigned intervention throughout follow-up. “Lack of adherence includes imperfect compliance, cessation of intervention, crossovers to the comparator intervention and switches to another active intervention.” (Higgins et al., 2016, p. 25).

3. Quantitative non-randomized studies	Methodological quality criteria
Non-randomized studies are defined as any quantitative studies estimating the effectiveness of an intervention or studying other exposures that do not use randomization to allocate units to comparison groups (Higgins and Green, 2008). Common designs include (this list if not exhaustive): **Non-randomized controlled trials** The intervention is assigned by researchers, but there is no randomization, e.g., a pseudo-randomization. A nonrandom method of allocation is not reliable in producing alone similar groups. **Cohort study** Subsets of a defined population are assessed as exposed, not exposed, or exposed at different degrees to factors of interest. Participants are followed over time to determine if an outcome occurs (prospective longitudinal). **Case-control study** Cases, e.g., patients, associated with a certain outcome are selected, alongside a corresponding group of controls. Data is collected on whether cases and controls were exposed to the factor under study (retrospective). **Cross-sectional analytic study** At one particular time, the relationship between healthrelated characteristics (outcome) and other factors	3.1. Are the participants representative of the target population? Explanations Indicators of representativeness include: clear description of the target population and of the sample (inclusion and exclusion criteria), reasons why certain eligible individuals chose not to participate, and any attempts to achieve a sample of participants that represents the target population.
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)? Explanations Indicators of appropriate measurements include: the variables are clearly defined and accurately measured; the measurements are justified and appropriate for answering the research question; the measurements reflect what they are supposed to measure; validated and reliability tested measures of the intervention/exposure and outcome of interest are used, or variables are measured using ‘gold standard’.
	3.3. Are there complete outcome data? Explanations Almost all the participants contributed to almost all measures. There is no absolute and standard cut-off value for acceptable complete outcome data. Agree among your team what is considered complete outcome data in your field (and based on the targeted journal) and apply this uniformly across all the included studies. For example, in the literature, acceptable complete data value ranged from 80% (Thomas et al., 2004; Zaza et al., 2000) to 95% (Higgins et al., 2016). Similarly, different acceptable withdrawal/dropouts rates have been suggested: 5% (de Vet et al., 1997; MacLehose et al., 2000), 20% (Sindhu et al., 1997; Van Tulder et al., 2003) and 30% for follow-up of more than one year (Viswanathan and Berkman, 2012).
	3.4. Are the confounders accounted for in the design and analysis? Explanations Confounders are factors that predict both the outcome of interest and the intervention received/exposure at baseline. They can distort the interpretation of findings and need to be considered in the design and analysis of a non-randomized study. Confounding bias is low if there is no confounding expected, or appropriate methods to control for confounders are used (such as stratification, regression, matching, standardization, and inverse probability weighting).

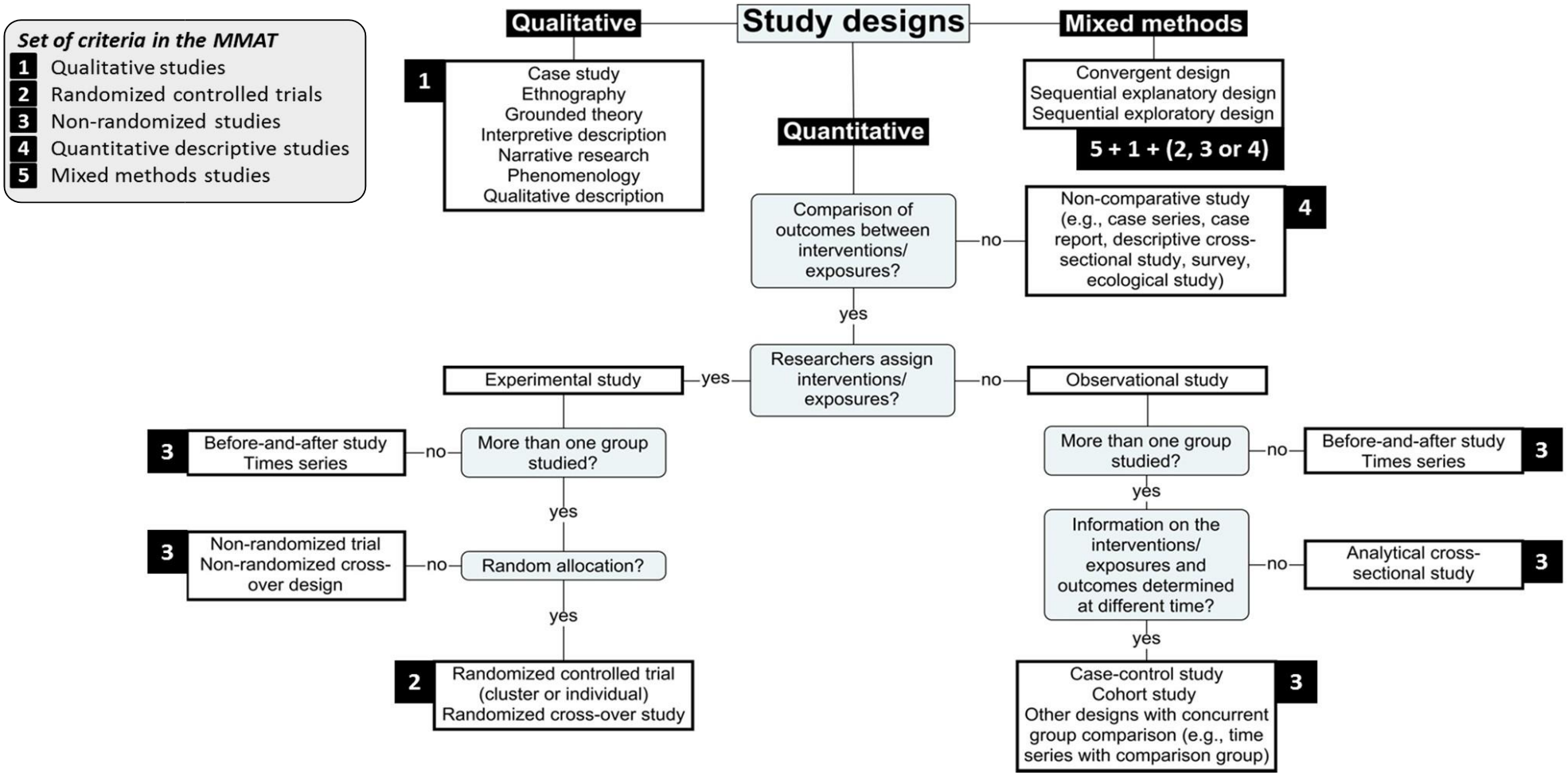
(intervention/exposure) is examined. E.g., the frequency of outcomes is compared in different population subgroups according to the presence/absence (or level) of the intervention/exposure. Key references for non-randomized studies: Higgins and Green (2008); Porta et al. (2014); Sterne et al. (2016); Wells et al. (2000)	3.5 During the study period, is the intervention administered (or exposure occurred) as intended? Explanations For intervention studies, consider whether the participants were treated in a way that is consistent with the planned intervention. Since the intervention is assigned by researchers, consider whether there was a presence of contamination (e.g., the control group may be indirectly exposed to the intervention) or whether unplanned co-interventions were present in one group (Sterne et al., 2016). For observational studies, consider whether changes occurred in the exposure status among the participants. If yes, check if these changes are likely to influence the outcome of interest, were adjusted for, or whether unplanned co-exposures were present in one group (Morgan et al., 2017).
4. Quantitative descriptive studies	**Methodological quality criteria**
Quantitative descriptive studies are "concerned with and designed only to describe the existing distribution of variables without much regard to causal relationships or other hypotheses" (Porta et al., 2014, p. 72). They are used to monitoring the population, planning, and generating hypothesis (Grimes and Schulz, 2002). Common designs include the following single-group studies (this list if not exhaustive): **Incidence or prevalence study without comparison group** In a defined population at one particular time, what is happening in a population, e.g., frequencies of factors (importance of problems), is described (portrayed). **Survey** "Research method by which information is gathered by asking people questions on a specific topic and the data collection procedure is standardized and well defined." (Bennett et al., 2011, p. 3).	4.1. Is the sampling strategy relevant to address the research question? Explanations Sampling strategy refers to the way the sample was selected. There are two main categories of sampling strategies: probability sampling (involve random selection) and non-probability sampling. Depending on the research question, probability sampling might be preferable. Nonprobability sampling does not provide equal chance of being selected. To judge this criterion, consider whether the source of sample is relevant to the target population; a clear justification of the sample frame used is provided; or the sampling procedure is adequate.
	4.2. Is the sample representative of the target population? Explanations There should be a match between respondents and the target population. Indicators of representativeness include: clear description of the target population and of the sample (such as respective sizes and inclusion and exclusion criteria), reasons why certain eligible individuals chose not to participate, and any attempts to achieve a sample of participants that represents the target population.
	4.3. Are the measurements appropriate? Explanations Indicators of appropriate measurements include: the variables are clearly defined and accurately measured, the measurements are justified and appropriate for answering the research question; the measurements reflect what they are supposed to measure; validated and reliability tested measures of the outcome of interest are used, variables are measured using 'gold standard', or questionnaires are pre-tested prior to data collection.

Case series A collection of individuals with similar characteristics are used to describe an outcome. **Case report** An individual or a group with a unique/unusual outcome is described in detail. Key references: Critical Appraisal Skills Programme (2017); Draugalis et al. (2008)	4.4. Is the risk of nonresponse bias low? Explanations Nonresponse bias consists of "an error of nonobservation reflecting an unsuccessful attempt to obtain the desired information from an eligible unit." (Federal Committee on Statistical Methodology, 2001, p. 6). To judge this criterion, consider whether the respondents and nonrespondents are different on the variable of interest. This information might not always be reported in a paper. Some indicators of low nonresponse bias can be considered such as a low nonresponse rate, reasons for nonresponse (e.g., noncontacts vs. refusals), and statistical compensation for nonresponse (e.g., imputation). The nonresponse bias is might not be pertinent for case series and case report. This criterion could be adapted. For instance, complete data on the cases might be important to consider in these designs.
	4.5. Is the statistical analysis appropriate to answer the research question? Explanations The statistical analyses used should be clearly stated and justified in order to judge if they are appropriate for the design and research question, and if any problems with data analysis limited the interpretation of the results.
5. Mixed methods studies	**Methodological quality criteria**
Mixed methods (MM) research involves combining qualitative (QUAL) and quantitative (QUAN) methods. In this tool, to be considered MM, studies have to meet the following criteria (Creswell and Plano Clark, 2017): (a) at least one QUAL method and one QUAN method are combined; (b) each method is used rigorously in accordance to the generally accepted criteria in the area (or tradition) of research invoked; and (c) the combination of the methods is carried out at the minimum through a MM design (defined *a priori*, or emerging) and the integration of the QUAL and QUAN phases, results, and data. Common designs include (this list if not exhaustive): **Convergent design**	5.1. Is there an adequate rationale for using a mixed methods design to address the research question? Explanations The reasons for conducting a mixed methods study should be clearly explained. Several reasons can be invoked such as to enhance or build upon qualitative findings with quantitative results and vice versa; to provide a comprehensive and complete understanding of a phenomenon or to develop and test instruments (Bryman, 2006).
	5.2. Are the different components of the study effectively integrated to answer the research question? Explanations Integration is a core component of mixed methods research and is defined as the "explicit interrelating of the quantitative and qualitative component in a mixed methods study" (Plano Clark and Ivankova, 2015, p. 40). Look for information on how qualitative and quantitative phases, results, and data were integrated (Pluye et al., 2018). For instance, how data gathered by both research methods was brought together to form a complete picture (e.g., joint displays) and when integration occurred (e.g., during the data collection-analysis or/and during the interpretation of qualitative and quantitative results).

The QUAL and QUAN components are usually (but not necessarily) concomitant. The purpose is to examine the same phenomenon by interpreting QUAL and QUAN results (bringing data analysis together at the interpretation stage), or by integrating QUAL and QUAN datasets (e.g., data on same cases), or by transforming data (e.g., quantization of qualitative data). **Sequential explanatory design** Results of the phase 1 - QUAN component inform the phase 2 - QUAL component. The purpose is to explain QUAN results using QUAL findings. E.g., the QUAN results guide the selection of QUAL data sources and data collection, and the QUAL findings contribute to the interpretation of QUAN results. **Sequential exploratory design** Results of the phase 1 - QUAL component inform the phase 2 - QUAN component. The purpose is to explore, develop and test an instrument (or taxonomy), or a conceptual framework (or theoretical model). E.g., the QUAL findings inform the QUAN data collection, and the QUAN results allow a statistical generalization of the QUAL findings. Key references: Creswell et al. (2011); Creswell and Plano Clark, (2017); O'Cathain (2010)	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? Explanations This criterion is related to meta-inference, which is defined as the overall interpretations derived from integrating qualitative and quantitative findings (Teddlie and Tashakkori, 2009). Meta-inference occurs during the interpretation of the findings from the integration of the qualitative and quantitative components, and shows the added value of conducting a mixed methods study rather than having two separate studies.
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? Explanations When integrating the findings from the qualitative and quantitative components, divergences and inconsistencies (also called conflicts, contradictions, discordances, discrepancies, and dissonances) can be found. It is not sufficient to only report the divergences; they need to be explained. Different strategies to address the divergences have been suggested such as reconciliation, initiation, bracketing and exclusion (Pluye et al., 2009b). Rate this criterion 'Yes' if there is no divergence.
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? Explanations The quality of the qualitative and quantitative components should be individually appraised to ensure that no important threats to trustworthiness are present. To appraise 5.5, use criteria for the qualitative component (1.1 to 1.5), and the appropriate criteria for the quantitative component (2.1 to 2.5, or 3.1 to 3.5, or 4.1 to 4.5). The quality of both components should be high for the mixed methods study to be considered of good quality. The premise is that the overall quality of a mixed methods study cannot exceed the quality of its weakest component. For example, if the quantitative component is rated high quality and the qualitative component is rated low quality, the overall rating for this criterion will be of low quality.

Appendix 2

Algorithm for selecting the study categories to rate in the MMAT



Note Adapted from National Institute for Health Care Excellence. (2012). *Methods for the development of nice public health guidance*. London: National Institute for Health and Care Excellence; and Scottish Intercollegiate Guidelines Network. (2017). *Algorithm for classifying study design for questions of effectiveness*. Retrieved December 1, 2017, from http://www.sign.ac.uk/assets/study_design.pdf.

Appendix 3

Quality appraisal of papers using the MMAT

Paper 1

Whiting, D., Glogowska, M., Fazel, S., & Lennox, B. (2024). Approaches and challenges to assessing risk of violence in first episode psychosis: A qualitative interview study of clinicians, patients and carers. *Early Intervention in Psychiatry*, *18*(8), 624–632. https://doi.org/10.1111/eip.13502

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?		X		Uses thematic analysis with a constant comparative method. Unclear justification given for why this method was used.
	1.2. Are the qualitative data collection methods adequate to address the research question?	X			
	1.3. Are the findings adequately derived from the data?	X			
	1.4. Is the interpretation of results sufficiently substantiated by data?	X			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	X			

Paper 2

Bone, A., Terry, R., & Whitfield, R. (2023). “It’s a dent, not a break”: an exploration of how care co-ordinators understand and navigate boundaries in early intervention in psychosis services. *Psychosis*, *15*(4), 381-393. https://doi.org/10.1080/17522439.2022.2108489

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can’t tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is ‘No’ or ‘Can’t tell’ to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	X			
	1.2. Are the qualitative data collection methods adequate to address the research question?	X			
	1.3. Are the findings adequately derived from the data?	X			
	1.4. Is the interpretation of results sufficiently substantiated by data?	X			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	X			

Paper 3

Nguyen, J., Goldsmith, L., Rains, L. S., & Gillard, S. (2021). Peer support in early intervention in psychosis: a qualitative research study. *Journal of Mental Health*, *31*(2), 196–202. https://doi.org/10.1080/09638237.2021.1922647

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	X			
	1.2. Are the qualitative data collection methods adequate to address the research question?	X			
	1.3. Are the findings adequately derived from the data?	X			
	1.4. Is the interpretation of results sufficiently substantiated by data?	X			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	X			

Paper 4

Lonsdale, N., & Webber, M. (2021). Practitioner opinions of crisis plans within early intervention in psychosis services: A mixed methods study.

