BMJ Open

Mental health workers' perspectives on the implementation of a peer support intervention in five countries: qualitative findings from the UPSIDES study

Maria Hildegard Haun ,[1] Selina Girit,[1] Yael Goldfarb,[2] Jasmine Kalha,[3] Palak Korde,[3] Eric Kwebiiha,[4] Galia Moran,[2] Rachel Mtei,[5] Jackline Niwemuhwezi,[5] Rebecca Nixdorf,[6] Lena Nugent,[6] Bernd Puschner ,[1] Mary Ramesh,[5] Grace Kathryn Ryan,[7] Mike Slade,[8] Ashleigh Charles ,[8] Silvia Krumm[1]

To cite: Haun MH, Girit S, Goldfarb Y, *et al*. Mental health workers' perspectives on the implementation of a peer support intervention in five countries: qualitative findings from the UPSIDES study. *BMJ Open* 2024;**14**:e081963. doi:10.1136/bmjopen-2023-081963

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (https://doi.org/10.1136/bmjopen-2023-081963).

Received 14 November 2023
Accepted 03 April 2024

For numbered affiliations see end of article.

Correspondence to
Maria Hildegard Haun;
maria.haun@uni-ulm.de

ABSTRACT

Objective The introduction of peer support in mental health teams creates opportunities and challenges for both peer and non-peer staff. However, the majority of research on mental health workers' (MHWs) experiences with peer support comes from high-income countries. Using Peer Support In Developing Empowering Mental Health Services (UPSIDES) is an international multicentre study, which aims at scaling up peer support for people with severe mental illness in Europe, Asia and Africa. This study investigates MHWs experiences with UPSIDES peer support.

Design Six focus groups with MHWs were conducted approximately 18 months after the implementation of the UPSIDES peer support intervention. Transcripts were analysed with a descriptive approach using thematic content analysis.

Setting Qualitative data were collected in Ulm and Hamburg (Germany), Butabika (Uganda), Dar es Salaam (Tanzania), Be'er Sheva (Israel) and Pune (India).

Participants 25 MHWs (19 females and 6 males) from UPSIDES study sites in the UPSIDES Trial (ISRCTN26008944) participated.

Findings Five overarching themes were identified in MHWs' discussions: MHWs valued peer support workers (PSWs) for sharing their lived experiences with service users (theme 1), gained trust in peer support over time (theme 2) and provided support to them (theme 3). Participants from lower-resource study sites reported additional benefits, including reduced workload. PSWs extending their roles beyond what MHWs perceived as appropriate was described as a challenge (theme 4). Perceptions about PSWs varied based on previous peer support experience, ranging from considering PSWs as equal team members to viewing them as service users (theme 5).

Conclusions Considering local context is essential in order to understand MHWs' views on the cooperation with PSWs. Especially in settings with less prior experience of peer support, implementers should make extra effort to promote interaction between MHWs and PSWs. In order to better understand the determinants of successful implementation of peer support in diverse settings, further research should investigate the impact of contextual factors (eg, resource availability and cultural values).

Trial registration number ISRCTN26008944.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ To allow discussion of the issues, challenges and successes that arose for MHWs when working together with PSWs, data were collected within a defined time period following the implementation.
⇒ As this is a qualitative study participants' views may not be representative of all MHWs' views at each implementing site.
⇒ Power hierarchies and other interpersonal dynamics between MHWs may have affected focus group discussions.
⇒ Analysts' positionality, language and cultural backgrounds can influence the interpretation of qualitative data; in this case, German and Israeli researchers analysed transcripts translated from local languages into English.

INTRODUCTION

PSWs are people with lived experience who draw on their own experience to support, facilitate, guide and mentor others on their journey of recovery.[1] Several qualitative studies and literature reviews have highlighted challenges resulting from the introduction of peer support into mental health teams, both for peer and non-peer staff.[2–10] These include, for example, the disruption of established roles and power dynamics between professionals and service users (SUs).[2 11] Role conflicts can impede integration into the service team and act as a barrier

to the implementation of peer support in mental health settings.[2]

In a recent narrative review of 38 studies, Mirbahaeddin and Chreim summarised the following factors that influence the implementation of peer support on three different levels[12]: (1) on the microlevel, interpersonal factors, such as the presence or absence of trust and understanding between peer and non-peer staff; (2) on the mesolevel, implementation factors, including organisational culture (hierarchical vs less hierarchical) and leadership engagement and (3) factors at the macrolevel, such as political frameworks and the allocation of financial resources for recovery-oriented interventions. This multilevel perspective highlights the interconnection of factors across the different levels, creating a dynamic interplay of influences on implementation. Hence, the interpersonal relations between mental health workers (MHWs) and PSWs (interpersonal level) are strongly intertwined with organisational factors (mesolevel) and social and cultural factors (macrolevel).

At the same time, the relevance, impact and interplay of contextual factors on the implementation of peer support can vary significantly across different mental health settings. Therefore, taking into account and perspectives of different stakeholders (eg, from PSWs or MHWs) as well as local needs is crucial in both research and practical implementation.[13 14] However, most studies of peer support are conducted in high-income countries (HICs) such as the USA,[15 16] the UK,[7 17 18] Israel[19] or Germany[6 20 21] which raises questions about the transferability of findings to more diverse settings.[14 22] There are few empirical studies comparing MHWs' experiences collaborating with PSWs in different settings.[23 24] In order to address this gap, as part of the UPSIDES project ('Using Peer Support In Developing Empowering Mental Health Services'), we conducted focus group discussions (FGDs) to compare MHWs' experiences after the implementation of a peer support intervention in diverse settings, including lower-income and non-Anglophone countries.

UPSIDES is an international multicentre study carrying out mixed-methods implementation research on the scale-up of peer support for people with severe mental illness at six study sites in low-income, middle-income and HICs.[25–27] Evaluation of the intervention includes a randomised controlled trial to assess the effectiveness of UPSIDES peer support as well as qualitative process evaluation involving various stakeholders.[26 27] Before the start of the UPSIDES intervention, we conducted FGDs with 35 MHWs from the UPSIDES implementation sites in Germany, Uganda, Tanzania, Israel and India on their expectations regarding peer support.[24] MHWs shared an overall positive attitude about peer support but also expressed some concerns, including PSWs possibly giving inadequate advice to SUs. Furthermore, results suggest that the local context, such as prior experience with PSWs and availability of resources, impacts MHWs' attitudes towards peer support, including their expectations of tasks, roles and role boundaries. For instance, some MHWs from study sites with greater previous peer support experience considered flexible role boundaries as an option, whereas MHWs from other study sites strongly agreed on the need for role clarity. An important question is whether and to what extent MHWs' expectations towards collaboration with PSWs change after the implementation of the UPSIDES intervention and through collaboration with PSWs. Considering that PSWs' roles in multidisciplinary mental health teams evolve over a long time frame,[20] we aim to explore MHWs' longer-term experiences collaborating with UPSIDES PSWs. This qualitative study asks: What are MHWs experiences with peer support work in low-income, middle-income and HICs 1.5 years after the implementation of UPSIDES peer support work?

METHODS

We followed COREQ (Consolidated criteria for reporting qualitative research) guidelines for reporting on qualitative studies[28] (see online supplemental additional file 1).

Patient and public involvement

This qualitative study is a component of the UPSIDES project, which was developed in partnership with various stakeholders, such as Su representatives, health professionals, managers or policy-makers. Stakeholders are involved in every stage of the implementation, for example, through local and international advisory boards. SUs participate in various roles within this project, as PSWs and, in some cases, as peer researchers.

UPSIDES peer support intervention

UPSIDES peer support is delivered for up to 6 months with a minimum of three contacts between UPSIDES PSWs and SUs in a one-to-one and/or group setting. The UPSIDES intervention has several core features shared across implementing sites. For example, all PSWs must be trained according to the UPSIDES Training Manual and Workbook to deliver peer support aligned with nine core principles that include peer and recovery-oriented practices such as mutual understanding.[29] However, UPSIDES peer support is also designed to be flexible and responsive to the needs of a particular context and was thus adapted to different mental health settings.[26 27 29 30]

Study sites

FGDs with MHWs took place at the study sites in Pune (India), Be'er Sheva (Israel), Dar es Salaam (Tanzania), Hamburg (Germany), Butabika (Uganda) and Ulm/Guenzburg (Germany). The discussion in Hamburg took place online due to pandemic restrictions. The study sites differed in terms of urban versus rural setting, service provision (inpatient vs outpatient, community service) and the extent of their prior experience with peer support.[2 26] A summary of the study context can be found in online supplemental additional file 2. This study, including data collection and analysis, was conducted in close collaboration with all six study sites.

Recruitment

To maximise variation, participants were recruited from multidisciplinary mental health teams at each study site via a purposive sampling strategy by local research workers. Potential participants were contacted in person, by email orphone. MHWs interested in study participation received a written invitation (via email or letter) with specific dates and venues. For the online FGD, technical requirements and instructions for participants were communicated prior to the FGD session. Participants were assured that their data would be kept anonymous. They were provided with study information (oral and written forms) and an informed consent form approved by ethics committee (see online supplemental additional file 3). Details are described in the study protocol.[26] Only participants who provided written informed consent were included. Participants received compensation for their time according to site-specific remuneration policies agreed with local ethics committees.

Procedure

FGDs with MHWs were conducted approximately 18 months after the UPSIDES intervention had started. Due to lockdown measures during the COVID-19 pandemic, study sites had to pause the intervention for varying lengths of time. Site-specific intervention pauses were included in the time frame for the FGDs; consequently, the earliest FGD was completed in July 2021 and the latest in March 2022. The FGDs took place at the study sites or, in one case, online (Hamburg, Germany).

Participants

25 participants took part in 6 FGDs total. Study participants came from a variety of professional disciplines and backgrounds (eg, psychiatrists, psychotherapists, nurses, occupational therapists and social workers). 19 participants identified as female and 6 identified as male. Participants' age ranged from 30 to 60, with an average age of 43 (see table 1).

Data collection

To capture a wide range of attitudes, knowledge and experiences emerging when MHWs discussing peer support, we conducted FGDs. Data were collected using a semi-structured topic guide. The topic guide was developed in cooperation between research workers from the study sites in Germany (Ulm) and Israel (SK, MHH, GM). A preliminary topic guide based on researchers' pre-existing knowledge and evidence-based literature was provided to the partners in each study site. Research workers at each site reviewed the topic guide. The final topic guide included the following four topics: (1) the impact of UPSIDES peer support, (2) collaboration, (3) role clarity and (4) team culture. The FGD guide can be found in online supplemental additional file 2. FGDs were conducted in the local language or English and were audio recorded. The online FGD was facilitated in accordance with the site's data protection guidelines. During the online FGD, participants could both see and hear each other. Both the in-person and online FGDs followed a similar procedure. Each FGD session was facilitated by a moderator and an assistant who were either trained through UPSIDES or had previous experience conducting qualitative research. The FGD moderator introduced each topic with a key question. Moderators asked subquestions if the key question did not generate sufficient discussion. At the end of the FGD, a short questionnaire was given to participants. The questionnaire gathered basic demographic information including participants' gender, age and professional background. After each session, the moderator and assistant wrote field notes about their impressions of the group dynamics and the discussion surrounding the main topics and regarding research questions.

Transcription and translation

Study materials including topic guides were forward translated from English to the local language by a bilingual speaker at each study site. In some cases, this required rephrasing questions, though without altering their core

Table 1 Characteristic of focus groups and participants

Study site	Ulm/Guenzburg, Germany (ULM)	Butabika, Uganda (BU)	Pune, India (PU)	Be'er Sheva, Israel (BGU)	Hamburg, Germany (UKE)	Dar es Salaam, Tanzania (DS)
N (gender)	4 (f=3, m=1)	6 (f=4, m=2)	3 (f=1, m=2)	6 (f=6)	3 (f=2, m=1)	3 (f=3)
Mean age in years (range)	52 (48–57)	42 (35–54)	41 (30–54)	47 (34–59)	43 (31–60)	43 (34–52)
Date	7 September 2021	24 August 2021	29 March 2022	19 July 2021	24 January 2022	23 February 2022
Duration	70 min	51 min	32 min	90 min	120 min	50 min
Location	Department of Psychiatry II, Guenzburg	Recovery College, Butabika Hospital	Hospital for Mental Health, Pune	Centre of Israel, Lod	online	Muhimbili National Hospital, Dar es Salaam

f, female; m, male.

meaning. Audio files were transcribed verbatim in the language used in the FGD. Any personal information captured in the transcripts was replaced with participant numbers. A bilingual speaker then translated transcripts into English. Two researchers as part of the UPSIDES translation team checked all final translated transcripts to ensure comprehensibility for analysis.[31]

Analysis

Following the thematic content analysis approach of Braun and Clarke,[32 33] the process of analysis was divided into five steps. In step 1, transcripts were read and reread by three researchers independently. In step 2, initial codes were generated to capture MHWs' views on peer support. Different recurring themes and codes were discussed. In step 3, based on the codes, a preliminary coding-tree with potential themes was developed. In step 4, the preliminary coding system and corresponding themes were discussed until a consensus on the final coding system was reached. In step 5, relevant themes, for example, MHWs' cooperation with PSWs, were further developed and elaborated in greater detail. Triangulation was carried out by the use of multiple analysts to ensure that the interpretations were informed by a range of perspectives. Researchers from the relevant study site were contacted in case of uncertainties or difficulties in understanding arising from the analysis of transcripts. Results in general as well as the analysis of the verbatim quotes were validated through consultation via email and online meetings with local research teams. Questions for validation can be found in online supplemental additional file 2. We used MAXQDA 2020[34] for managing codes, coding trees and memos.