Health & Social Care in the Community, *29*(6), 1936–1947. https://doi.org/10.1111/hsc.13308

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	X			
	5.2. Are the different components of the study effectively integrated to answer the research question?	X			
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	X			
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	X			
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	X			

Paper 5

Stefanidou, T., Wang, J., Morant, N., Lloyd-Evans, B., & Johnson, S. (2021). Loneliness in early psychosis: a qualitative study exploring the views of mental health practitioners in early intervention services. BMC psychiatry, 21, 134–134. https://doi.org/10.1186/s12888-021-03138-w

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	X			
	1.2. Are the qualitative data collection methods adequate to address the research question?	X			
	1.3. Are the findings adequately derived from the data?	X			
	1.4. Is the interpretation of results sufficiently substantiated by data?	X			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	X			

Paper 6

Bogen-Johnston, L., deVisser, R., Strauss, C., & Hayward, M. (2020). A qualitative study exploring how Practitioners within Early Intervention in Psychosis Services engage with Service Users' experiences of voice hearing? *Journal of Psychiatric and Mental Health Nursing*, *27*(5), 607–615. https://doi.org/10.1111/jpm.12612

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	X			
	1.2. Are the qualitative data collection methods adequate to address the research question?	X			
	1.3. Are the findings adequately derived from the data?	X			
	1.4. Is the interpretation of results sufficiently substantiated by data?	X			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	X			

Paper 7

Woodward, S., Bucci, S., Edge, D., & Berry, K. (2019). Barriers and facilitators to “moving on” from early intervention in psychosis services. *Early intervention in Psychiatry*, *13*(4), 914-921. https://doi.org/10.1111/eip.12708

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can’t tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is ‘No’ or ‘Can’t tell’ to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	X			
	1.2. Are the qualitative data collection methods adequate to address the research question?	X			
	1.3. Are the findings adequately derived from the data?	X			
	1.4. Is the interpretation of results sufficiently substantiated by data?	X			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	X			

Paper 8

White, H., Price, L., & Barker, T. (2017). Exploring the impact of peer support in early intervention in psychosis. *Mental Health and Social Inclusion*, *21*(2), 102–109. https://doi.org/10.1108/MHSI-12-2016-0036

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	X			
	1.2. Are the qualitative data collection methods adequate to address the research question?	X			
	1.3. Are the findings adequately derived from the data?	X			
	1.4. Is the interpretation of results sufficiently substantiated by data?	X			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	X			

Paper 9

Morton, A., Fairhurst, A., & Ryan, R. (2010). Promoting recovery: service user and staff perceptions of resilience provided by a new Early Intervention in Psychosis service. *Early Intervention in Psychiatry*, *4*(1), 89–92. https://doi.org/10.1111/j.1751-7893.2009.00151.x

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			

Paper 10

Marshall, M., Lockwood, A., Lewis, S., & Fiander, M. (2004). Essential elements of an early intervention service for psychosis: The opinions of expert clinicians. *BMC Psychiatry*, *4*(1), 17–17.https://doi.org/10.1186/1471-244X-4-17

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			

Appendix 4

Early Intervention in Psychiatry author guidelines

Reviews which synthesize important information on a topic of general interest to early intervention in psychiatry (suggested word count for text 5000; abstract maximum 250);

Your manuscript: this should be an editable file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision.

Your main document file should include:

· A short informative title containing the major key words. The title should not contain abbreviations;

· The full names of the authors with institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;

· Acknowledgments;

· Abstract structured (intro/methods/results/conclusion) or unstructured; Original Article, Review, Brief Report, Early Intervention in the Real World submissions must have an abstract that states in 250 words (150 words for Brief Reports) or fewer the purpose, basic procedures, main findings and principal conclusions of the study. The abstract should not contain abbreviations or references.

· Up to seven keywords; for the purposes of indexing, keywords should be supplied below the abstract, in alphabetical order, and should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at http://www.nlm.nih.gov/mesh/meshhome.html.

· Practitioner Points (optional) Authors will need to provide no more than 3 'key points', written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;

· Main body: preferably formatted as introduction, materials & methods, results, discussion, conclusion;

· References;

· Tables (each table complete with title and footnotes);

· Figure legends: Legends should be supplied as a complete list in the text.

Paper 2: Empirical Paper

Barriers and facilitators to peer support in Early Intervention in Psychosis Services

Total word count: 8,394 words

(Excluding title page, references, and appendices)

This empirical paper has been prepared in accordance with author guidelines for Mental Health Science. The author guidelines are in Appendix 14.

This paper broadly follows author guidelines for Mental Health Science, however further editing and formatting will be completed prior to submission to the journal.

Abstract

Background

The peer staff workforce is growing in the NHS. Guidelines recommend Early Intervention in Psychosis (EIP) services offer peer support, and evidence suggests that peer support can be beneficial for people who experience psychosis. However, there is a lack of research into peer support in EIP services.

Aim: To further understand the experiences of peer staff in EIP services by exploring the perceived barriers and facilitators to implementing peer support in these services.

Method

Eight participants with experience of working in a peer staff role delivering peer support to clients in EIP services took part in semi-structured interviews. Reflexive thematic analysis was used to analyse the data.

Results

Two themes were developed: ‘Three approaches in one service’ and ‘Organisational culture and perceptions of peer support’. The main barriers and facilitators found were organisational approaches, team culture and perceptions of peer support.

Conclusions

Challenges implementing peer support in EIP services can lead to peer support not being fully and appropriately utilised. Clinical implications highlight the importance of EIP teams understanding peer support and its value, and for peer support to be delivered in line with its defining principles.

Key words

Peer support, psychosis, early intervention, thematic, qualitative

Introduction

History of peer support for mental health difficulties

Peer support in its current form originated from the Mental Health Consumer Movement (MHCM) in the USA in the 1970's. Former patients started this movement due to their experiences of unresponsive, harmful and institutionalising mental health services, leaving many feeling stigmatised, misunderstood and mistreated (Davidson et al., 1999; Ostrow & Adams, 2012; Stratford et al., 2019). The MHCM sought to move away from the primarily biological lens of mental health services, to understanding mental health difficulties as being as a result of social and environmental factors (Ostrow & Adams, 2012; Mead et al., 2001). Many consumer-led activities followed, including mutual support groups and consumer-run services independent from mental health services (Emerick, 1989; Kauhann et al., 1989; Mead et al., 2001).

Emergence of peer support in mental health services

In the USA, the rise of peer support services and the formalisation of peer support in mental health systems began in the 1980s in recognition of the value of mutual support (Gagne et al., 2018*;* Ong et al., 2023) and the drive for mental health services to be more consumer-driven and recovery orientated (Ostrow & Adams, 2012).

Formal peer staff roles were subsequently introduced within mainstream mental health services across several English-speaking countries including the UK, Australia and Canada (Gillard et al., 2017; Stratford et al., 2019). Peer staff employed by mental health services tend to use their experience of mental health difficulties and accessing services, along with the principles of peer support, to work directly with people accessing mental health services (clients). Peer staff can also be involved in

activities such as attending team meetings and delivering training (Schutt & Rogers, 2009).

Peer support principles

The sharing of lived experience and the principles underpinning peer support are its defining characteristics (Gillard et al., 2017; Repper et al., 2013). These principles include developing safe, mutual and reciprocal relationships, valuing experiential knowledge, choice and control over the delivery and receipt of peer support, and empowerment to utilise one's strengths (Gillard et al., 2017). Peer support takes a non-directive, non-prescriptive approach, aiming to move away from a culture of illness and disability to one of health and ability (Gillard et al., 2017; Mead et al., 2001).

The reciprocal nature of relationships between peer staff and clients are characterised by the non-expert and equal positions taken by peer staff, differing from the more traditional 'expert' positions of mental health professionals (Repper et al., 2013). This enables the peer relationship to take a mutual approach to giving, receiving and exploring areas such as people's stories, strengths, experiences and challenges (Mead & MacNeil, 2006; Mead et al, 2001; Repper et al., 2013; Repper & Carter, 2011).

A further peer support principle is promoting social inclusion to 'build and strengthen positive connections with their peers, networks and wider communities' (Gillard et al., 2017. p. 139). Peer support's unique position helps explore the meaning that people make from their mental health difficulties, including experiences of being marginalised and misunderstood, and seeks to help people re-connect with communities (Gillard et al., 2017; Mead et al, 2001; Repper et al., 2013).

These principles can inform the implementation, delivery and evaluation of peer support in mental health services, including the training and supervision of peer staff (Gillard et al., 2017; Repper et al., 2013).

Peer support evidence base

Literature reviews outline the potential benefits of peer support for people with mental health difficulties, including improved self-reported recovery (White et al., 2020), sense of hope and control (Davidson et al., 2012), empowerment (Burke et al., 2019; Repper & Carter, 2010; White et al., 2020) self-esteem, community integration, confidence, social support and social functioning (Repper & Carter, 2010). Peer support has also been associated with a decrease in stigmatisation, symptom distress, and levels of depression and psychosis (Davidson et al., 2012; Repper & Carter, 2010). A systematic review by Cooper et al. (2024) found that, despite mixed results, evidence suggests that peer support may improve recovery, self-efficacy and depression symptoms. Research has also highlighted the potential benefits of peer staff working within mental health teams, as their unique position means that they can act as a ‘bridge’ between clients and service providers, facilitating better understanding between them (Chinman et al., 2006; White et al., 2017).

The benefits of peer support for people with mental health difficulties are often identified in qualitative research (Burke et al., 2019; Ochocka et al., 2006; Simmons et al., 2020). However, there is inconsistency in the evidence investigating the effectiveness and benefits of peer support, as quantitative research in this area has produced mixed findings and/or had inconsistent research design (Lloyd-Evans et al., 2014; Lyons et al., 2021; Pitt et al., 2013; White et al., 2020). Gillard et al. (2017) highlighted that quantitative peer support research to date has been inconsistent

regarding what peer support interventions involve, whether these are in line with peer support principles and whether it is truly peer support that is being evaluated.

The implementation of peer support into mental health services

As the peer workforce grows, evidence highlights challenges with integrating and implementing formal peer support in services. This includes concerns about retaining the principles of peer support within statutory mental health services, which focus on standardisation of assessment and intervention, efficiency and measurable outcomes (Gillard & Holley, 2014; Faulkner & Kalathil, 2012; Repper et al., 2013).

Peer staff in the NHS have been found to be concerned about the risk of the professionalisation of peer support, reporting that the structured and hierarchical NHS culture can inhibit peer support's organic, flexible and client-led approach (Faulkner & Basset, 2012; Faulkner & Kalathil, 2012; Gillard & Holley, 2014; Robertson et al., 2024). Guidelines for implementing peer support in mental health services have been developed, outlining ways to address such challenges and maintain the unique characteristics of peer support (Gillard et al., 2017; Penney, 2018; Repper & Carter, 2010; Repper et al., 2013).

Challenges with teams understanding peer support and peer staff roles have been found to impact the implementation of peer support in the NHS (Gillard et al., 2022; Gillard et al., 2024; Robertson et al., 2024) and in mental health services outside the UK (Kemp & Henderson, 2012; Viking et al., 2022). For example, teams misunderstanding peer support can impact the willingness of non-peer staff to work with peer staff (Ibrahim et al., 2020) and lead to peer staff being given work that was not appropriate for their role (Clossey et al., 2016). Research highlights the importance of organisations and teams adequately preparing for the implementation

of peer support in mental health services (Hopkins et al., 2021; Repper et al., 2013; Repper & Carter, 2010; Robertson et al., 2024).

Early Intervention in Psychosis (EIP) services

People who experience psychosis have experiences including seeing or hearing things that others cannot (known as hallucinations) and having beliefs that others do not view as being true (known as delusions) (NHS, 2023). Experiencing symptoms of psychosis for the first time is commonly referred to as a First Episode of Psychosis (FEP) in clinical practice and literature (NHS England, 2023). EIP services have been established internationally to support people experiencing a FEP, and were introduced in the UK in 1999 as part of the NHS framework (Department of Health, 1999).

Evidence suggests providing timely evidence-based treatments within EIP services improves outcomes for those who experience a FEP including improved engagement with services, quality of life, social and occupational functioning (e.g. employment), as well as reduced hospital re-admissions and use of crisis and inpatient services (Correll et al., 2018; Craig et al., 2004; Dodgson et al., 2008; Garety et al., 2006; NHS England, 2023). EIP services typically support clients for three years, aiming to avoid prematurely discharging clients from services or transitioning clients to another service (NHS England, 2023). A range of interventions are offered by multi-disciplinary teams, including psychological, pharmacological, social, occupational, and educational interventions, peer support, as well as support for families and carers (Neale & Kinnair, 2017; National Institute for Health and Care Excellence [NICE], 2014).

Peer support in EIP services

NICE guidelines recommend peer support for adults with psychosis (NICE, 2014) and for EIP services to employ peer staff as part of their workforce (NHS England, 2023). The NHS Mental Health Implementation Plan from 2019 states that work is being done to grow the peer staff workforce in community adult mental health services (NHS England, 2019). The NHS Peer Support Workers Census from 2023 found that there were over 700 whole-time equivalent peer staff working within the NHS in England on 31st March 2023, with 16 EIP services in England employing peer staff (NHS Benchmarking Network, 2023).

Despite the growing peer staff workforce within EIP services, there has not yet been an evaluation of the impact of peer support in EIP services e.g. benefits for clients. The NHS Mental Health Implementation Plan from 2019 states that understanding peer staff roles will be an important element of pilots taking place in 2019/20 (NHS England, 2019).

Health Education England's (HEE) Evidence Brief for Peer Support Workers from 2023 outlined one pilot assessing the feasibility and impact of peer support in an NHS EIP service (HEE eWIN, 2023). The pilot by Proctor et al. (2019) found that there was perceived enthusiasm and assumed readiness for having peer support in the EIP team initially. However, unvoiced concerns by non-peer EIP staff were not raised until later on, negatively impacting the implementation of peer support e.g. concerns about peer staffs' ability to manage their well-being and support that of others, resulting in a 'risk averse approach and narrowing of the peer support role' (Proctor et al., 2019, p. 2).

Proctor et al. (2019) suggests aiding EIP teams understanding of and preparation for peer support through developing clear processes and procedures for implementing peer support, and providing non-peer EIP staff with opportunities to

express any concerns they have about peer support implementation in safe environments, in consultation with team leads.

Two studies have so far explored the perspectives of staff on peer support in EIP services in the UK. White et al. (2017) explored non-peer staff views on peer support being delivered within an EIP service and found that peer support was seen to improve clients' engagement with services and facilitate understanding between service providers and clients. Nguyen et al. (2021) investigated peer staff perspectives on their role and the support required for peer staff in EIP services. Peer staff perceived peer support as a meaningful source of support for clients, highlighting the importance of peer support for destigmatising psychosis in EIP services (Nguyen et al., 2021). Nguyen et al. (2021) also found that EIP teams understanding peer staff roles was important for peer staff to feel supported in their role and work effectively.