FINDINGS

Five overarching themes were identified in MHWs' discussions of their experiences when working together with PSWs: added value through peer support work (theme 1); gaining trust through interaction (theme 2); supporting PSWs (theme 3); crossing boundaries or 'stay in their line of work?' (theme 4) and oscillating views on PSWs: colleagues or SUs? (theme 5). Each of these themes is divided into subthemes and illustrated with quotes below. Further illustrative quotes can be found in online supplemental additional file 4. Participants' quotes are labelled according to the country of the study site Ulm (ULM) and Hamburg (UKE), Germany; Butabika, Uganda (BU); Dar es Salaam, Tanzania (DS); Be'er Sheva, Israel (BGU) and Pune, India (PU).

Added value through peer support

MHWs discussed a broad spectrum of positive experiences and developments including the benefits of peer support for SUs, PSWs, mental health teams and mental health services. MHWs in study sites with lower financial and human resources (Butabika, Dar es Salaam) emphasised the benefits of UPSIDES for mental health services, for example, reduction of workload for MHWs' or improved mental health services in the communities.

Improved well-being of SUs and peer support workers

MHWs described PSWs as having less professional distance towards SUs. From MHWs' perspectives, PSWs and SUs share a 'common ground' (ULM 92) based on their lived experience, which facilitates contacts and relationships between PSWs and SUs (ULM 88, UKE 42, 48, 93).

> I experienced that it was incredibly easy for the colleague (PSW) to get into very close contact with the visitors (SUs), because it was clear that there was a common ground, that there was somehow a common history (…) (ULM 92).

> Just the same thing. Because they underwent the same suffering or the symptomology, so they can understand what the patient wants to convey (PU 9).

Above all, MHWs perceived PSWs as positive role models for SUs, providing emotional support and practical advice for daily living by sharing experiences. MHWs emphasised the positive effects of sharing experiences on SUs' motivation and self-confidence (BGU 38, 85; BU 19, 36, 59; DS 11, 38, 64; PU 10–14, 264).

> So giving hope and of course also the role model. 'I am someone who has perhaps often felt the way you do, but in the long run I have found a way' (…) This gives hope and strengthens empowerment. (…) So it's simply also a chance for more eye level (UKE 48).

MHWs from the Butabika study site valued PSWs for their unique relationships with SUs, which, in their view, could not be provided by MHWs:

> (…) there are things that I cannot give out just because I don't wear such shoes …, I do not have such an experience (…) these [PSWs] are people who have used this medication, who have been called names…, who have been treated as outcasts because of their mental illness…, for sure, I can never give out such support because I have never been in those shoes. So if there is someone who has gone through this, someone that has a vivid experience of living with mental illness, it has more meaning when this PSW shares their lived experience to patients. This person is going to truly share what I can never share …, because I have not been in those shoes before (BU 51).

Participants in Butabika and Dar es Salaam stressed that PSWs also encouraged SUs to take medication and adhere to treatment by sharing experiences with medicines (BU 19, 50; DS 15, 17, 34):

> (…) peer support workers shared their stories that they also have mental illnesses and they are taking the same medicine as them, when they heard the peer support workers, it has motivated them that one day they will also be well, so confidence increased (DS, 64).

At the same time, MHWs in the Butabika FGD described peer support as a way to strengthen non-pharmacological approaches:

> (…) right now we appreciate the role of the medical model…, but as you go on we have also brought on board non pharmacological methods and peer support is part of them. So this [peer support] is another piece of the jigsaw puzzle that has played a very big role in complementing the services that we offer since we aim at offering holistic care to our service users (BU 64).

MHWs across sites highlighted the benefits of peer support for PSWs themselves, including improved well-being and self-confidence (BGU 108; BU 9, 11; DS 8, 19; UKE 24, 45, 135). Particularly at the Dar es Salaam and Butabika study sites, MHWs emphasised that UPSIDES supported PSWs as well as SUs to become more productive and get into work, which led to less stigmatisation and increased social inclusion (BU 82; DS 19, 64, 74). Additionally, participants in the FGDs in Pune, Butabika and Dar es Salaam reported financial reimbursement and professional development as important opportunities for PSWs to move towards greater financial independence (BU 13; DS 11; PU 18).

Broadened perspectives for mental health teams

MHWs viewed PSWs as adding value to mental health teams. Participants in the FGDs in Butabika, Ulm/Germany and Israel valued the cooperation with PSWs as an opportunity to gain better understanding of SUs' needs, and to broaden professional perspectives within mental health teams (BGU 207; BU 38; ULM 14, 92, 144).

> (…) we are incredibly grateful, because she [PSW] simply fills this gap, sometimes telling us which situation someone [service user] can perceive as excessive demands (…) she [PSW] can read it differently and has a different approach, and that's very great (ULM 54).

> (…) many times it [peer support] gives a different voice, a voice that is not always heard, not because it's being ignored or anything, it's just a voice we can't always bring, you can't always bring the copers [SUs] themselves, who use the service, to a staff meeting because it's not always possible to expose them to information. So here people speak out of experience and coping (BGU 178).

One participant from the FGD in Ulm reported that through cooperation with PSWs, more attention can be drawn to the way MHWs talk about SUs (ULM 132) and how they cope with their own mental health issues within the team:

> (…) perhaps one has also become more vigilant (…) one's own vulnerability is perhaps also valued more, I would say. This has led to a lot of attentiveness, a lot of looking (…) (ULM 92).

Participants from the FGD in Be'er Sheva emphasised further positive contributions of PSWs to the team in terms of the disclosure of mental health problems. One participant in the Be'er Sheva FGD highlighted what they gained from openly expressing mental health needs at the workplace:

> (….) the ability to open a conversation with a manager. To come and say I am not well, I'm too tired, I need a break, I feel I can burst out at work, I feel that I'm having some relapse and I'm going to the doctor to get medicinal care. These are things that people who don't get the… people who don't get the chance to have their coping present in the workplace, it's harder for them to work. Because here they [PSWs] don't need to hide anything. (BGU 124-128).

Particular value of peer support in low-resource settings

MHWs at study sites in Uganda and Tanzania appreciated PSWs' potential as an additional workforce for mental health services by reducing MHWs' daily workload: '*There have been another pair of hands regarding human resource wise*' (BU 55) '(…) *which I was supposed to do* [visiting SUs in their home] *has been done by them with a great impact.*' (DS 55). MHWs in these FGDs also reported that, as a consequence of fewer relapses and thus fewer readmissions, the workload for service staff has been diminished (BU 14; DS 30, 53, 59, 62):

> (…) since peer support has helped patients to maintain their recovery…, readmissions have reduced. In trying to help their peers it has also helped the hospital at large because relapse rates have reduced …so it reduces on congestion on wards, overspending on food…, and such things (BU 54).

FGD participants at the two African sites described PSWs as a link between the community and the hospital, which made mental health services more accessible for SUs and their families (DS 57, BU 42). MHWs in the Butabika FGD described PSWs as 'ambassadors' (BU 55) for the hospital to the community. Participants reported that PSWs supported SUs, including during the pandemic (often by phone), by providing education on mental health:

> The PSWs can now move up to the patients' homes, and health educate the family members about mental illness. Some family members have now known that even though someone is mentally sick…, he or she can live a normal life (BU 19).

> (…) all our mental health units were closed and used for Covid patients (…) Our PSWs help us to bridge up that gap of reaching out and supporting these [mental health] patients (BU 83).

Furthermore, MHWs described peer support in the community and in churches as a way to reduce stigma and violence and promote human rights (BU 16, 50). This was considered especially important in more rural

areas where discrimination and violence against SUs may be more common: '*(…) where our patients were formerly put on chains and tied with ropes so it [peer support] has done a great job to sensitize the communities'* (BU 17). From the viewpoint of Butabika's MHWs, the work of PSWs also intersects with ongoing advocacy efforts that have helped to promote awareness about mental health in communities.

> External activists like Mental Health Uganda have helped a big deal in promotion of mental health services …, many people out there don't still believe that mental illness is a disease…, they attribute it to witchcraft…, bad luck…, so such organizations…, when they are in place, they help to promote awareness…, and people come to understand that mental illness can be treated …, instead of rushing to witch doctors (…) (BU 71)

Due to the perceived benefits of peer support for SUs, PSWs and mental health services, MHWs from the Butabika and Dar es Salaam sites expressed a strong need to continue or even expand peer support in their settings (BU 77, 80, 83; DS 91).

Gaining trust through interaction

Based on their positive experiences with PSWs, participants reported that trust in the concept of peer support increased over time. For instance, one participant in the FGD in Butabika explained that, against expectations, MHWs were pleasantly surprised by PSWs' work performance, leading to a positive impact on the attitudes of MHWs and other hospital staff:

> (…) they [the PSWs] have proved to health workers that they are a group of individuals who can perform…, actually they have surprised health workers that they can perform beyond expectations …, and that has helped to change the attitudes not only of the health care workers but also the other kind of the non-health worker staff we have in the hospital (BU 42).

A participant in the FGD Be'er Sheva described that MHWs '*started to trust the consumers as providers [PSWs] more because they could facilitate [an UPSIDES group intervention] and hold it through'* (BGU 231). Furthermore, one participant from Dar es Salaam FGD reported that mental health staff '(…) *had seen [positive] changes from the patients who had been enrolled in the project'* (DS 6) (DS 48, 53), and therefore, recommended peer support services to SUs.

Participants across sites emphasised the importance of everyday contacts between MHWs and PSWs. Conversely, limited opportunities to work together were described as a problem, particularly in the FGDs in Hamburg and Ulm (Germany), where MHWs reported only limited personal contact with PSWs on a daily basis (UKE 12, 153). Participants in the FGD in Ulm reported fewer opportunities to engage with PSWs, foremost due to pandemic restrictions, which negatively impacted the integration of PSWs into their mental health teams (ULM 18, 26, 58).

> (…) that was just a bit difficult with Corona, I think, that it wasn't so possible on the wards that they were there and really integrated into the team, but somehow always had to go to the park or look for a room somewhere with the clients. (…) I don't think it really worked with the integration, which was actually intended. (…) I've heard from the peer support worker, I recently met some of them again, and they also said, well, we're still somehow outside (ULM 152).

Participants discussed further challenges that limited the exchange between PSWs, SUs and MHWs and may have also hindered the establishment of a trusting working relationship. For instance, in Pune, it was difficult for SUs and PSWs to meet, because of the high number of appointments SUs have during their limited time in the outpatient centre (PU 227–229). Furthermore, MHWs in the FGD in Butabika reported limited time for professional exchange and support due to heavy workload:

> The main challenge I observed had to do with the timeframe…, because at times PSWs would come to the ward and find that we are very busy…, and they would feel a bit ignored and not helped out in time (…) (BU 22).

Supporting PSWs

In some FGDs, a close and encouraging relationship between MHWs and PSWs was seen as key to PSW performance.

> (…) the staff (…) have got close to our PSWs (…) sitting with them in the office and assigning them duties …, to me it's a big thing and I truly appreciate it. Because it gives them [the PSWs] a proper sense of belonging (…) And that pushes them to even work harder because they want to make a difference (BU 34).
>
> (…) they [PSWs] involved us and we gave them the cooperation which was needed (DS 51-52).

This is closely related to a team culture, which was described as supportive for PSWs.

> So we have a lot of openness and the colleagues, when they notice that there is something critical going on (…) she [the PSWs] takes herself out of it or is in very close contact and gives us the opportunity to say, hey you, no problem, you do your desk [task] and then we step in. So we really have a very fluid cooperation, but it is possible because there is a great deal of openness and trust (ULM 58).