Previous studies have called for further research into the implementation of peer support in EIP services (Nguyen et al., 2021; White et al., 2020). While Nguyen et al. (2021) highlighted the benefits of peer support in EIP services, it did not fully explore how peer support can be effectively implemented within the specific EIP service context. This current study therefore aimed to address this gap by examining the perspectives of current and former peer staff on the barriers and facilitators to implementing peer support in EIP services.

Research in this area has not yet captured the views of peer staff from diverse localities and ethnic backgrounds. White et al. (2020) collected data from a single EIP service, and all participants in Nguyen et al. (2021) were White-British, despite evidence that Black and minority ethnic groups are overrepresented in psychosis services (Morgan et al., 2004; Singh et al., 2007). To address these limitations, this

study sought to recruit participants from various regions and include participants from Black and minority ethnic backgrounds.

Research question and aims

Given the limited research on peer staff experiences in EIP services and the gaps in the current evidence base, this study aimed to contribute to the literature by exploring the perspectives of people with experience of working as peer staff in EIP services on the barriers and facilitators associated with implementing peer support in EIP services.

Method

Design

Purposive sampling was used to recruit people with experience of working in a peer staff role delivering peer support to clients within EIP services in the UK. This included:

- Current or previous peer staff. There was no cut off as to how long-ago participants were in this role, providing they were able to adequately answer questions about their experience.
- Voluntary or paid peer staff.
- Peer staff who had delivered peer support in individual or group form.

In addition to this, people had to meet the following inclusion criteria to participate in the study:

- Be 18 years old and above.
- Be able to speak, read and understand English.
- Be able to attend research interviews online via Microsoft Teams.
- Have had direct experience of delivering peer support to clients.

Participants were recruited from five NHS Trust sites in England, selected for their EIP services employing current or former peer staff. Recruiting across multiple sites was necessary to recruit the required number of participants, and ensured findings reflected a range of experiences across different EIP services.

Recruitment took place from October 2024 to January 2025. The study was advertised using the study advert (Appendix 4) and participant information sheet (Appendix 3), which outlined how people could contact the researcher to express an interest in participating. People who contacted the researcher asking to participate and met the inclusion criteria were sent a copy of the consent form (Appendix 5). Consent was obtained through participants completing and returning their consent form to the researcher. Participant demographics and an overview of their peer support experience (e.g. duration of this experience, current or previous experience) were collected using the participant information form (Appendix 6). The debrief sheet (Appendix 7) was given to participants after they undertook the research interview.

Data collection

Interviews were audio recorded and conducted by the researcher virtually using Microsoft Teams software. A semi-structured interview approach was used, where open questions were asked related to the research question. This allowed participants to share their perspectives, while also being able to elaborate on anything that was important to them. See Appendix 8 for interview protocol. During interviews, field notes were taken to support with reflexivity and data analysis (Appendix 9).

Participants

Eight participants were recruited. Interviews were an hour in duration on average. Participant demographics and characteristics are represented in Table 1.

Table 1

Participant demographics and characteristics

Characteristic	Participants, n (%)
Total	8 (100)
Age	
30-39	1 (12.5)
40-49	5 (62.5)
50-59	1 (12.5)
60-69	1 (12.5)
Gender	
Male	6 (75)
Female	2 (25)
Ethnicity	
White British	5 (62.5)
White British/Irish	1 (12.5)
Black British/Jamaican	1 (12.5)
Black British/African	1 (12.5)
Duration of peer support experience	
6 months – 1 year	1 (12.5)
1 – 2 years	1 (12.5)
3 – 4 years	3 (37.5)
5 – 6 years	1 (12.5)
7 – 8 years	2 (25)

Paid or voluntary peer support experience	
Paid	7 (87.5)
Voluntary	1 (12.5)
Current or previous peer support experience	
Current	7 (87.5)
Previous	1 (12.5)
Group or individual peer support experience	
Group and individual	7 (87.5)
Individual	1 (12.5)

Data analysis

All interviews were transcribed, coded, and analysed by the researcher using Reflexive Thematic Analysis (RTA). Qualitative methods are recommended for peer support research (Gillard et al., 2017). RTA was selected as the most suitable approach to address the research question given its focus on exploring shared meaning across data and generating practical insights, which aligned with the study's objectives (Braun & Clarke, 2020; Sandelowski & Leeman, 2012). RTA emphasises reflexivity, enabling the researcher to critically reflect on their role in the analytic process and demonstrate how situated knowledge is produced (Braun & Clarke, 2022). To support this, the researcher maintained reflective field notes throughout (Appendix 9).

RTA's ability to identify themes and shared experiences was better suited to exploring peer staff experiences in EIP services than Interpretative Phenomenological Analysis, which focuses on individual, first-person accounts (Braun & Clarke, 2020). Due to the theoretical underpinnings of peer support and its

evidence-base, Grounded Theory was not felt to be an appropriate as it is typically used to develop new theoretical frameworks in under-researched areas (Charmaz & Thornberg, 2021; Foley & Timonen, 2015).

Inductive and deductive approaches were applied at different stages of the analytical process. The inductive orientation was used in the initial coding stage to interpret meaning from the data (Braun & Clarke, 2022). The deductive orientation used the research question, informed by existing theory and research, to provide an interpretive lens for meaning making in the data, and applied at the latter stage when reviewing and refining themes to consider how final themes answered the research question. This included using the EIP approach and peer support principles to interpret the data in the deductive stages of the analysis. For example, subtheme 1.3, impact of EIP service approach on peer support, was developed by grouping codes from participant transcripts about perceptions and meaning making around aspects of the EIP service approach relating to peer support e.g. supporting clients who have experienced FEP, support being provided for three years.

Themes were discussed and reviewed with the research supervisor (KG) at the University of Staffordshire to support with finalising themes. Following the analysis, findings were sent to participants for member checking (Braun & Clarke, 2022).

Peer staff involvement in the study

People with experience of working as peer staff in EIP services were consulted on the development of research documents (e.g. participant information sheet), the interview protocol, and the executive summary.

Member checking took place for participants who opted in to be contacted about this, using guidance from Birt et al. (2016) and Braun and Clarke (2022). All participants agreed to be contacted after interviews to take part in member checking

(Consent form, Appendix 5). The researcher asked for participant feedback on provisional research findings, clarification on interview extracts and confirmed that participants agreed for extracts to be used in the research report. Participants who provided feedback reported that findings accurately represented their experiences.

Epistemological position

This research used a critical realist approach, which sees the data as an interpretation of reality shaped by participant's perceptions which are constructed by and embedded in their context e.g. language, cultural context (Braun & Clarke, 2022).

Reflexivity

Reflexivity as part of qualitative research is recommended to increase the reliability of analysis and rigour, as well as facilitating the identification of subjective experience used as a resource during the analytical process (Braun & Clarke, 2022; Johnson et al., 2020; Olmos-Vega et al., 2023).

I kept a reflexive diary throughout the research process, and recorded field notes during participant interviews (Appendix 9 and 10). These were used to reflect on my subjective experience, processes and understanding of the research topic, including how my professional experience and worldview may have impacted my interpretation of the findings. Reflexivity was also facilitated through consulting with my supervisor, and triangulating and checking themes and subthemes with the research team and in reflexive group sessions (Mruck & Breuer, 2003; Olmos-Vega et al., 2023).

I was aware that I was closely positioned to the topic area as I have experience working within EIP services alongside peer staff and have a personal position of valuing peer support. I reflected on how my experience of working in EIP services and knowledge of the EIP service approach informed the interpretation of the data in

the latter stages of the analysis where the deductive orientation was used. I grouped codes from participant transcripts relating to peer support and the EIP service approach, including EIP services supporting clients with FEP specifically and that the service is offered for up to three years. This subsequently shaped the development of subtheme 1.3, impact of EIP service approach on peer support, capturing how aspects of the service approach impacted peer support.

A further consideration was that I have not experienced psychosis or had experiences of receiving or delivering peer support, so my view was as a professional outsider with experience of working in EIP services. People with experience of delivering peer support in EIP services were therefore involved in the design, analysis and dissemination of the research as recommended by Gillard (2017).

Results

Two themes with five associated sub-themes were developed outlining the main barriers and facilitators to peer support in EIP services (Table 2). These are discussed below with participant extracts, with additional examples provided in Appendix 13. Theme one focuses on the interaction between EIP structures, policies, and procedures. In contrast, theme two captures underlying concepts such as culture and meaning making around peer support.

Table 2

Themes and sub-themes

Themes	Summary
1. Three approaches in one service	Experiences of the impact of the peer support, EIP service and NHS organisation's approach on peer support in EIP services.

1.1. Flexibility in the peer role	Importance of flexibility to peer staff working in EIP services.
1.2 Clash in the organisation and peer support approaches	Differences in the NHS organisation's approach and the peer support approach, and the impacts of this on peer support in EIP services.
1.3 Impact of EIP service approach on peer support	How aspects of the EIP service approach can impact peer support.
2. Organisational culture and perceptions of peer support	Experiences of the influence of organisational and team culture on how peer support is perceived and integrated in EIP services.
2.1: Peer support as valued equal	Experiences of team culture which understands and values peer support, and sees it as equal within the service, and how this impacts peer support in EIP services.
2.2: Peer support as misunderstood and undervalued	Experiences of working in teams which do not fully understand and value peer support, or see it as equal in the service, and how this impacts peer support in EIP services.

Theme 1: Three approaches in one service

This theme outlined participant's experiences of the peer support approach, the wider NHS organisation's approach and the EIP service's approach being used alongside each other in EIP services.

Subtheme 1.1: Flexibility in the peer role

Participants shared that flexibility facilitated peer support in EIP services. Participants benefitted from being given flexibility, choice and control about what their peer staff role involved day-to-day e.g. direct client work, staff training, contributing to team meetings. There were perceived benefits to shaping the role around each peer staff members' skills, abilities and preferences for their professional development and how to use their lived experience: "[Peer staff] having the freedom to utilise peer support by being open with it and allowing us to utilise our skills, our strengths and bring that to the table" (Participant 1). Participant 4 spoke about how there were 'lots of different ways' to utilise the lived experience of peer staff, and having variety in peer staff roles makes "it a more interesting job". Experiences varied in terms of how much flexibility participants had in their peer staff role.

There were perceived benefits to peer staff taking a flexible and person-centred approach to their client work. This involved adapting the delivery of peer support to meet each clients' individual needs e.g. doing different activities with clients, seeing clients in different locations, being flexible with how much time they spent with clients.

> The flexibility of it's really good because you can actually work to the person's needs rather than thinking, you've got an hour with them and you're watching the clock. I think that's been really, really useful. We [client and peer staff member] go for group walks, and it's amazing how they just open up and talk when they're at nature and feeling relaxed. They open up much, much more than if I was sat in an office with them. (Participant 5).

Subtheme 1.2: Clash in the organisation and peer support approaches

Many participants perceived there to be differences between the NHS organisation's approach, which was more rigid and procedural, and the peer support approach, which was more client-led and flexible. Participants spoke about their experiences of these approaches clashing, making it "difficult to marry up the needs of the service and the needs of the person [client]" (Participant 3).

Some participants shared how they had come across challenges with trying to implement a flexible, client-led approach to delivering peer support, as the organisation, and EIP services in turn, had structured procedures for clients' journeys through services. For example, clients receive support from the service, including peer support, following undertaking an assessment process, which may then lead to the service accepting or 'taking on' a client. Participant 2 spoke about asking their team if peer support could be offered as part of clients' assessment appointments and being unsure why this would not be possible:

> A recent conversation I've had with people in my team is why don't I [peer support staff member] go on assessments, see people right from the off and get to know them, just me being there. I've got lived experience of being through the service, I know what the assessment process is like, I get all that, why don't I go in from the start?' And I got back; 'Well, no. it's an initial meeting, we might not be taking them on, we might not be doing this, we might not be doing that. (Participant 2).

Most participants had experienced challenges delivering peer support in a way that stayed true to the peer support principles. Many, like Participant 7, shared feeling pressure to "fit in", or to feel "like square pegs being firmly hammered into round holes" (Participant 7) and deliver peer support in a way that aligned more with the organisations approach. Participants 1 and 3 said:

> Allowing us [peer staff] to really be ourselves as well, and not, kind of, trying to box us in like or mould us to what you think peer support should be. It's been quite frustrating for us [peer staff] when they [the service] tried to do that. (Participant 1).
>
> [the peer support approach is] definitely not ‘doing to’, but ‘doing with’ and I always struggle if I've been asked to do something specific, unless it's understandably necessary. You know, ‘we need to work on this person's [clients] this or that’ and it's like, oh, OK. But sometimes that's not necessarily a priority for that person [client]. (Participant 3).

Participants had varying experiences of how much or little they had been able to work in line with the peer support principles. Some had been given more opportunities to implement peer support in a more flexible and less structured way, despite limitations within the team and organisation:

> They [the team] were just really encouraging, open minded. Which I think can be quite difficult in the NHS, to find the time and let people get a bit creative. So, that was nice that we had that opportunity where we felt that we could really make it [peer support] our own. (Participant 6).

Subtheme 1.3: Impact of EIP service approach on peer support

Most participants shared that there were aspects of the approach used by the EIP service which facilitated peer support. EIP services provide support over the course of three years to people who have experienced a FEP (NHS England, 2023). Participants spoke about how this length of time allowed for more time to develop relationships with clients “over a longer period of time, which is obviously afforded to you when you work within the early intervention service because of being able to

work with somebody for three years" (Participant 3). Additionally, Participant 8 shared:

> [Peer support is] a gradual way of working with service users. Because, with early intervention team, we have service users for three years. So, it's not something that comes and ends in just that moment, it's gradual work that you continuously do with them (Participant 8).

Some spoke about the benefits of EIP services supporting people with FEP specifically and because of this, peer support in EIP services often focussed on mutually sharing unique lived experiences related to FEP, which many participants felt "added value" (Participant 7) and was beneficial to clients. Participant 6 shared:

> There was some funny bits of it [psychosis]. It's kind of black humour, but I was able to joke about [FEP] with some of the service users. Not all of them … We were able to almost like laugh about certain bits, which I found incredibly healing … that's not something that I could have ever done with someone else who hasn't been through it, because people just wouldn't get it and it would just be weird if they're like, 'that's hilarious', you know, unless you've been in that. (Participant 6).

Theme 2: Organisational culture and perceptions of peer support

Subtheme 2.1: Peer support as valued equal

Participants spoke about the importance of working within an EIP team which understands and values peer support: "The role needs to be supported properly, understood in teams properly, and supported in terms of how they're [peer staff] going to go about using lived experience" (Participant 4). Additionally, Participant 5 shared: "Even though I haven't got those levels of qualification, I never feel like I'm

beneath anyone else or like I'm not as valued as anyone else, which is really important”.

Some participants recounted their experiences of peer support being understood and valued in teams where there was an open and supportive culture: “I think the team that I work with naturally are open and receptive. They have a very open attitude to what we're dealing with. It's not just me. It's an open attitude to what we're doing [peer support]” (Participant 7). Participant 8 stated: “They [the team] can help you navigate these waters and be able to support the service users as best as you can”.

Many participants reported the importance of feeling empowered and respected in their peer staff role, and for peer support to be perceived by teams as equal to other forms of support within the service: “I'm not saying support. I'm saying it's actually more empowerment to the value that someone can bring, which to me is more like respect for that value” (Participant 7). Participant 1 spoke about their experience of teams encouraging them to share their lived experience and perspectives, which helped them feel empowered in their role:

> They [the team] try to understand. They just show that they’re with you, and they're supportive and encouraging and empowering, like telling you, you know, “your voice matters”. All of these things are really, really positive like rather than shutting you down.