MHWs across sites reported that they supported PSWs in their tasks, particularly when problems occurred, although with different approaches. Some participants seemed to prefer a more open exchange between MHWs and PSWs (ULM 122). In '*difficult situations and excessive demands (…) we rather discussed what would be too much now and where she [the PSWs] has to take care of herself a bit and*

look.' (UKE 54). Other participants reported more direct approaches for support, including providing PSWs with clear instruction:

> They [PSWs] were afraid about the roles which they were going to perform but after meeting with them and encouraging them they became confident (…) they were given a clear description of their roles, they were told if they see certain symptoms from the services users then they should come for treatment at the hospital. (DS 42).

Crossing boundaries or 'stay in line of work'?

MHWs discussed challenges when working together with PSWs. While in some FGDs, problems regarding cooperation were rarely mentioned (BU, BGU, UKE), other FGDs reported more conflicts with PSWs in more detail (PU, DS, ULM). PSWs extending their roles beyond what MHWs perceive as appropriate was reported as one major challenge.

Participants in the Ulm FGD reported that in their view, PSWs sometimes had '*too much motivation, [and] too little demarcation [towards SUs]'* or '*overtaxed themselves'* (ULM 108, 116) by slipping into a therapeutic role (ULM 38). Participants in the Dar es Salaam and Pune FGDs reported problems with PSWs overstepping their roles by giving medical advices to SUs (PU 107–117).

> (…) sometimes he [the PSW] wants to give clinical advice [to SUs] but can't, he seems to be unable to stay in his line of work, there are few of them who do that and it happens a few times (DS 26).

One participant from the Be'er Sheva FGD described how problems in cooperation arose when PSWs' perceptions of SUs' needs were inflexible and they were not interested in MHWs' points of view.

> (…) there is a less 'sexy' side to this involvement of a person that has experience-based knowledge. This kind of, let's call it [self-]righteousness [of the PSW], of knowing the coper's [SU] range of reactions best, how he can react and what should have been done, sometimes these are very emotional things and the ability to detach is not always monitored (BGU 193-197).

In the Dar es Salaam FGD, PSWs were described as being 'overconfident' (DS 28) in their new roles as PSWs and thus, not following rules. In the following statement PSWs' overstepping boundaries is framed as a result of their former negative experiences as SUs.

> (…) the thing that I have seen most is that they [PSWs] were overconfident which made them not stay in their line of work. The other thing is seeing themselves as doctors and you can't tell him anything because he/she [the PSW] is already in a position to lead others, so his/her position as a patient, whom we were continuing to monitor was forgotten. So, they had become overconfident, but since you understand them you lower yourself, some of them used to disrespect us. (DS 28).

At the same time, participants from the FGD in Dar es Salaam claimed that PSWs' roles and tasks are clearly described and followed by PSWs:

> Peer support workers had their roles, they were trained about the things which they are supposed to do and were given their roles, which they were very careful to ensure that they don't interfere with the roles of the mental health professionals (DS 34-36).

MHWs in the Dar es Salaam and Pune FGDs expressed rather mixed views on the frequency and relevance of situations in which role conflicts with PSWs occurred. While some participants pointed out that PSWs failed to comply with employee rules more frequently (PU 41–45), other MHWs reported only isolated cases: '*it is just that one person [PSW]'* (PU 122, 195). Participants from the FGD in Dar es Salaam emphasised that role conflicts had no negative impact on peer support at their study site:

> I didn't get any report on any kind of confusion that a person has done something which was supposed to be done by professionals, there was no such reports and I considered that everything went well, they [PSWs] continued with their positions. There was the issue of overconfidence as a person sees himself/herself as a health provider but we haven't got any report that he/she gave medicine (DS 40).

Some MHWs remarked on factors that seemed to improve role clarity. In Israel, the UPSIDES intervention was designed as a small group format, which led to a clear distribution of tasks and roles*: '(…) it was very clear that it is a group they [PSWs] facilitated, and it didn't overlap with the other things, everyone had their role*' (BGU 180–182).

MHWs in the FGD in Butabika in particular, reported that ongoing training for both PSWs and MHWs '*cleared the air and the concerns that were there. It has also brought harmony and harmonization of work …, each one knows exactly what they are supposed to do…'* (BU 48).

Oscillating views on PSWs: colleagues or SUs?

Some participants expressed uncertainties around how to treat PSWs either as colleagues or as SUs. Participants in the Ulm FGD expressed uncertainties around their own role when working with PSWs, especially when there were conflicts around PSWs' tasks and when PSWs were perceived as being unwell:

> (…) it has been difficult for me to understand the understanding of the role (…) to what extent do I have to support the person [PSWs] psychologically so that he can fulfil his task, yes, and to what extent do I advise him regarding the interaction with his client? (…) if he [the PSW] becomes unstable or, from my point of view, chooses a course of action that I as a therapist do not approve of (…) then it becomes a

problem. He is not my supervisee, where I can say 'stop, yes, it doesn't work' (ULM 38).

MHW's also expressed uncertainties around MHWs' responsibility in guiding PSWs in their roles. Participants described a need to support PSWs, but they were also concerned that giving advice could be taken negatively by the PSWs ('*He is not my supervisee'* ULM 38). One participant in the Be'er Sheva FGD highlighted that supporting PSWs could be demanding for MHWs, requiring time, patience, and suitable tools: '*(…) sometimes there is high emotionality* [in the cooperation with PSWs] (…) *things are being said and done in a very high volume…* [or] *over-identification with service users (…) I have always told myself: 'God give me the strength to deal with this', I need more tools to deal with this'* (BGU 140).

Another participant in the Be'er Sheva FGD reported that managing the PSWs led to their own role challenges '*(…) it [relapses of the PSW or other conflict] triggers all sorts of other emotions that we are suddenly under two [professional] hats, a therapist and a manager'* (BGU 149). For this participant, this required the need of being '*less of a therapist and more of a manager, and put boundaries'* (BGU 153). Here, the risk of perceiving PSWs as SUs is addressed, which may lead MHWs to take on a therapist role and thus create a power imbalance, resulting in MHWs doubting a PSWs' capability as a colleague. One participant at the Butabika FGD also emphasised that differentiating between the role of PSWs and the role of SUs is important in order to collaborate effectively:

> Some [MHWs] looked at them [PSWs] in that picture of being a service user and with a way of undermining them (…) Because if you have cared for them…, you still look at them as patients (…) [and] they (PSWs) felt a little inferior to the Health Workers (BU 26).

While in some FGDs, MHWs emphasised the importance of distinguishing between the SU and the PSW role, this was less discussed in the Pune FGD. In this FGD, MHWs frequently highlighted PSWs' mental health as a potential source of conflict during collaboration. One participant expressed concerns that PSWs' mental health could limit their understanding of peer roles, or hierarchies, particularly in situations where conflicts may arise.