Those who felt peer support had been understood, valued and seen as equal in teams reported subsequently feeling more confident and empowered in their peer staff role. Participant 5 spoke about how they felt that their input in team meetings had been listened to and valued by other team members, making them more confident to speak up in team meetings:

> Because I haven't got the clinical knowledge, I've only got my own experience, at first, I felt very self-conscious about raising stuff in MDT [team meetings]. But I've, sort of, gained my confidence now and I feel now that my opinion is valued as much as everyone else in the team, and it is.

Subtheme 2.2: Peer support as misunderstood and undervalued

Many participants expressed that, from their experiences, EIP teams did not fully understand peer support and the peer staff role: “Most of the barriers are around staff awareness of what peer support workers do, and the importance, and how much benefit that the person gets from having that peer support worker” (Participant 3). Participant 8 stated: “I don't think they [the team] fully get it [peer support] at the moment”.

Another common experience was that participants perceived that peer support was not valued as much as they felt it should be within teams, and that peer support was not seen as equal to or having the same priority as other forms of support offered by EIP services: “It [peer support] was seen as a nice add on. If, you know, they've got time. I don't think it was seen as a priority” (Participant 6). Participant 3 said that this was “hard to deal with” particularly when peer support was “less on that priority level”, and they had experiences of “medical reviews, kind of, overarching the peer support work”.

Some spoke about their experience of peer staffs’ perspectives not being equally valued or prioritised in teams compared to that of other staff and disciplines. This was seen to lead to there being missed opportunities for their lived experience to be heard within the team e.g. during team meetings when making decisions about client care: “You’ve tried to have that little voice of advocate for the person using the service and sometimes it feels like it's dismissed. So, that can be quite hard”

(Participant 1). Participant 3 expressed that: “Even now with peer support being integrated into services more, you can still come up against barriers and boundaries as far as professional opinion and things like that, instead of it being peer led”.

Participants who had experienced challenges with peer support being misunderstood and undervalued in teams shared that they could feel devalued and helpless in their peer roles, making them reluctant to share their views within teams in future, leading to them withdrawing and feeling that they were “not going to bother to say anything” (Participant 1). Participant 3 shared:

> You can see what's going on around you sometimes and feel a little bit helpless, or feel that you've got a good idea but sometimes it might be vetoed by, thinking about medication changes or that sort of thing. And that can be quite hard.

Participant 4 stated that it was “crucial” for the team to understand peer support and the value of peer staffs’ contributions “otherwise, peers are going to be left feeling devalued when all we've really done was apply for a job which we probably were very passionate about at the beginning”.

Many participants spoke about how raising awareness of peer support and its value within teams was part of their role. Participant 5 shared that peer support had become more utilised in the team in which they had worked as other staff members grew to understand and value peer support: “Once the team started to understand the value of peer support and started to understand what the role was about, the referrals started coming in, it was a much more positive experience.”

Some had continued to experience challenges with teams understanding, valuing and prioritising peer support despite efforts to address these issues within their peer staff role:

> We try to explain the role of the peer support worker, how you might use a peer support worker, and what a peer support worker offers. We feel like it seems at the time like you've done a good job, because we get the applause and everybody's like ‘oh that's really well done’, but then it goes back to being the same thing again when we're sitting there sometimes it's like not enough work coming through. (Participant 1).

Many participants felt that the impact of service pressures on EIP teams could impact how much teams understood, valued and prioritised peer support, as peer support could get “lost” due to “other pressures or needs of the team or organisational need” (Participant 3). Participants perceived that high staff workload and busyness of staff in teams could lead peer support not being considered for clients:

> There's so much we have to do for the people [clients] we're working with. I don't think it's, anyone's fault or anything, it's just everyone's got so much to try and think about, that it [peer support] just slips slowly but surely. (Participant 2).
>
> Maybe it's they're [other staff] so busy with the case or whatever, they're not really looking elsewhere sometimes. So, to be honest, I couldn't put a finger on it because that leaves us [peer staff], kind of, always guessing. And we're always wondering why. But we [peer staff] don't even know ourselves why this happens. Like we feel that peer support is so clear cut, but we [peer staff] just don't understand why we're not used. (Participant 1).

Discussion

This research aimed to develop upon previous literature on peer support in EIP services by exploring the perceived barriers and facilitators associated with delivering peer support in EIP services.

The main facilitators to peer support in EIP services were peer staff having flexibility in their role, EIP teams having an open and supportive culture, and EIP teams understanding and valuing peer support, perceiving it as equal to other forms of support within the service. Two key aspects of the EIP service approach were found to be potential facilitators to peer support. EIP services supporting clients for three years was perceived to allow peer staff more time to develop peer relationships with clients, and EIP services specifically supporting people with FEP was seen to add value by allowing for peer support to focus on mutually sharing unique experiences related to psychosis.

The main barriers to peer support in EIP services were the NHS organisation's approach conflicting with that of peer support, and EIP teams not fully understanding and valuing peer support, perceiving it as less of a priority or not equal in the service.

These barriers and facilitators influenced how much peer staff were able to deliver peer support in line with its principles, and the appropriate utilisation of peer staff and their lived experience within teams.

The importance of flexibility

This study found that flexibility within the peer role facilitated peer support in EIP services. This included peer staff having flexibility when delivering peer support to clients and when shaping the peer staff role. These findings align with peer support principles around taking a non-directive approach and providing choice and control in both the delivery and receipt of peer support (Clay et al., 2005; Gillard et al., 2017; Repper et al., 2013).

Clash in organisation and peer support approach

A perceived barrier to delivering peer support in line with its principles was the difference between the peer support approach and that of the NHS as an

organisation. Peer staff experienced challenges implementing the more client-led, flexible peer support approach within an organisation with more rigid and procedural ways of working, reflecting findings of past research highlighting concerns about retaining the principles of peer support within statutory mental health services (Davidson, 1999; Gillard & Holley, 2014; Gillard et al., 2017; Faulkner & Kalathil, 2012; Repper et al., 2013).

The findings of our study reflect that of previous research suggesting peer staff working in mental health services can have concerns about the risk of professionalisation of peer support due to the structured and hierarchical NHS culture, which could limit peer support's organic, flexible and client-led approach (Gillard & Holley, 2014; Faulkner & Basset, 2012; Faulkner & Kalathil, 2012; Robertson et al., 2024). Our findings suggest that this is also a concern for peer staff in EIP services, with peer staff feeling a pressure to 'fit in' and deliver peer support in a way that aligned more with the organisations approach.

Similar challenges have arisen in other instances when mainstream mental health services attempt to integrate non-medical, lived experience-led approaches. For example, Hearing Voices Groups (HVGs) were originally independent of mental health services, emphasising personal meaning-making and valuing lived experience (Corstens et al., 2014). While HVGs in community settings have been found to be beneficial to voice-hearers (Corentin et al., 2023; Hornstein et al., 2021; Hornstein et al., 2024), research has highlighted challenges incorporating them into the NHS, due to the differences between the ethos of HVG's and the NHS raising questions about whether NHS-led groups can genuinely reflect HVG principles (Branitsky et al., 2025; Jones & Jacobsen, 2022). Such challenges may therefore not only affect the peer

staff workforce but also pose broader barriers to the NHS adopting lived experience-led, non-medical model approaches.

Impact of the EIP service approach on peer support

EIP services support people who experience a FEP usually over the course of three years (NHS England, 2023). Our findings suggest that aspects of the EIP approach could be facilitators to peer support. EIP services supporting clients for three years allowed for support to be delivered over a long period of time if required. Participants perceived this to be beneficial for clients who may benefit from more time to develop safe, trusting and mutual relationships with peer staff. No other studies to date suggest that the EIP service approach (despite being different from the peer support approach) can be a facilitator to peer support due to the length of time clients are supported by EIP services.

EIP services supporting clients with FEP specifically was seen to facilitate peer support. Our findings suggest that peer support in EIP services mostly focuses on sharing lived experiences unique to FEP, benefitting clients in EIP services. This reflects the findings of Nguyen et al. (2021) that peer staff in EIP services perceive having similar experiences to clients fosters a sense of mutuality and facilitates interpersonal connections given the unique experiences associated with psychosis.

Understanding, valuing and prioritising peer support

This study found that non-peer staff in EIP teams can have a lack of understanding about peer support and peer staff roles in EIP services. Similar challenges have been found in peer support research in EIP services (Nguyen et al., 2021) and other mental health services in the NHS (Gillard et al., 2022; Gillard et al., 2024; Robertson et al., 2024). Proctor et al. (2019) suggested having clear

processes and procedures when implementing peer support to aid the understanding of peer support in EIP teams.

How much peer support was valued and prioritised within teams was found to be a key barrier and facilitator to peer support in EIP services suggesting EIP teams must value and prioritise peer support, and the value that peer staff could bring to the service, for peer support to be effectively implemented and delivered in EIP services. Ehrlich et al. (2020) found that peer support and peer staff integrating into mental health teams can help teams see the value of peer support, but this required non-peer staff to 'focus on unique strengths that peer support workers bring, in addition to lived experience with mental illness as a carer or consumer' (Ehrlich et al., 2020. p. 1).

Open and supportive team culture

Our findings suggest that peer staff perceive EIP teams which understand and value peer support to be those who are open to peer support and are encouraging and supportive of peer staff. Previous research into peer support in EIP services has found that peer staff benefit from teams which are supportive and have good team working (Nguyen et al., 2021) and that it can be important for there to be a good 'fit' between peer staff and the EIP team (White et al., 2017). Peer staff working in mental health services have been found to benefit from trusting and supportive workplace cultures (Cooper et al., 2024).

Impacts on peer staff

Our findings suggest that peer staff can experience improved confidence and empowerment in their role within EIP teams that understand and value peer support, and have an open and supportive culture. Previous research has similarly found that peer roles can have positive impacts on peer staff e.g. improving empowerment,

self-efficacy, self-confidence and self-esteem (Barlow et al., 2005; Bracke et al., 2008; Faulkner & Basset, 2012; Fortuna et al., 2022; Gillard et al., 2022; Salzer et al., 2013).

Where there were challenges with EIP teams understanding and valuing peer support, peer staff could feel devalued and helpless in their role. It has been found that peer staff can feel as though they are not taken seriously (Clossey et al., 2016) and that their value can be undermined if their roles are not acknowledged or understood by their colleagues (Gillard et al., 2022). Robertson et al. (2024) suggest that there can be a negative burden on peer staff experiencing barriers to working in line with peer support principles within rigid systems and cultures.

Peer staff as a bridge between EIP service and clients

Previous research suggests peer staff can bring a different perspective to non-peer staff given their lived experience, helping to bridge a gap in understanding between clients and non-peer staff in EIP and other mental health services (Nguyen et al., 2021; Viking et al., 2022; White et al., 2017). Peer staff can act as advocates for clients, highlighting clients' perspectives and rights within teams, and helping to address the sense of 'us and them' stigma which can exist in mental health settings (Nguyen et al., 2021; Viking et al., 2022; White et al., 2017).

Our findings suggest that this bridging role of peer staff could be missed or underutilised in EIP services if peer support is not adequately understood, valued and prioritised within teams, impacting factors such as peer staffs' willingness and confidence to share their perspectives and lived experience within teams. Conversely, in teams where peer support is understood, valued and prioritised, we found that peer staff are more likely to share their perspectives and lived experience within teams. NHS guidelines recommend the promotion of supportive and inclusive

team cultures across the NHS and recognise the importance of this for all NHS staff (NHS England, 2019).

Service pressures

The impact of service pressures was found to affect the prioritisation of peer support when compared to other forms of support in EIP services. Non-peer staff were viewed as being busy and having high workloads, leading to peer support getting ‘lost’ and not being considered or prioritised as a form of support for many clients. Previous research similarly suggests EIP staff can perceive service pressures to impact client care (Morton et al., 2010), and pressures such as busy teams and lack of time, resources and funding can present challenges to implementing peer support in other services (Cooper et al. 2024; Robertson et al., 2024).

Strengths and limitations

People with experience of delivering peer support in EIP services were consulted on the research design, analysis and dissemination. This is a strength of the study given recommendations that peer staff should be involved in research in this area (Gillard et al., 2017). A potential limitation of the study was that it was not peer-led. However, RTA was beneficial given the research context, allowing the researcher to consider and clearly state how their position and perspectives shaped the analytical process.

A strength of this study was that there was a variation in participants ages, ethnicities, and number of years employed as peer staff. Peer staff from various localities were recruited, meaning that participants were representative of a range of EIP services in England, but not the whole of the UK.

Clinical recommendations

EIP services considering or already implementing peer support should ensure teams understand what peer support is, what peer staff roles involve, and promote the value of peer support e.g. through peer-led training to teams about the role and value of peer support. Peer support should be delivered in line with its principles, so that the uniqueness of the approach is retained and protected.

Stakeholders, EIP service leads and supervisors of peer staff in EIP services would benefit from utilising guidance on peer support implementation and maintaining the unique characteristics of peer support (Health Education England, 2020. p. 48-53; Gillard et al., 2017; Penney, 2018; Repper & Carter, 2010; Repper et al., 2013). This includes using the peer support principles to shape the evaluation of peer support, and in peer staff training and supervision.

Clinical Psychologists in EIP teams are well-positioned to support a broader understanding of peer support in EIP services, including supporting teams to reflect on and address any issues regarding team culture and power imbalances.

Future research

Future research and/or service evaluations should explore the extent to which peer support is being delivered in line with its principles within EIP services, including potential impacts of organisational context on this. Further investigation into perceptions of non-peer EIP staff on peer support could be beneficial, as well as exploring how the EIP approach may facilitate peer support.

Conclusion

This research aimed to add to previous literature on peer support in EIP services by exploring the perceived barriers and facilitators associated with delivering peer support in EIP services. Semi-structured interviews were conducted with eight

participants with experience working as peer staff in EIP services. Two themes were developed: ‘Three approaches in one service’ and ‘Organisational culture and perceptions of peer support’. The main barriers and facilitators found were organisational approaches, team culture and perceptions of peer support. These factors influenced how much peer staff were able to deliver peer support in line with its principles, and the appropriate utilisation of peer staffs’ lived experience within teams.

How much these barriers and facilitators were present varied across participants. Our findings suggest that challenges implementing peer support in EIP services can lead to peer support not being fully and appropriately utilised, despite research and guidance highlighting the importance of peer support in EIP services. Clinical implications outline the importance of EIP teams understanding peer support and its value, and for peer support to be delivered in line with its defining principles.

References

Barlow, J. H., Bancroft, G. V., & Turner, A. P. (2005). Volunteer, lay tutors' experiences of the Chronic Disease Self-Management Course: being valued and adding value. *Health Education Research*, *20*(2), 128–136. https://doi.org/10.1093/her/cyg112

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative Health Research*, *26*(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Bracke, P., Christiaens, W., & Verhaeghe, M. (2008). Self-Esteem, Self-Efficacy, and the Balance of Peer Support Among Persons With Chronic Mental Health Problems. *Journal of Applied Social Psychology*, *38*(2), 436–459. https://doi.org/10.1111/j.1559-1816.2008.00312.x

Branitsky A, Morrison AP, Longden E, Bucci S and Varese F (2025) Staff and voice hearer perspectives on Hearing Voices Groups in the NHS: a mixed-methods cross-sectional survey. *Frontiers in Psychology, 16,* 1583370. https://doi.org/10.3389/fpsyg.2025.1583370

Braun, V., & Clarke, V. (2020). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and psychotherapy research, 21*(1), 37-47. https://doi.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2022). *Thematic analysis: a practical guide*. SAGE Publications Ltd. https://uk.sagepub.com/en-gb/eur/thematic-analysis/book248481

Burke, E., Pyle, M., Machin, K., Varese, F., & Morrison, A. P. (2019). The Effects of Peer Support on Empowerment, Self-Efficacy, and Internalized Stigma: A

Narrative Synthesis and Meta-Analysis. *Stigma and Health*, *4*(3), 337–356. https://doi.org/10.1037/sah0000148

Charmaz, K., & Thornberg, R. (2021) The pursuit of quality in grounded theory, *Qualitative Research in Psychology, 18*(3), 305-327. https://doi.org/10.1080/14780887.2020.1780357

Chinman, M., Young, A. S., Hassell, J., & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *The Journal of Behavioral Health Services & Research*, *33*(2), 176–195. https://doi.org/10.1007/s11414-006-9009-3

Clay, S., Schell, B., Corrigan, P. W., & Ralph, R. O. (2005). *On our own, together: Peer programs for people with mental illness.* Vanderbilt University Press. https://psycnet.apa.org/record/2005-05842-000

Clossey, L., Gillen, J., Frankel, H., & Hernandez, J. (2016). The experience of certified peer specialists in mental health. *Social Work in Mental Health*, *14*(4), 408-427. http://doi.org/10.1080/15332985.2015.1038412

Cooper, R. E., Saunders, K. R. K., Greenburgh, A., Shah, P., Appleton, R., Machin, K., Jeynes, T., Barnett, P., Allan, S. M., Griffiths, J., Stuart, R., Mitchell, L., Chipp, B., Jeffreys, S., Lloyd-Evans, B., Simpson, A., & Johnson, S. (2024). The effectiveness, implementation, and experiences of peer support approaches for mental health: a systematic umbrella review. *BMC Medicine*, *22*(1), 72–45. https://doi.org/10.1186/s12916-024-03260-y

Corentin, C., Fitzgerald, C., & Goodwin, J. (2023). Benefits of hearing voices groups other self-help groups for voice hearers: A systematic review. *Issues in Mental Health Nursing, 44*(4), 228–244. https://doi.org/10.1080/01612840.2023.2189953

Correll, C. U., Galling, B., Pawar, A., Krivko, A., Bonetto, C., Ruggeri, M., Craig, T. J., Nordentoft, M., Robinson, D. G., & Kane, J. M. (2018). Comparison of early intervention services vs treatment as usual for early-phase psychosis: a systematic review, meta-analysis, and meta-regression. *JAMA psychiatry*, *75*(6), 555-565. https://doi.org/10.1001/jamapsychiatry.2018.0623

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., and Thomas, N. (2014). Emerging perspectives from the hearing voices movement: implications for research and practice. *Schizophrenia Bulletin, 40*(4), 285–294. https://doi.org/10.1093/schbul/sbu007

Craig, T. K. J., Garety, P., Power, P., Rahaman, N., Colbert, S., Fornells-Ambrojo, M., & Dunn, G. (2004). The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. *BMJ*, *329*(7474), 1067–1070. https://doi.org/10.1136/bmj.38246.594873.7C

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

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (1999). Peer Support Among Individuals With Severe Mental Illness: A Review of the Evidence. *Clinical Psychology*, *6*(2), 165–187. https://doi.org/10.1093/clipsy.6.2.165

Department of Health. (1999). *A National Service Framework for Mental Health: Modern Standards & Service Models.* Department of Health and Social Care. https://assets.publishing.service.gov.uk/media/5a7a050040f0b66eab99926f/National_Service_Framework_for_Mental_Health.pdf

Dodgson, G., Crebbin, K., Pickering, C., Mitford, E., Brabban, A., & Paxton, R. (2008). Early intervention in psychosis service and psychiatric admissions. *Psychiatric Bulletin of the Royal College of Psychiatrists*, *32*(11), 413–416. https://doi.org/10.1192/pb.bp.107.017442

Ehrlich, C., Slattery, M., Vilic, G., Chester, P., & Crompton, D. (2020). What happens when peer support workers are introduced as members of community-based clinical mental health service delivery teams: a qualitative study. *Journal of Interprofessional Care*, *34*(1), 107–115. https://doi.org/10.1080/13561820.2019.1612334

Emerick, R. E. (1989). Group demographics in the mental patient movement: Group location, age, and size as structural factors. *Community Mental Health Journal*, *25*(4), 277-300. https://doi.org/10.1007/BF00755676

Faulkner, A., & Basset, T. (2012). A helping hand: taking peer support into the 21st century. *Mental Health and Social Inclusion*, *16*(1), 41–47. https://doi.org/10.1108/20428301211205892

Faulkner, A., & Kalathil, J. (2012, April). *The freedom to be, the chance to dream: Preserving user-led peer support in mental health.* London: Together for Mental Wellbeing. https://www.peerzone.org/wp-content/uploads/2021/12/Peer_Support_Faulkner_0.pdf

Foley, G., & Timonen, V. (2015). Using grounded theory method to capture and analyze health care experiences. Health services research, 50(4), 1195-1210. https://doi.org/10.1111/1475-6773.12275

Fortuna, K. L., Solomon, P., & Rivera, J. (2022). An Update of Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients.

Psychiatric Quarterly, *93*(2), 571–586. https://doi.org/10.1007/s11126-022-09971-w

Frieh, E. C. (2024). Resistance to the biomedicalization of mental illness through peer support: The case of peer specialists and mental health. *Social Science & Medicine*, *341*, 116521. https://doi.org/10.1016/j.socscimed.2023.116521

Gagne, C. A., Finch, W. L., Myrick, K. J., & Davis, L. M. (2018). Peer Workers in the Behavioral and Integrated Health Workforce: Opportunities and Future Directions. *American Journal of Preventive Medicine*, *54*(6), S258–S266. https://doi.org/10.1016/j.amepre.2018.03.010

Garety, P. A., Craig, T. K. J., Dunn, G., Fornells-Ambrojo, M., Colbert, S., Rahaman, N., Read, J., & Power, P., (2006). Specialised care for early psychosis: symptoms, social functioning and patient satisfaction: Randomised controlled trial. *British Journal of Psychiatry*, *188*(1), 37–45. https://doi.org/10.1192/bjp.bp.104.007286

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

Gillard, S., Foster, R., White, S., Barlow, S., Bhattacharya, R., Binfield, P., Eborall, R., Faulkner, A., Gibson, S., Goldsmith, L. P., Simpson, A., Lucock, M., Marks, J., Morshead, R., Patel, S., Priebe, S., Repper, J., Rinaldi, M., Ussher, M., & Worner, J. (2022). The impact of working as a peer worker in mental health services: a longitudinal mixed methods study. *BMC Psychiatry*, *22*(1), 373–373. https://doi.org/10.1186/s12888-022-03999-9

Gillard, S., & Holley, J. (2014). Peer workers in mental health services: Literature overview. *Advances in Psychiatric Treatment: The Royal College of Psychiatrists' Journal of Continuing Professional Development*, *20*(4), 286–292. https://doi.org/10.1192/apt.bp.113.011940

Health Education England. (2020, October). *The Competence Framework for Mental Health Peer Support Workers.* https://www.hee.nhs.uk/sites/default/files/documents/The%20Competence%20Framework%20for%20MH%20PSWs%20-%20Part%202%20-%20Full%20listing%20of%20the%20competences.pdf

Health Education England eWIN. (2023, November 15). *Evidence Brief: Peer Support Workers.* UK: Workforce, Training and Education Knowledge Management Team. https://www.ewin.nhs.uk/sites/default/files/Peer%20Support%20Workers_Evidence%20Brief_0.pdf

Hopkins, L., Pedwell, G., Wilson, K., & Howell-Jay, P. (2021). Implementing youth peer support in an early psychosis program. *The Journal of Mental Health Training, Education, and Practice*, *16*(2), 85–98. https://doi.org/10.1108/JMHTEP-03-2020-0014

Hornstein, G. A., Branitsky, A., & Robinson Putnam, E. (2021). The diverse functions of hearing voices peer-support groups: findings and case examples from a US national study. *Psychosis, 14*(1), 46–56. https://doi.org/10.1080/17522439.2021.1897653

Hornstein, G. A., Branitsky, A., & Robinson Putnam, E. (2024). The benefits of hearing voices groups: more findings from a US national study. *Psychosis, 17*(1), 1–11. https://doi.org/10.1080/17522439.2024.2351848

Ibrahim, N., Thompson, D., Nixdorf, R., Kalha, J., Mpango, R., Moran, G., Mueller-Stierlin, A., Ryan, G., Mahlke, C., Shamba, D., Puschner, B., Repper, J., & Slade, M. (2020). A systematic review of influences on implementation of peer support work for adults with mental health problems. *Social Psychiatry and Psychiatric Epidemiology*, *55*(3), 285–293. https://doi.org/10.1007/s00127-019-01739-1

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A Review of the Quality Indicators of Rigor in Qualitative Research. *American Journal of Pharmaceutical Education*, *84*(1), 138–146. https://doi.org/10.5688/ajpe7120

Jones, B., & Jacobsen, P. (2021). Mental health professionals' attitudes and knowledge about hearing voices groups. *Psychosis, 14*(2), 153–161. https://doi.org/10.1080/17522439.2021.1936142

Kaufmann, C. L., Freund, P. D., & Wilson, J. (1989). Self help in the mental health system: A model for consumer-provider collaboration. *Psychosocial Rehabilitation Journal*, *13*(1), 5-21. https://doi.org/10.1037/h0099517

Kemp, V., & Henderson, A. R. (2012). Challenges Faced by Mental Health Peer Support Workers: Peer Support from the Peer Supporter's Point of View. *Psychiatric Rehabilitation Journal*, *35*(4), 337–340. https://doi.org/10.2975/35.4.2012.337.340

Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., Johnson, S., & Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry*, *14*(1), 39–39. https://doi.org/10.1186/1471-244X-14-39

Lyons, N., Cooper, C., & Lloyd-Evans, B. (2021). A systematic review and meta-analysis of group peer support interventions for people experiencing mental health

conditions. *BMC Psychiatry*, *21*(1), 1–315. https://doi.org/10.1186/s12888-021-03321-z

MacLellan, J., Surey, J., Abubakar, I., & Stagg, H. R. (2015). Peer support workers in health: A qualitative metasynthesis of their experiences. *PloS One*, *10*(10), e0141122–e0141122. https://doi.org/10.1371/journal.pone.0141122

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

Mead, S., & MacNeil, C. (2006). Peer support: What makes it unique. *International Journal of Psychosocial Rehabilitation*, *10*(2), 29-37. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=c41b0e9590189b32604b9d31b6955a3101b39a99

Morgan, C., Mallett, R., Hutchinson, G., & Leff, J. (2004). Negative pathways to psychiatric care and ethnicity: The bridge between social science and psychiatry. *Social Science & Medicine, 58*(4), 739–752. https://doi.org/10.1016/S0277-9536(03)00233-8

Mruck, K., & Breuer, F. (2003). Subjectivity and Reflexivity in Qualitative Research — A New FQS Issue. *Historical Social Research*, *28*(3), 189–212. https://doi.org/10.12759/hsr.28.2003.3.189-212

National Institute for Health and Care Excellence. (2014, February 1). *Psychosis and Schizophrenia in Adults: Prevention and Management.* https://www.nice.org.uk/guidance/cg178/resources/psychosis-and-schizophrenia-in-adults-pdf-248578083781

Neale, A., & Kinnair, D. (2017). Early intervention in psychosis services. *British Journal of General Practice*, *67*(661), 370-371. https://doi.org/10.3399/bjgp17X692069

Nguyen, J., Goldsmith, L., Rains, L. S., & Gillard, S. (2021). Peer support in early intervention in psychosis: a qualitative research study. *Journal of Mental Health*, *31*(2), 196-202. https://doi.org/10.1080/09638237.2021.1922647

NHS. (2023, September 5). *Overview – Psychosis.* Mental Health Conditions. https://www.nhs.uk/mental-health/conditions/psychosis/overview/

NHS Benchmarking Network. (2023, September). *Peer Support Workers Census 2023 Bespoke Report*. https://s3.eu-west-2.amazonaws.com/nhsbn-static/Peer%20Support%20Workers/2023/Peer%20Support%20Workers%20Workforce%20Census%202023.pdf

NHS England. (2019, July). *NHS Mental Health Implementation Plan 2019/20 – 2023/24.* https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

NHS England. (2023, February 16). *Implementing the early intervention in psychosis access and waiting time standard.* https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf

Ochocka, J., Nelson, G., Janzen, R., & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 3-A qualitative study of impacts of participation on new members. *Journal of Community Psychology*, *34*(3), 273–283. https://doi.org/10.1002/jcop.20099

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher*, *45*(3), 241–251. https://doi.org/10.1080/0142159X.2022.2057287

Ong, Q. S., Yang, H. Z., Kuek, J. H. L., & Goh, Y. S. (2023). Implementation of peer-support services in Asia: A scoping review. *Journal of Psychiatric and Mental Health Nursing*, *30*(3), 309–325. https://doi.org/10.1111/jpm.12879

Ostrow, L., & Adams, N. (2012). Recovery in the USA: From politics to peer support. *International review of psychiatry*, *24*(1), 70-78. https://doi.org/10.3109/09540261.2012.659659

Penney, D., (2018). *Defining "peer support": Implications for policy, practice, and research.* Advocates for human potential, inc. https://mamh-web.files.svdcdn.com/production/files/DPenney_Defining_peer_support_2018_Final.pdf

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S. E., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adult clients of statutory mental health services. *Cochrane Database of Systematic Reviews,* (3), CD004807–CD004807. https://doi.org/10.1002/14651858.CD004807.pub2

Proctor, K., Wood, R., & Newman-Taylor, K. (2019). Welcoming peer workers in NHS settings: facilitating readiness with an early intervention in psychosis team. *Mental Health and Social Inclusion*, *23*(1), 30-35. https://doi.org/10.1108/MHSI-08-2018-0028

Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R., & Rennison, J. (2013). *Peer support workers: Theory and practice.* ImROC Briefing Paper. London: Centre for Mental Health.

https://www.researchintorecovery.com/files/RRNJuly13_ImROCbriefing_peer_support_workers.pdf

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*(4), 392–411. https://doi.org/10.3109/09638237.2011.583947

Robertson, S., Leigh-Phippard, H., Robertson, D., Thomson, A., Casey, J., & Walsh, L. J. (2024). What supports the emotional well-being of peer workers in an NHS mental health service? *Mental Health and Social Inclusion*, *29*(7), 1-12. https://doi.org/10.1108/MHSI-02-2024-0023

Salzer, M. S., Darr, N., Calhoun, G., Boyer, W., Loss, R. E., Goessel, J., Schwenk, E., & Brusilovskiy, E. (2013). Benefits of Working as a Certified Peer Specialist: Results From a Statewide Survey. *Psychiatric Rehabilitation Journal*, *36*(3), 219–221. https://doi.org/10.1037/prj0000016

Sandelowski, M., & Leeman, J. (2012). Writing usable qualitative health research findings. *Qualitative Health Research, 22*(10), 1404–1413. https://doi.org/10.1177/1049732312450368

Schutt, R. K., & Rogers, E. S. (2009). Empowerment and peer support: Structure and process of self-help in a consumer-run center for individuals with mental illness. *Journal of Community Psychology*, *37*(6), 697-710. https://doi.org/10.1002/jcop.20325

Simmons, M. B., Grace, D., Fava, N. J., Coates, D., Dimopoulos-Bick, T., Batchelor, S., Howe, D., & Montague, A. E. (2020). The Experiences of Youth Mental Health Peer Workers over Time: A Qualitative Study with Longitudinal Analysis. *Community Mental Health Journal*, *56*(5), 906–914. https://doi.org/10.1007/s10597-020-00554-2

Singh, S. P., Greenwood, N., White, S., & Churchill, R. (2007). Ethnicity and detention in the UK: A systematic review and metaanalysis. European Psychiatry, 22(S1), S168–S168. https://doi:10.1016/j.eurpsy.2007.01.550

Stratford, A. C., Halpin, M., Phillips, K., Skerritt, F., Beales, A., Cheng, V., Hammond, M., O'Hagan, M., Loreto, C., Tiengtom, K., Kobe, B., Harrington, S., Fisher, D., & Davidson, L. (2019). The growth of peer support: an international charter. Journal of *Mental Health*, *28*(6), 627–632. https://doi.org/10.1080/09638237.2017.1340593

Viking, T., Wenzer, J., Hylin, U., & Nilsson, L. (2022). Peer support workers' role and expertise and interprofessional learning in mental health care: a scoping review. *Journal of Interprofessional Care*, *36*(6), 828–838. https://doi.org/10.1080/13561820.2021.2014796

White, S., Foster, R., Marks, J., Morshead, R., Goldsmith, L., Barlow, S., Sin, J., & Gillard, S. (2020). The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis. *BMC Psychiatry*, *20*(1), 534–534. https://doi.org/10.1186/s12888-020-02923-3

White, H., Price, L., & Barker, T. (2017). Exploring the impact of peer support in early intervention in psychosis. Mental Health and Social Inclusion, 21(2), 102-109. https://doi.org/10.1108/MHSI-12-2016-0036

Appendices

Appendix 1

Ethical approval from the University of Staffordshire (SU_23_073)

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name	Catrin Coates
Title of Study	Exploring the barriers and facilitators to peer support in Early Intervention in Psychosis services
Status of approval:	**Approved**

Thank you for your submission to the Independent Peer Review (IPR) Panel. Your application is now approved.