> PSW was insisting on what medicines to be given which is more beneficial to the patient (…) and so at times we are unsure whether it is a genuine problem or their own symptoms have relapsed. (…) It can be the part of the illness which might have worsened and because of that she was not able to understand cognitively, she was not able to take that incident properly (PU107-128).

In the Pune FGD, further problems were identified around collaboration; for example, PSWs not fully understanding work processes on the wards and talking to family members instead of SUs (PU 178–185). In addition, some Pune MHWs suggested there was a need for increased monitoring and supervision of PSWs (PU 152).

> R1—And the task that they [PSWs] are doing, are they doing it correctly or not, for that also it is important to keep a watch. R2—Supervision should be there R1—Supervision is not very adequate. A lot of times they do it as they wish. (…) This is what I have seen a lot of times. And then they have this and because of the psychiatric problems, they tend to rule the Psychiatrists. Even to the other superior officers or anyone they show their dominance (PU 36-45).

DISCUSSION

The purpose of this study was to explore the attitudes of MHWs towards peer support following the implementation of a peer support intervention across six study sites in Africa, Asia and Europe. FGDs revealed many similarities across study sites. Echoing findings of previous results MHWs valued PSWs for sharing their lived experience with SUs and acknowledged them as positive role models for SUs.[5–7 17 24 35] Notably, at implementation sites with fewer resources, such as Butabika (Uganda) and Dar es Salaam (Tanzania), MHWs cited a number of benefits beyond the previously defined core competencies and activity domains of peer support.[36] In these study sites, MHWs reported reduced workload for MHWs and improved provision of mental health services in the community. As they might perceive peer support as an integral and indispensable part of mental healthcare provision, particular MHWs in these FGDs expressed a strong desire for the continued implementation and even expansion of peer support.

Preintervention findings of UPSIDES[24] suggest that MHWs were concerned about possible downsides of peer support, such as negative effects on SUs and PSWs, decreased service quality and reputational damage to mental health services. The results of this postintervention data collection do not support these concerns. On the contrary, and in line with previous findings,[11 21] MHWs in our study reported an increase in recovery orientations among some mental health teams, including a broader and deeper understanding of SUs' needs and an increased awareness of mental health issues at the workplace. However, compared with the preintervention FGDs, some of the initial concerns expressed by MHWs persisted. For example, uncertainties around collaborating with PSWs due to PSWs' lived experiences of mental health problems and concerns about PSWs ability to handle the demands of their roles (eg, becoming overwhelmed).[8 9 20 37] Furthermore, some MHWs expressed uncertainties about how to perceive PSWs—as colleagues or as SUs. Perceiving PSWs as SUs rather than colleagues can be problematic, as it may contribute to power imbalances between PSWs and MHWs, impeding successful team integration.[18] Shifting views of PSWs, sometimes as SUs and other times as colleagues were reported more

frequently at study sites where MHWs typically had less experience with peer support (Ulm, Dar es Salaam and Pune). Participants in study sites with more experience in implementing peer-delivered interventions (Be'er Sheva, Hamburg and Butabika) emphasised that MHWs should be clear about the role of PSWs as colleagues.[24]

Our findings suggest that MHWs' views are influenced by contextual factors, including prior experience of peer support. Some MHWs in the Hamburg and Be'er Sheva FGDs reported greater openness towards engaging in dialogue with PSWs, for example, negotiating unclear boundaries and supporting the role processes of PSWs. One reason for this may be due to their experience with peer support, which means they are more equipped to handle tensions, conflicts and uncertainties compared with MHWs from study sites with less peer support experience. In the Pune and Dar es Salaam FGDs, MHWs stressed the importance of establishing rules and regulations for PSWs, particularly when role ambiguities and conflicts arise. However, a strong need for role clarity also poses problems, and while clear role descriptions are key for implementing peer support effectively, overstandardisation of peer support, including narrow role specifications, may limit flexibility and individuality. These could in turn negatively affect the unique relationship between SUs and PSWs and the PSWs' ability to shape their role.[9 20 24]

Regardless of previous peer support experience our research suggests that MHWs developed trust in the abilities of PSWs over time and provided them with support. Previous research[9 38 38] describes this process as an 'evolution' of acceptance and appreciation of PSWs' roles by non-peer staff which can also contribute to reducing stigma towards mental health problems.[11 24 36]

Implications and recommendations for practice

Previous studies have offered recommendations to support MHWs in addressing challenges through training and supervision for peer as well as non-peer staff.[2 10 39–41] In addition, based on our study findings, we recommend the consideration of specific contextual and local needs, including those related to MHWs. Therefore, local implementation strategies should actively involve MHWs and their different expectations of peer support,[19 42] in order to build contextually appropriate solutions. Previous peer support experience appears to play a crucial role in terms of the attitudes of MHWs when working with PSWs. Mental health service management should provide structures that promote regular interactions between MHWs and PSWs on a daily basis. This appears to be important, particularly because research has shown that social contact contributes to stigma reduction.[37] Especially in settings with less experience in peer support these structures along with sufficient time for role development could help to facilitate better understanding between PSWs and MHWs. Furthermore, MHWs' expectations of peer support and their need for role clarification seem to differ between mental health settings. Therefore, we recommend the adaption of site-specific training modules and practice-orientated supervision, which aims to address role distribution and potential challenges at a local level for non-peer staff. Future studies should explore the impact of cultural values and norms on MHWs' perceptions of peer support, including analysing how these values delineate boundaries and set expectations when MHWs and PSWs work with each other.

Strengths and limitations

There are several strengths to this study. First, this study draws together findings from sites in Africa, Asia and Europe on the attitudes and experiences of MHWs who have collaborated with PSWs as part of the UPSIDES project. Second, since data were collected within a defined time period following implementation, this allows for discussion around issues, challenges and successes that arose when working with PSWs. Third, we were able to compare the findings of preintervention FGDs with postintervention FGDs to better understand how MHWs' views of PSWs may change over time and with experience.

Several limitations of this study can be identified. We used a purposive sampling strategy and our findings are based on a small sample of MHWs. Our findings cannot be generalised to other MHWs' experiences with peer support and are not representative. Furthermore, power dynamics and personal relationships can impact FGDs, especially when participants have pre-existing relationships (eg, as colleagues). Also, MHWs' views on working with PSWs may not accurately reflect the day-to-day realities of peer support. Future studies may benefit from the inclusion of observational data (eg, ethnography) to help shed light on different facets of daily practice and mitigate the influence of potential social desirability bias inherent in MHWs' reported statements.