Action now required:
You must now apply to the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without Health Research Authority (HRA) and/or REC approval, and site-specific approvals. Please note that the University Sponsor contact to be named on the form is Prof Sarahjane Jones.

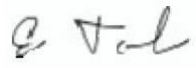
Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received HRA and/or REC approval, and relevant Trusts/organisations have confirmed their capacity and capability to support your study, you can commence your research.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any divergence from this approved application.

When your study is complete, please send an end of study report to me: e.tolhurst@staffs.ac.uk. A template can be found on the ethics Blackboard site.

Comments for your consideration: None



Signed: Dr Edward Tolhurst Date: 9th May 2024

University IPR coordinator

Appendix 2

Ethical approval from NHS Health Research Authority (IRAS: 336244)

Miss C Coates

School of Health, Science and Wellbeing

Email: approvals@hra.nhs.uk

Staffordshire University, Science Centre

Leek Road, Stoke-on-Trent

ST4 2DFN/A

23 September 2024

Dear Miss Coates,

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

Study title:	**Exploring the barriers and facilitators to peer support in Early Intervention in Psychosis services**
IRAS project ID:	**336244**
Protocol number:	**Not applicable**
REC reference:	**24/HRA/3877**
Sponsor	**Staffordshire University**

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

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

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

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

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

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

What are my notification responsibilities during the study?

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

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

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

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **336244**. Please quote this on all correspondence.

Yours sincerely,

Chris King

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Dr Sarahjane Jones, Sponsor's Representative*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Sponsor ethical approval]		
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Sponsor insurance and indemnity document 2]		
Copies of materials calling attention of potential participants to the research [Study advert]	1	10 May 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor insurance and indemnity document 1]		01 August 2024
Interview schedules or topic guides for participants [Interview protocol]	1	10 May 2024
IRAS Application Form [IRAS_Form_13092024]		13 September 2024
Letters of invitation to participant [Invitation letter]	1	10 May 2024
Other [Participant information form]	1	10 May 2024
Other [Debrief sheet]	1	10 May 2024
Other [Risk assessment]	1	10 May 2024
Other [Risk Assessment]	1	10 May 2024
Other [Organisation Information Document]	1	11 September 2024
Other [Schedule of Events]	1	11 September 2024
Participant consent form [Participant consent form]	1	01 July 2024
Participant information sheet (PIS) [Participant information sheet]	1	18 September 2024
Research protocol or project proposal [Research protocol]	1	18 September 2024
Summary CV for Chief Investigator (CI) [Lead researcher CV]		10 May 2024
Summary CV for supervisor (student research) [Supervisor CV]		10 May 2024

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	**Expectations related to confirmation of capacity and capability**	**Agreement to be used**	**Funding arrangements**	**Oversight expectations**	**HR Good Practice Resource Pack expectations**
Research activities and procedures as per the protocol and other study documents willtake place at participating NHS organisations.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. Due to the nature of the activities involved, organisations will be expected to provide that confirmation to the sponsor • Within **35 days** of receipt of the local information pack • After HRA/HCRW Approval has been issued. If the organisation is not able to formally confirm capacity and capability within this timeframe, they	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	Study funding arrangements are detailed in the Organisation Information Document	A Local Collaborator should be appointed at participating NHS organisations	Where an external individual is conducting only research activities that are limited to access to staff, or staff data (in either identifiable or anonymised form), or anonymised patient data then a Letter of Access is required only if these activities will take place in NHS facilities. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). . Where these activities will not take place in NHS facilities then no arrangements under the HR Good Practise Pack are required.

	must inform the sponsor of this and provide a justification. If the sponsor is not satisfied with the justification, then the sponsor may escalate to the National Coordinating Function where the participating NHS organisation is located.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 3

Participant information sheet

Information about the research

Study title: Exploring the barriers and facilitators to peer support in Early Intervention in Psychosis Services

NHS ethics reference ID: 336244

This research is being conducted as part of a student study.

We would like to invite you to take part in a research study. It is up to you whether you want to take part. Before you decide, we would like you to know why this research is being done and what it would involve for you. Please read through this information and feel free to ask if anything you read is not clear or you would like to know more about the study. Details of who to contact can be found at the end of this document.

What is the research?

We want to explore the potential barriers and facilitators to peer support in Early Intervention in Psychosis (EIP) services. We are looking for people who have experience of delivering peer support in EIP services to take part in an interview to share their experiences of providing peer support. These interviews will explore what works well (facilitators) and what doesn't work so well (barriers) in peer support in EIP services. Interviews will last approximately one hour and be mostly over Microsoft Teams.

You can take part if you are over 18 years of age and have either previously been or currently are in a peer support role in an EIP service in the UK. This study hopes to capture and better understand the experiences of peer support staff in EIP services, so please do consider taking part if you meet the inclusion criteria (see below for full inclusion and exclusion criteria).

Who is conducting the research?

The research is being led by Catrin Coates, Trainee Clinical Psychologist at Staffordshire University. The research is being supervised by Dr Kim Gordon (Staffordshire

University) and Dr Laura Betteney (North Staffordshire Combined Healthcare NHS Trust). People with experience of delivering peer support in EIP services have consulted on the design of the research.

Why is this research being undertaken?

Research has found that people who have experienced psychosis benefit from peer support. Peer support is growing within the NHS, including in EIP services, and research has started to look at how peer support is delivered in these services. We want to find out what works well (facilitators) and what doesn't work so well (barriers) in peer support in EIP services from the perspectives of the people who have the experience of delivering this. We hope that by better-understanding these barriers and facilitators, our findings will contribute to research in this area, and inform and improve the delivery of peer support in EIP services in the future.

Who can take part?

To take part in this research, you must:

- Be 18 years old and above.
- Be able to attend research interviews online via Microsoft Teams.
- Be able to speak, read, and understand English.
- Have experience of delivering peer support in EIP services in the NHS in the UK. We define peer support staff as; people who have lived experience of psychosis and have subsequently been recruited and worked in EIP services for a role related to using their lived experience to support clients in their recovery. This includes:
    - Current or previous peer support staff. There is no cut off as to how long ago people were in a peer support role, as long as they are able adequately answer questions about their experience of the role
    - Voluntary or paid peer support staff
    - Those who have delivered peer support in individual or group form

You will unfortunately not be able to take part in this research if:

- You do not meet the inclusion criteria above.
- You do not have direct experience of delivering peer support to clients. Peer support staff who have other roles will not be included in this study e.g. supporting carers, providing consultation to services, assisting with recruitment.
- You have experience of delivering peer support in services other than NHS EIP services, such as Community Mental Health Teams (CMHTs).
- You are unable to speak, read, and understand English.

Previous research in this area has not always been able to adequately capture experiences of under-represented peer support staff groups, such as black and ethnic minorities. Where possible, we hope to include these populations in this research so that our participant sample can be diverse and representative of the peer support staff group working in EIP services.

What will taking part involve?

The steps to taking part are:

1. If you meet the inclusion criteria and want to take part in the study, please contact the lead researcher to let them know you are interested in taking part. Details of who to contact can be found at the end of this document.
2. You will then be given the opportunity to ask any questions. You will be given a consent form to read, and you will sign the consent form if you agree to take part in the study.
3. You will be given a participant information form to complete. This will ask for some demographic information (age, gender etc.) and have questions about your peer support experience e.g. is your peer support experience current or previous.
4. You will then please return the signed consent form and completed participant information form to the lead researcher.
5. The lead researcher will then contact you to arrange a time for your interview.
6. You will take part in an interview. You will be asked about your experience of delivering peer support in EIP services, and the potential barriers and facilitators to this. Interviews will last approximately 60 minutes and will be recorded. Each participant will take part in one interview. Interviews will mostly be conducted virtually via Microsoft Teams. If you would prefer your interview to take place face to face at an NHS site, please let the lead researcher know and we will try to accommodate this.

Do I have to take part?

It is up to you to decide whether or not to take part in this study. If you do decide to take part, you can withdraw from the study until the data analysis process starts. People who take part in the study will be made aware of the deadline for withdrawing. If you do decide to withdraw, you will be asked why you want to withdraw, but it is your choice whether you want to share this.

Will my information be kept confidential?

Yes, your information will be kept confidential, anonymous and securely stored. Data will be processed in accordance with The Data Protection Act 2018, which is the UK's implementation of the General Data Protection Regulation (GDPR). Data will be saved in encrypted, password protected files on the Staffordshire University server, and the data will only be used for this project. This data will include:

- Demographic information: Age, gender and ethnicity.
- Information about your peer support experience: Duration and type of experience.
- Anonymised interview transcripts.

Interviews will be recorded via Microsoft Teams and stored separately from the other participant information on the University server. Any potentially identifying information will be removed from the interview transcripts. The principle researcher will be the only person with access to participant data and the data collected for the research i.e. interview transcripts. However, access to anonymised transcripts may be provided to research team or during research supervision as necessary and if, for example, support is needed with analysis of data. Data including interview transcripts and other non-personal will be stored for 10 years as per Staffordshire University's policy.

The data controller for this project will be Staffordshire University. The university will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the GDPR is a 'task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk. For concerns and complaints, please contact the Co-Chair of the University Ethics committee, Prof Sarahjane Jones - Sarahjane.jones@staffs.ac.uk.

The findings will be analysed and presented in written form. We will present a summary of the participants demographics overall and we may use some words from the interviews in the report to support our findings. This information will be kept anonymous and confidential.

What are the possible benefits to taking part?

This project aims to better-understand how people experience delivering peer support in EIP services, and the perceived facilitators (what works well) and barriers (what doesn't work so well) associated with this. We hope that the findings of this study will contribute to existing research in this area, and help inform and improve the delivery of peer support in EIP services in the future.

What are the possible risks of taking part?

There may be a risk that participants feel distressed during or after research interviews. Given the nature of peer support, it may be that participants will talk about how their role relates to their own lived experience in the interviews. Therefore, talking about delivering peer support could potentially be a sensitive topic. However, the focus of the study will be on the participant's roles as peer support staff, not their lived experience.

Being a staff member working in mental health services can be emotive and challenging at times, regardless of a persons lived experience. Therefore, asking staff about their role within the NHS may also be emotive. As participants have experience of being in

peer support roles, we anticipate that they have the skills in talking about these topics without experiencing significant distress. If you think that answering interview questions about this topic may be distressing, it may be best not to participate. Ways to access support will be shared with participants after the interviews, and will also be outlined in a debrief sheet given to participants at the end of the study.

There is a small risk of the possible identification of participants who take part in the study. Although we do not anticipate this will occur, there may be a risk of identification due to the specific staff group and services the participants are being recruited from.

The steps that will be taken to reduce this risk are:

- Keeping participant information anonymous and confidential
- Removing personally identifiable information from the interview transcripts
- Collecting, storing and processing data in line with the Data Protection Act 2018
- Not disclosing which EIP services participants are or were previously working. We will, however, specify which NHS Trusts the participants were recruited from. As there are several EIP services in the country with peer support staff, we expect the risk of identification to be minimal.

What will happen to the results of the study?

Responses to interviews will be analysed and written up as a thesis as part of the Doctorate in Clinical Psychology programme. An executive summary will also be written, which gives an overview of the study and its main points. Data analysis will not report on individual data and participants will not be identified in these documents. The results will be submitted to be published in journals and presented at conferences.

You can decide if you would like to be contacted after you have taken part in the research. You can select either opt in or opt out on the Consent Form to indicate your choice. If you want to be contacted, you will be asked for your feedback on the findings before the research project is completed. Once the research project is completed, you will have the opportunity to provide general feedback on the project and receive a summary of the research report.

What should I do if I want to take part?

If you want to take part in the study, please contact the lead researcher, Catrin Coates, on **c042156m@student.staffs.ac.uk** to let them know you are interested in participating.

Who can I contact for further information?

If there is anything that has not been covered in this information or you would like to ask a question, please email the lead researcher, Catrin Coates, on **c042156m@student.staffs.ac.uk**.

Appendix 4

Study advert

A research study exploring the barriers and facilitators to peer support in Early Intervention in Psychosis (EIP) services

NHS ethics reference ID: 336244

Do you have experience of delivering peer support in an Early Intervention in Psychosis Service?

Are you in this role at the moment or have you had this role in the past?

If you have experience of delivering peer support in EIP services and are 18 years old or above, we would like to invite you to take part in our study.

We are interested in finding out what works well (facilitators) and what doesn't work so well (barriers) in peer support in EIP services.

Participants will take part in an interview to share their experiences of delivering peer support, and the potential barriers and facilitators to this. Interviews will be with the lead researcher, will last approximately one hour, and be mostly over Microsoft Teams.

We hope that hearing peer support staffs perspectives will help us get a better-understanding of the barriers and facilitators to peer support in EIP services. Our findings will contribute to research in this area and hopefully inform future delivery of peer support in EIP services.

To take part in this study you must:

- Have direct experience of delivering peer support in EIP services in the NHS
- Be 18 years old and above
- Be able to speak, read, and understand English
- Be able to attend research interviews online via Microsoft Teams

If you would like to take part in the study, want more information or have any questions, please contact lead researcher, Catrin Coates, via email on *c042156m@student.staffs.ac.uk*.

Thank you!

Appendix 5

Participant consent form

Consent form

Study title: Exploring the barriers and facilitators to peer support in

Early Intervention in Psychosis Services

NHS ethics reference ID: 336244

Please read through the following information. If you consent to taking part in the study, please initial each box accordingly and sign below to confirm that you have read and understood this information, and voluntarily consent to take part in this study.

	If you agree, please initial box below
1. I confirm that I have read and understood the information sheet. I have had sufficient time to consider the information, ask questions and have had any questions answered.	
2. I confirm that I am at least 18 years of age and can speak, read, and understand English.	
3. I confirm that I have experience of working as a peer support staff member in an Early Intervention in Psychosis service within the NHS in the UK.	
4. I understand that my participation is voluntary and I am free to withdraw at any time until the data analysis process begins. I understand that if I do withdraw, I may be asked why I have withdrawn but I do not have to provide a reason for my withdrawal.	
5. I understand that my information will be kept confidential and anonymous.	
6. I understand that interview transcripts will be analysed by the lead researcher. I understand that this and any other data collected will be used only for this project.	
7. I understand that the lead researcher will be the only person with access to participant data and the data collected for the research. I agree that the lead researcher can share anonymised interview transcripts with the research team if support with data analysis is required. I consent to these individuals having access to my data.	
8. I agree for my research interview to be recorded via audio/video.	
9. I understand that my data will be saved in encrypted, password protected files on the lead researcher's University server.	
10. I agree that anonymised quotes from my interview can be used in research reports and publications.	
11. I agree to take part in this research study.	

I would like to be contacted after I have taken part in the research. Please check:

Opt in to being contacted ☐

Opt out of being contacted ☐

Name of Participant	Date	Signature
_____	_____	_____

Name of person taking consent	Date	Signature
_____	_____	_____

*1 copy for participant and 1 copy for researcher file

Name of researcher	Participant identification number
_____	_____

Appendix 6

Participant information form

Participant information form

Study title: Exploring the barriers and facilitators to peer support in Early Intervention in Psychosis Services

NHS ethics reference ID: 336244

Participant identification number (to be completed by the researcher):

Please answer the following questions to the best of your ability and return to the researcher with the consent form. This information will be kept anonymous and confidential.

Questions about your experience of delivering peer support. These questions need to be completed for you to take part in this research.

Number of years/months experience in a peer support role	
Is your peer support experience current or from a previous role?	
Have you delivered peer support on an individual basis, in a group, or both individual and group?	
Was your peer support experience in a voluntary or paid role?	

Demographic questions. Please complete these questions if you can. However, you do not have to complete these questions to take part in the study. If you do not want to answer any of these questions, please write 'prefer not to answer', thank you.

Age	
Gender	
Ethnicity	

Appendix 7

Participant debrief sheet

Debrief sheet

Study title: Exploring the barriers and facilitators to peer support in Early Intervention in Psychosis Services

NHS ethics reference ID: 336244

Thank you for taking the time to take part in this study. It is much appreciated.

Aims of the study

This study aims to explore the potential barriers and facilitators to peer support in Early Intervention in Psychosis (EIP) services. We want to find out what works well (facilitators) and what doesn't work so well (barriers) from the perspectives of the people with experience of delivering peer support in EIP services. We hope that our findings will contribute to research in this area and inform and improve the delivery of peer support in EIP services in the future.

If you would like any further information about the study, please feel free to get in touch with the lead researcher, Catrin Coates, on c042156m@student.staffs.ac.uk.

How we protect your information

Participant information will be kept confidential and anonymous. Data will be collected, stored and processed in line with the Data Protection Act 1998. The data will be used only for this project and only the research team will have access to the full data. When we present the findings, we will summarise the participants overall demographics and we may use words from the interviews to support our findings. This will be kept anonymous and confidential.

Your right to withdraw

You can withdraw from the study until the data analysis process starts. You will be informed by email of the deadline for withdrawing. If you do decide to withdraw, you will be asked why you want to withdraw, but it is your choice whether you want to share this.

What support is available to me?

If participation in this study causes you to feel distressed in any way, and you would like to discuss this, we recommend the following services:

Samaritans	**Phone:** 116 123 (available for free 24 hours a day) **Email:** jo@samaritans.org **Website:** https://www.samaritans.org
MIND	**Phone:** 0300 123 3393 (Monday – Friday 9am – 6pm, network charges apply) **Email:** info@mind.org.uk **Website:** https://www.mind.org.uk

Another useful resource is NHS 24 (111).

Thank you again for talking to us about your experience!

Appendix 8

Research interview protocol

Study title: Exploring the barriers and facilitators to peer support in Early Intervention in Psychosis services

Question 1: How have you found/did you find delivering peer support in Early Intervention in Psychosis services?
Prompts: What was it like? What did you enjoy? What did you find most challenging? How did you find - getting into peer support? Your time delivering peer support? Moving on from the peer support role?
Question 2: What are the facilitators to peer support?
Prompts: What aspects have worked well - in the service? in the team? in relation to staff support? with other peer staff? when supporting clients? What has been good about it? What helped or worked well – when getting into peer support? During your time delivering peer support? When moving on from the peer support role? Anything else?
Question 3: What are the barriers or challenges to delivering peer support?
Prompts: What has been difficult? What aspects have not worked so well - in the service? in the team? in relation to staff support? with other peer staff? when supporting clients? What were the barriers or challenges – getting into peer support? During your time delivering peer support? When moving on from the peer support role? Anything else?
Question 4: Have you shared or reflected on these barriers and facilitators previously/before?
Prompts: How have you done this? With who? In what format e.g. supervision, group supervision, in team meetings? How did this go? When did you do this e.g. when you started the role, during your time delivering peer support, or when moving on from peer support? Anything else?
Question 5: Has delivering peer support had any impact on you?
Prompts: Has this impact been positive or negative? What have you taken from peer support? How did this impact you at different times in your peer support journey

e.g. when getting into peer support, during your time delivering peer support, when moving on from the peer support role? Anything else?

Question 6: Is there anything else you want to add before the end of the interview?

Appendix 9

Extract from field notes taken during participant interviews

Some participants have spoken about challenges implementing peer support in teams e.g. peer staff views not being listened to, peer staff feeling helpless. In interviews, participants mostly say that they are not sure or uncertain about why this happens. It has been challenging at times to know who much to prompt around potential issues of power and culture within teams, so I have not offered any of my own suggestions or leading prompts about this during interviews, instead I have moved on from this topic if participants have said that they had nothing more to add about this topic.

During some of the recent interviews, participants have spoken about what they do in their peer support role e.g. how they deliver peer support to clients. I have noticed differences between how peer support seemed to be implemented in service from participants account of their role. However, the interview protocol does not ask any specific questions about what their role looks like or how peer support is delivered, as this doesn't fit with the research question. While this is interesting, likely not enough information and not relevant enough to the research question to include this information. Some participants also did not talk a lot about how they deliver peer support so reports of this were varied.

Appendix 10

Extract from reflexive journal used during research process

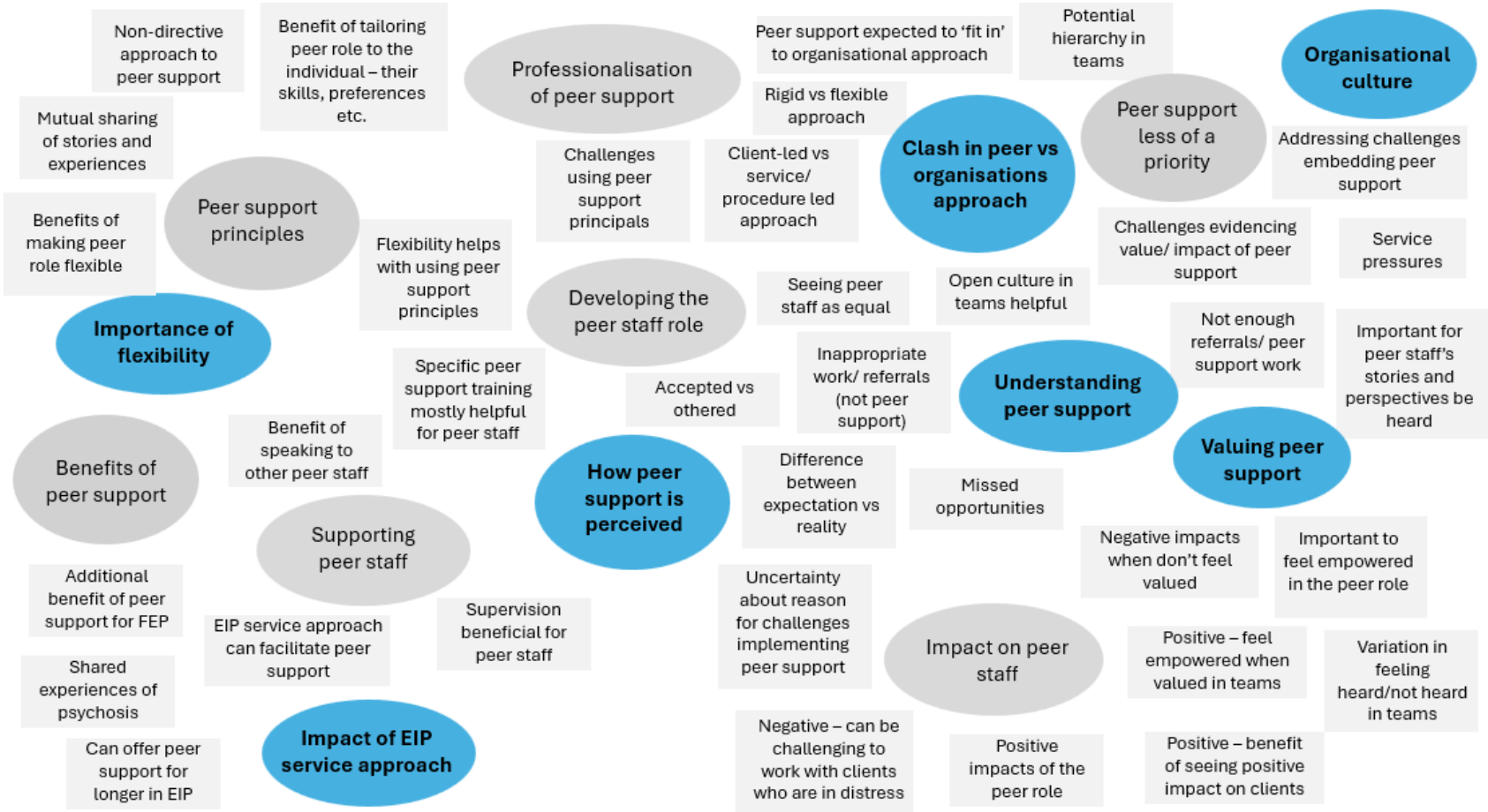
During the process of data collection and analysis, I have been aware of my own feelings of frustration regarding pressures of working within the NHS. I have noticed this arising during participant interviews when participants have spoken about limitations of and challenges in their peer role e.g. difficulties being able to work flexibly due to issues like service pressures. I have found it helpful to keep these reflective notes, which have helped me consider my personal position during this research, particularly during the process of analysing the data.

I am conscious of the recommendations I have read from previous research and the peer support community for such research to be led by peers, and that my position as someone without lived experience of psychosis or being a peer staff member will impact the process of data analysis. I reflected on how I have experiences working in Early Intervention in Psychosis services alongside peer staff, and this experience has led to my position of valuing peer support within mental health services due to my observations and witnessing the benefits that peer support can have for clients in these services.

During data analysis, I have noticed that there seemed to be a clearer sense of what types of team culture work well for peer support and facilitate peer support, but not much information from participants about team cultures which can be barriers or present challenges to peer support. There seems to also be something about how individual non-peer staff in EIP teams perceive and value peer support – participants have said that some staff do and some don't but, but there has been little shared about why certain staff might place more value on peer support and listening to peer staff perspectives and lived experience. Perhaps there is a difference in power and a sense of hierarchy between staff members/disciplines within teams? Although this has not been explicitly said/named by participants, I perceived this could be something unsaid when participants spoke about not being heard, valued etc. e.g. 'having a little voice of advocacy'.

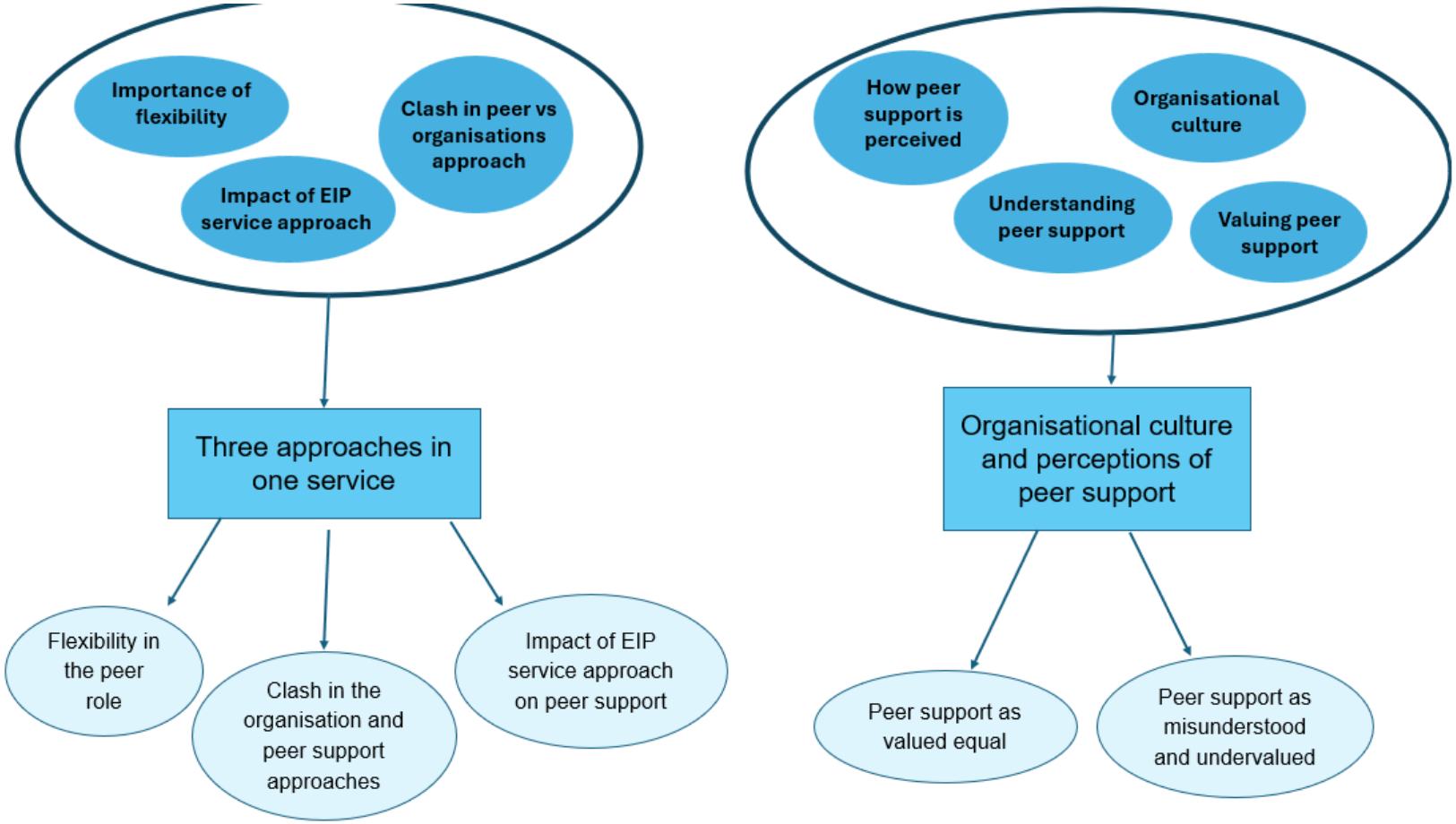
Appendix 11

Working map of grouped codes being developed into themes and sub-themes



Appendix 12

Working map of the development of themes and sub-themes



Appendix 13

Additional extracts from participant interviews

Themes	Sub-themes	Interview extracts
Theme 1 Three approaches in one service	1.1: Flexibility in the peer role	‘For me, I think it it's about being involved with that person [client] and doing things with them and stuff. So, whatever activities they [client] may want to do.’ (Participant 3). ‘Not all service users, you know, they [clients] might not want to have a conversation of peer support, but they'd love to read someone else's story, and that can mean a lot to them. Or there might be a piece of art that we've done that they can really connect with.’ (Participant 6). ‘If I brought them [the client] into the office, then I don't think our relationship would have developed in the way that it has. So, it's about being flexible to be able to do things that they [clients] want to do.’ (Participant 5). ‘That was important to have that flexibility.’ (Participant 6). ‘It’s helpful to give people [peer staff] the freedom to study or train to, kind of, evolve in the role. I don't think that you should get people doing the same things day in, day out, all day. I think that you're not going to inspire people, and I think it's unfair.’ (Participant 4). ‘I think the flexibility of the role as well has been really good because I'm very much left to organise my own diary. You don't feel pressured. You know, you can give each client the time that they need. No one's ever saying to me ‘you can only spend an hour with that person’, you know.’ (Participant 5).
	1.2: Clash in the organisation and peer support approaches	‘Sometimes it's like, we [peer staff] could be just walking alongside somebody [client] and I think where sometimes in the clinical role you're probably expected to have this little tick list where you need to get the person back at work and you need to get all these things. We're not, and that's all good, but I think sometimes with us, I think it's a lot to do with timing. Not every not everybody's ready to just jump straight back in. And I think where we can understand that a bit more, we can just sometimes want to walk alongside that