The positionality, language and cultural backgrounds of the analysts as well as the methods used can influence the interpretation of qualitative data. In our study, cultural aspects impacting MHWs view on peer support were maybe overlocked in the analysis due the rather descriptive method, the certain cultural background of the analysis team (German/Israeli) and the translation process of the transcripts from local language into English. In order to gain a comprehensive understanding of cultural aspects of the cooperation between MHWs and PSWs in different study sites, future studies should include cultural analysis.

In our study, data collection and validation were closely conducted in collaboration with research workers from the six implementing sites. However, for future studies, it is essential to promote closer collaboration among researchers from all countries represented in the sampling throughout all stages of data analysis, including the initial phase of analysis. This collaboration is crucial in capturing diverse perspectives particularly when examining issues like roles and role allocation, where cultural aspects play a significant role.

Conclusions

Our study provides further support to the proposition that, regardless of the setting, when MHWs work together with PSWs, they tend to gain trust in peer support and acknowledge its benefits over time. Nevertheless, the implementation of peer support in daily practice can pose various challenges for MHWs, particularly the disruption of established roles and power dynamics.

Yet, there is no widely agreed consensus on what components of peer support can and cannot be modified.[43] Our study suggests that future research should focus on modifiable and non-modifiable components of peer support work in diverse settings, and determining which modifications of peer support roles and tasks are effective in which setting. Additionally, prospective studies should investigate the impact of contextual factors such as cultural values or service setting (eg, inpatient vs outpatient), and the implementation of peer support more generally to enhance understanding around implementation barriers and facilitators and their complex interplay across diverse settings.

Author affiliations
[1]Department of Psychiatry II, Ulm University, Ulm, Germany
[2]Department of Social Work, Ben-Gurion University of the Negev, Be'er-Sheva, Israel
[3]Centre for Mental Health Law and Policy, Indian Law Society, Pune, India
[4]Butabika National Referral Hospital, Kampala, Uganda
[5]Department of Health Systems, Impact Evaluation and Policy, Ifakara Health Institute, Dar es Salaam, Tanzania
[6]Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
[7]Centre for Global Mental Health, London School of Hygiene and Tropical Medicine, London, UK
[8]School of Health Sciences, Institute of Mental Health, University of Nottingham, Nottingham, UK

X Grace Kathryn Ryan @gracekryan and Ashleigh Charles @Mh_Ashleigh

Acknowledgements The study Using Peer Support In Developing Empowering Mental Health Services (UPSIDES) is a multicentre collaboration between the Department for Psychiatry and Psychotherapy II at Ulm University, Germany (Bernd Puschner, coordinator); the Institute of Mental Health at University of Nottingham, UK (Mike Slade); the Department of Psychiatry at University Hospital Hamburg-Eppendorf, Germany (Candelaria Mahlke); Butabika National Referral Hospital, Uganda (Juliet Nakku); the Centre for Global Mental Health at London School of Hygiene and Tropical Medicine, UK (Grace Ryan); Ifakara Health Institute, Dar es Salaam, Tanzania (Donat Shamba); the Department of Social Work at Ben Gurion University of the Negev, Be'er Sheva, Israel (Galia Moran) and the Centre for Mental Health Law and Policy, Pune, India (Jasmine Kalha).

Contributors SK, GM and BP conceived and designed the study. Data collection: MHH, SG, YG, JK, PK, EK, GM, RM, JN, RN, LN and MR. Data analysis: MHH, SK, SG. Writing–original draft preparation: MHH. Review and editing: SK, AC and GR. The manuscript has been critically revised for important intellectual content by MHH, SG, YG, JK, PK, EK, GM, RM, JN, RN, LN, BP, MR, GR, MS, AC, SK. All authors read and approved the final manuscript. MH and SK are the guarantors and accept full responsibility for the finished work and/or the conduct of the study, had access to the data, and controlled the decision to publish.

Funding This work was supported by the European Union's Horizon 2020 research and innovation program under grant agreement No 779263. MS acknowledges the support of Nord University and the NIHR Nottingham Biomedical Research Centre. This publication reflects only the authors' view. The commission is not responsible for any use that may be made of the information it contains.

Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Consent obtained directly from patient(s).

Ethics approval The study protocol of UPSIDES has been approved by the UPSIDES Ethics Advisor, the Ethics Commission of Ulm University, Germany (ref. 254/19), the Local Psychological Ethics Commission at the Centre for Psychosocial Medicine, Hamburg, Germany (ref. LPEK-0095), the Uganda National Council for Science and Technology (ref. SS 4990), the National Institute for Medical Research, Dar es Salaam, and Ministry of Health, Community Development, Gender, Elderly & Children, Dodoma, Tanzania (ref. NIMR/HQ/R.8a/Vol. IX/3328), the Human Subjects Research Committee of Ben-Gurion University, Israel (ref. 1787–1) and the Indian Law Society (ref. ILS/37/2018).

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement No data are available. All transcript fragments which informed the analysis presented in this publication are included within the paper and its online supplement files. Full transcripts are not publicly available as they contain information that could compromise the privacy of research participants.

ORCID iDs
Maria Hildegard Haun http://orcid.org/0000-0001-9542-6247
Bernd Puschner http://orcid.org/0000-0002-2929-4271
Ashleigh Charles http://orcid.org/0000-0003-2222-4358

REFERENCES

1 Repper J, Carter T. A review of the literature on peer support in mental health services. *J Ment Health* 2011;20:392–411.
2 Ibrahim N, Thompson D, Nixdorf R, *et al*. A systematic review of influences on implementation of peer support work for adults with mental health problems. *Soc Psychiatry Psychiatr Epidemiol* 2020;55:285–93.
3 Kilpatrick E, Keeney S, McCauley C-O. Tokenistic or genuinely effective? Exploring the views of voluntary sector staff regarding the emerging peer support worker role in mental health. *J Psychiatr Ment Health Nurs* 2017;24:503–12.
4 Moran GS, Russinova Z, Gidugu V, *et al*. Challenges experienced by paid peer providers in mental health recovery: a qualitative study. *Community Ment Health J* 2013;49:281–91.
5 Vandewalle J, Debyser B, Beeckman D, *et al*. Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: a literature review. *Int J Nurs Stud* 2016;60:234–50.
6 Otte I, Werning A, Nossek A, *et al*. Challenges faced by peer support workers during the integration into hospital-based mental health-care teams: results from a qualitative interview study. *Int J Soc Psychiatry* 2020;66:263–9.
7 Gillard SG, Edwards C, Gibson SL, *et al*. Introducing peer worker roles into UK mental health service teams: a qualitative analysis of the Organisation benefits and challenges. *BMC Health Serv Res* 2013;13:188.
8 Janoušková M, Vlčková K, Harcuba V, *et al*. The challenges of inter-role conflicts for peer support workers. *Psychiatr Serv* 2022;73:1424–7.
9 Asad S, Chreim S. Peer support providers' role experiences on Interprofessional mental health care teams: a qualitative study. *Community Ment Health J* 2016;52:767–74.