		person and gently. Whatever it is that they want or how they see their life is what's important to them. It's kind of like guide them towards that.' (Participant 1). 'Sometimes you feel a little bit jostled in between that. So, you set yourself up, you can empathise and understand with patients and the people you support, and you can understand the impetus of where the organisational approach is coming in from.' (Participant 3). 'From conversations I've had with people who work in the third sector, peer support runs very differently from what they've told me, and they can just, kind of, get on and things aren't things are pressurised, or not as pressurised in the same way as what the NHS is.' (Participant 2). 'If I've ever struggled with work or anything like that, it's not usually about what's going on with the people I support, it's usually stresses around organisation, or difficulties at work that are, kind of, complicating things.' (Participant 3). 'A barrier I can see, that I hear from my colleagues in the team a lot, is 'this person is too unwell to work with'. I'm like: 'What does that mean? Can you explain what too unwell is, or why you think I wouldn't be able to work with them because they're too unwell?' And there's not really an answer that I get back. And I'm like, well, this doesn't help me to be able to work with people. Like, you want me to do my job, I want to do my job, but then you're saying that people are too unwell. I'm like: 'This is the point in peer support. We go and walk alongside someone, we go and just sit and be with them' is the easiest way to say it 'and we can have conversations about everyday stuff that has nothing to do with clinical work, and we're just there, we just help people'. And from my experience of the people that I have worked with, it's gone really well, it's just trying to show that, which seems to be really difficult.' (Participant 2). 'They were always willing to take ideas on. I mean, at the same time, we had to be pragmatic because there's budgets, there's time pressures.' (Participant 6).

	1.3: Impact of EIP service approach on peer support	‘Although everybody's experiences of psychosis are very different, there will be elements that are the same or that sort of shared experiences, whether that be voices or hallucinations or thinking you're being followed or paranoia. You know, they're all things that we all share in some ways. So, the more we get to know each other, the more, the more we can share those experiences in a safe way.’ (Participant 5). ‘As far as our provision for peer support, what I provide, which is probably more intense for those people within early intervention.’ (Participant 3). ‘There are lots of people [staff] in the team that have had their own experience of mental health, but not necessarily psychosis, so I think that's the thing that makes a difference.’ (Participant 5). ‘Also, sharing not just the dark things [about FEP], but some of the light things. There were moments of real ecstasy, which I will never experience like that. And almost felt privileged in one way to have some of that experience’. (Participant 6).
Theme 2 Organisational culture and perceptions of peer support	2.1: Peer support as valued equal	‘I've also talked to [other staff member] who asked me ‘what exactly is your role?’ Give them the leaflet, give them the literature, and they understand what [a] peer support worker is.’ (Participant 8). ‘So they’re [the team] actually willing and trying to make it a way where we feel valid or we feel like, yeah, validated. And we feel like our experience is being used in the right way.’ (Participant 1). ‘I tried to have the conversations with people [staff in the team] all the time and some people are willing and will put the time aside to be able to do that, whereas others won't, and I think that makes a difference.’ (Participant 2). ‘Just the fact that people actually stop and listen to what, you know, everybody stops and gives me the same space to talk as they give everyone else. And that, my concerns are noted and recorded, and acted upon if need be. So, that's really positive for me.’ (Participant 5).

		‘There are some other people [staff] that started after me, but they know what I'm capable of achieving, so they're more inclined to, kind of, ‘let the rains loose’ as such. Do you know what I mean? As far as that peer support is concerned. But then other ones are just slightly wary and stuff, and I think that's to do with lots of factors. But, yeah, it could be harder to work with some staff than others, really.’ (Participant 3). ‘And that gave me the confidence to do that role, knowing that I had them [the tea] to support me. So yeah, I think it was just all those things that they've [the team] put in place’. (Participant 6).
	2.2: Peer support as misunderstood and undervalued	‘At the start, nobody in the team really knew what I was there for.’ (Participant 5). ‘Peer support is so misunderstood.’ (Participant 7). ‘The other team [members], they wouldn't know what it [peer support] is all about. So sometimes they will give you jobs that are out of the limit of your work. Then you have to keep explaining; ‘actually I do this, I do this.’ (Participant 8). ‘We [peer staff] don't feel valued within the team sometimes.’ (Participant 1). ‘When you see a job like this for an early intervention team and you know how complicated it can be, being unwell, especially with psychosis, you think ‘Oh my God, they're going to be loving me!’ And it actually became quite frustrating to make the team to really see the value in what lived experience potentially can bring to a service like this’. (Participant 4). ‘I don't think it was seen as a priority. I think we were a little bit disappointed.’ (Participant 6). ‘Sometimes we'll go to talk to people one-on-one within our team and try to get them to understand. We've done talks over the years like in CPD sessions, where we will explain like the different ways we can use peer support, and sometimes it comes back and there’s like, yeah, clapping. But then we don't see no changes.’ (Participant 1). ‘I put together a presentation that I do for new starters. It seems to help for a little while and then I try and do that

		every year in away days that we have, and that's where my work will build up again, and then it will slowly fall off again.' (Participant 2). 'We've had quite a lot of new people join the team in the last 2 1/2 years, who weren't around when I started. So it's about, I suppose, reiterate what my role is, and how best to refer to me, and who's best to be working with me.' (Participant 5). 'So, maybe the work isn't flowing in, or maybe then you think that you're going to be asked your insight for lots of different things, and if you find that these aren't automatically happening, you can become quite disempowered and unappreciated over a period of time'. (Participant 4).

Appendix 14

Author guidelines for Mental Health Science for submission of empirical paper

https://onlinelibrary.wiley.com/page/journal/26423588/homepage/author-guidelines

Mental Health Science **offers Free Format submission for a simplified and streamlined submission process.**

Before you submit, you will need:

- Your manuscript: this should be an editable file (e.g. MS Word) including text, figures, and tables, or separate files—whichever you prefer. All required sections should be contained in your manuscript, including (where relevant; please see **Article Types**) abstract, introduction, methods, results, and discussion. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.

Main Text File
The main text file should be editable (e.g. MS Word) and include:

- A short informative title containing the major key words. The title should not contain abbreviations (see **Wiley's best practice SEO tips**)
- The full names of the authors with institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Acknowledgments;
- Abstract of 300 words or less, structured (Introduction/Methods/Results/Conclusion) or unstructured depending on **Article Types**;
- Up to seven keywords;
- Main body: formatted as Introduction, Methods, Results, Discussion for article types that report empirical data;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. At revision stages, figures should be uploaded as separate files (see below).

2. Article Types

Article Type	Description	Word Limit (main text only)	Abstract / Structure	Other Requirements
Research Article	Reports of new research findings or conceptual analyses that make a significant contribution to knowledge	3500 limit	Yes, structured	Data Availability Statement IRB Statement

Paper 3: Executive summary

Barriers and facilitators to peer support in Early Intervention in Psychosis Services

Word count: 1,130

This executive summary is aimed at staff, services and stakeholders involved in the implementation and delivery of peer support in Early Intervention in Psychosis Services in the NHS.

Barriers and facilitators to peer support in Early Intervention in Psychosis (EIP) Services

Background: The peer staff workforce is growing in the NHS. Guidelines recommend peer support be offered within EIP services and evidence suggests that peer support can be beneficial for people who experience psychosis. However, there is a lack of research into peer support in EIP services.

Study aims: This study aimed to further understand the experiences of peer staff in EIP services by exploring the perceived barriers and facilitators associated with implementing peer support in these services.

Method: Eight participants with experience of working in a peer staff role delivering peer support to clients in EIP services took part in semi-structured interviews. Reflexive thematic analysis was used to analyse the data. Peer staff in EIP services were involved in the research design, analysis and dissemination.

Results: Through reflexive thematic analysis of the data, two themes with five associated sub-themes were developed outlining the main barriers and facilitators to peer support in EIP services.

Theme 1 **Three approaches in one service**	**Experiences of the impact of the peer support, EIP service and NHS organisation's approach on peer support in EIP services.**
Subtheme 1.1 **Flexibility in the peer role**	➢ Flexibility was important to peer staff EIP services. ➢ This included flexibility when delivering peer support to clients, and flexibility for peer staff to develop and use their lived experience in the role.
Subtheme 1.2 **Clash in the organisation and peer support approaches**	➢ There were perceived differences between the organisations more rigid and service-led approach and peer support's more flexible and client-led approach. ➢ Many peer staff felt a pressure to 'fit in' and deliver peer support in a way that aligned more with the organisations approach, rather than being in line with the principles of peer support.
Subtheme 1.3 **Impact of EIP service approach on peer support**	➢ The EIP service approach was mostly seen as facilitating peer support. ➢ EIP services supporting clients for three years allowed peer staff more time to develop relationships with clients if needed. ➢ EIP supporting people with First Episode Psychosis specifically meant that peer support often involved mutually sharing unique experiences related to psychosis, which was felt to be beneficial for clients.

Theme 2 Organisational culture and perceptions of peer support	Experiences of the influence of organisational and team culture on how peer support is perceived and integrated in EIP services.
Subtheme 2.1 **Peer support as valued equal**	➢ Some peer staff had experiences of working in EIP teams which understands and values peer support, and sees it as equal within the service. ➢ These teams are often ones with open and supportive cultures. ➢ Peer staff felt more confident and empowered in their roles if they perceived the team understood and valued peer support.
Subtheme 2.2 **Peer support as misunderstood and undervalued**	➢ Some peer staff had experiences of working in EIP teams that did not fully understand and value peer support or see it as equal in the service. ➢ This can lead to missed opportunities to utilise peer staffs' lived experience ➢ This can also lead to peer staff feeling misunderstood and undervalued in teams and being reluctant to share their views within teams. ➢ Peer staff roles often involve raising team's awareness of peer support and its value, but these efforts do not always make the change they intend to. ➢ Service pressures influenced how much teams understood, valued and prioritised peer support.

Key findings:

- It is important for peer staff to have flexibility in their role and when working with clients in EIP services.
- Peer staff can experience challenges working in line with the principles of peer support in EIP services due to the organisations more rigid and service-led approach clashing with peer support's more flexible and client-led approach.
- Two key aspects of the EIP service approach could be facilitators to peer support. EIP services supporting clients for three years can allow peer staff more time to develop peer relationships with clients. EIP services specifically supporting people with FEP could add value by allowing for peer support to focus on mutually sharing unique experiences related to psychosis.
- Peer staff can experience variation in how much teams understand and value peer support, and whether it is given priority and seen as equal to the other forms of support which EIP services offer clients.
- These barriers and facilitators can influence the extent to which peer support is delivered in line with its principles within EIP services.

Clinical recommendations

1. For EIP services implementing peer support to ensure that teams have an understanding of what peer support is, what peer staff roles involve, and promote the value of peer support.
2. For EIP services to aim to deliver peer support in line with its principles so that the uniqueness of the peer support approach is retained (e.g. flexibility in the peer role, empowerment of peer staff and valuing lived experience).
3. For stakeholders, EIP service leads and supervisors of peer staff to utilise guidance around implementing peer support within services and maintaining the unique characteristics of peer support (see information below).
4. For Clinical Psychologists in EIP services to contribute to supporting a broader understanding of peer support.
5. Future evaluations of peer support in EIP services would benefit from exploring the extent to which peer support is being delivered in line with its principles.

Conclusion

This research aimed to add to previous literature on peer support in EIP services by exploring the perceived barriers and facilitators associated with delivering peer support in EIP services.

The main barriers and facilitators found were organisational approaches, team culture and perceptions of peer support. These factors influenced how much peer staff were able to deliver peer support in EIP services in line with its principles, and the appropriate utilisation of peer staffs' lived experience within EIP teams.

How much these barriers and facilitators were present varied across participants. Our findings suggest that challenges with the implementation of peer support in EIP services can lead to peer support not being fully and appropriately utilised, despite research and guidance highlighting the importance of peer support in EIP services.

Future research

It would be beneficial for future research to explore the extent to which peer support is being delivered in line with its principles within EIP services. Non-peer EIP staffs' perceptions of peer support could be beneficial to explore further.

Links to guidance and websites to support with implementing peer support within services
• IMROC website: https://www.imroc.org/ • The Competence Framework for Mental Health Peer Support Workers (Health Education England, 2020. p. 48-53). https://www.hee.nhs.uk/sites/default/files/documents/The%20Competence%20Framework%20for%20MH%20PSWs%20-%20Part%202%20-%20Full%20listing%20of%20the%20competences.pdf • Peer support workers: Theory and practice (Repper et al., 2013). https://static1.squarespace.com/static/65e873c27971d37984653be0/t/668ce21ba54f933596890e57/1720508956537/5ImROC-Peer-Support-Workers-Theory-and-Practice.pdf • Preparing Organisations for Peer Support: Creating a Culture and Context in which peer support workers thrive (Repper et al., 2019). https://static1.squarespace.com/static/65e873c27971d37984653be0/t/668c0afdb379ec78d6f680fd/1720453887036/17ImROC-Preparing-Organisations-PSW-Briefing-Paper-1.pdf

References

Health Education England. (2020, October). *The Competence Framework for Mental Health Peer Support Workers.* https://www.hee.nhs.uk/sites/default/files/documents/The%20Competence%20Framework%20for%20MH%20PSWs%20-%20Part%202%20-%20Full%20listing%20of%20the%20competences.pdf

Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R., & Rennison, J. (2013). *Peer support workers: Theory and practice.* ImROC Briefing Paper. London: Centre for Mental Health. https://www.researchintorecovery.com/files/RRNJuly13_ImROCbriefing_peer_support_workers.pdf

Repper, J., Walker, L., Skinner, S., & Ball, M. (2019). *Preparing Organisations for Peer Support: Creating a Culture and Context in which peer support workers thrive.* ImROC Briefing Paper. London: Centre for Mental Health. https://static1.squarespace.com/static/65e873c27971d37984653be0/t/668c0afdb379ec78d6f680fd/1720453887036/17ImROC-Preparing-Organisations-PSW-Briefing-Paper-1.pdf