10 Mutschler C, Bellamy C, Davidson L, *et al*. Implementation of peer support in mental health services: a systematic review of the literature. *Psychol Serv* 2022;19:360–74.
11 Miyamoto Y, Sono T. Lessons from peer support among individuals with mental health difficulties: a review of literature. *CPEMH* 2012;8:22–9.
12 Mirbahaeddin E, Chreim S. The stigma of identifying as having a lived experience runs before me: challenges for lived experience roles. *Adm Policy Ment Health* 2022;49:596–612.
13 Betancourt TS, Chambers DA. Optimizing an era of global mental health implementation science. *JAMA Psychiatry* 2016;73:99–100.
14 Ong QS, Yang HZ, Kuek JHL, *et al*. Implementation of peer-support services in Asia: a Scoping review. *J Psychiatr Ment Health Nurs* 2023;30:309–25.
15 Gates LB, Akabas SH. Developing strategies to integrate peer providers into the staff of mental health agencies. *Adm Policy Ment Health* 2007;34:293–306.
16 Adams WE. Unintended consequences of Institutionalizing peer support work in mental Healthcare. *Soc Sci Med* 2020;262.
17 Moore T, Zeeman L. 'More 'milk' than 'psychology or tablets': mental health professionals' perspectives on the value of peer support workers'. *Health Expect* 2021;24:234–42.
18 Collins R, Firth L, Shakespeare T. Very much evolving: a qualitative study of the views of psychiatrists about peer support workers. *J Ment Health* 2016;25:278–83.
19 Hornik-Lurie T, Shalev A, Haknazar L, *et al*. Implementing recovery-oriented interventions with staff in a psychiatric hospital: a mixed-methods study. *J Psychiatr Ment Health Nurs* 2018;25:569–81.
20 Nossek A, Werning A, Otte I, *et al*. Evolvement of peer support workers' roles in psychiatric hospitals: a longitudinal qualitative observation study. *Community Ment Health J* 2021;57:589–97.
21 Otte I, Werning A, Nossek A, *et al*. Beneficial effects of peer support in psychiatric hospitals. A critical reflection on the results of a qualitative interview and focus group study. *J Ment Health* 2020;29:289–95.
22 Bayettia C, Jadhavb S, Jainc S. The re-covering self: a critique of the recovery-based approach in India's mental health care. *Disability and the Global South* 2016.
23 Gillard S, Holley J, Gibson S, *et al*. Introducing new peer worker roles into mental health services in England: comparative case study research across a range of Organisational contexts. *Adm Policy Ment Health* 2015;42:682–94.
24 Krumm S, Haun M, Hiller S, *et al*. Mental health workers' perspectives on peer support in high-, middle- and low income settings: a focus group study. *BMC Psychiatry* 2022;22:604.
25 The World Bank. World Bank Country and Lending Groups, 2024. Available: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups
26 Moran GS, Kalha J, Mueller-Stierlin AS, *et al*. Peer support for people with severe mental illness versus usual care in high-, middle- and low-income countries: study protocol for a pragmatic, Multicentre, randomised controlled trial (UPSIDES-RCT). *Trials* 2020;21:371.
27 Puschner B, Repper J, Mahlke C, *et al*. Using peer support in developing empowering mental health services (UPSIDES): background, rationale and methodology. *Ann Glob Health* 2019;85:53.
28 Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19:349–57.
29 Mahlke C, Nixdorf R, Repper J, *et al*. UPSIDES peer support worker training manual and workbook: field version, 2020. Available: www.upsides.org
30 Nixdorf R, Nugent L, Aslam R, *et al*. A multi-national peer support intervention: the UPSIDES pilot phase. *Adv Mental Health* 2022;20:2–14.
31 Charles A, Korde P, Newby C, *et al*. Proportionate translation of study materials and measures in a multinational global health trial: methodology development and implementation. *BMJ Open* 2022;12:e058083.
32 Braun V, Clarke V. Using thematic analysis in psychology. *Qualit Res Psychol* 2006;3:77–101.
33 Braun V, Clarke V. Reflecting on Reflexive thematic analysis. *Qualit Res Sport Exercise Health* 2019;11:589–97.
34 VERBI Software. n.d. MAXQDA 2020 [computer software]. Berlin. Available: maxqda.com
35 Chisholm J, Petrakis M. Clinician perspectives about working alongside mental health peer workers in service teams. *Advances in Mental Health* 2022;20:51–63.
36 Fortuna KL, Solomon P, Rivera J. An update of peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatr Q* 2022;93:571–86.
37 Byrne L, Roper C, Happell B, *et al*. The stigma of identifying as having a lived experience runs before me: challenges for lived experience roles. *J Ment Health* 2019;28:260–6.
38 Tse S, Mak WWS, Lo IWK, *et al*. A one-year longitudinal qualitative study of peer support services in a non-Western context: the perspectives of peer support workers, service users, and Co-workers. *Psychiatry Res* 2017;255:27–35.
39 Davidson L, Bellamy C, Guy K, *et al*. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry* 2012;11:123–8.
40 Stefancic A, Bochicchio L, Tuda D, *et al*. Strategies and lessons learned for supporting and supervising peer specialists. *Psychiatr Serv* 2021;72:606–9.
41 Walker G, Bryant W. Peer support in adult mental health services: a Metasynthesis of qualitative findings. *Psychiatr Rehabil J* 2013;36:28–34.
42 Chinman M, Young AS, Hassell J, *et al*. Toward the implementation of mental health consumer provider services. *J Behav Health Serv Res* 2006;33:176–95.
43 Charles A, Thompson D, Nixdorf R, *et al*. Typology of modifications to peer support work for adults with mental health problems: systematic review. *Br J Psychiatry* 2020;216:301–7.