

Understanding Peer Support And Options For Action In Devon

A discussion document for Recovery Devon

Ann Ley (R & D Dept., Devon Partnership Trust)

Tel. 01392-403626

ann.ley@nhs.net

Introduction and outline of this document

At the 6th March meeting of Recovery Devon at Dart Farm, one of the topics under discussion was peer support. A need to clarify what is meant by peer support and identify where resources should be placed for its development was subsequently identified in the Spring issue of the Recovery Devon Newsletter and taken forward at the Recovery Devon meeting on 8th July. At that meeting the interest in peer support was further refined into an action plan for all interested parties to consider in what ways peer support could complement existing services. This discussion document is intended as a first step towards clarifying our understanding of peer support, with a view to subsequent modification, debate and action.

Peer support occurs naturally and universally but there are a variety of terms used in the context of mental health. The main terms used will be identified and described and there will be a modest attempt at summarising the information that exists for the benefits and concerns regarding the two types of peer support most likely to be appropriate to the situation in Devon: mutual self-help groups and peer employees. The research base is growing, but still in its infancy when it comes to methodological rigour. Findings (mostly from the US) will be separated into two categories containing the following types of study:

1. studies in which there is a comparison group, including a small number of randomised controlled trials (RCTs);
studies with a longitudinal design, i.e. the same people are studied over time.
2. reports based on descriptive findings, personal accounts or observation;
studies of complex interventions (peer support was only one component amongst other activities making it difficult to estimate its benefits).

Within the second category, there are some impressions of the Scottish experience of employing peer support workers (Simon Bradstreet, Scottish Recovery Network personal communication) and reports from South West London & St. Georges who have a substantial history of employing people who have used their services in mainstream posts. In 2008, peer workers employed by Sutton Mental Health Foundation provided peer support on Jasper Ward. There is also a brief mention of an Australian study by Sharon Lawn & colleagues. This study focused on peer workers supporting the transition from hospital to home and also forestalling hospital admission. The author of this study has kindly sent further detail and also her

personal observations. Finally, there will be a short section on UK peer support training including experience gained from the Intentional Peer Support course run in Devon in 2007 by Shery Mead and its subsequent development by Mind in Exeter and East Devon. In the interests of readability, references have been kept to a minimum. A fully referenced version is available on request.

What is meant by peer support?

In the context of mental health, a *peer* is taken to mean a person who has lived experience of serious mental health issues and is using or has used mental health services. Thus *support* is given by peers to others who have, by definition, shared experiences in common. This enables practical and emotional help to be exchanged in a way that is outside the realms of the professional relationship. Mutuality, however defined, is central to peer support. A much quoted description penned by Mary Ellen Copland and Shery Mead sums it up well: “Peer support is not like clinical support, and it is more than just being friends. In peer support we understand each other because we’ve ‘been there’, shared similar experiences and can model for each other a willingness to learn and grow. *We come together with the intention of changing unhelpful patterns, getting out of ‘stuck’ places, and building relationships that are respectful, mutually responsible, and potentially mutually transforming. Instead of taking care of each other and thinking of each other as ‘sick’, in peer support we build a sense of family and community that is mutually responsible and focused on recovery and social action*” (Copland & Mead, 2004). The second half of this quotation (in italics) underpins the philosophy and action of ‘Intentional Peer Support (IPS) the approach taught in Devon in 2007 by Shery Mead and used in a variety of settings by Sutton Mental Health Foundation – more of which later.

IPS is distinguished from other descriptions of peer support by its four essential features, which are termed the four tasks: ‘connection’, ‘worldview’, ‘mutuality’ and ‘moving towards’. Briefly, connection is about recognising when we are genuinely connecting with another person during an interaction and, importantly, recognising when we are not; worldview is about helping each other understand where our attitudes have come from and how we’ve come to think about things in different ways. Mutuality is about redefining help as a co-learning and growing process and moving towards is about helping each other move towards what we want instead of away from what we don’t want. It is the specific combination of the four tasks which distinguishes IPS from other forms of peer support. In particular, the IPS definition of mutuality is distinctive from more general, lay understandings of this word and also the framework of intentionality. IPS is peer support with a purpose – that of

supporting one another in moving towards the life we wish to lead based on an intentional style of relationship. The further exploration of ‘mutuality’ is of particular importance. There are unresolved conflicts between deployment of IPS in its pure form and its application in developing paid peer support workers or incorporation into peer provided services in statutory settings.

In what ways can peer support be used?

Peer support relationships range in terms of formality from naturally occurring friendships, through grassroots associations such as self-help and mutual support groups to peer-run programmes, and peer provided services which are commonly found in the U.S. Peer support in general has been federally funded in the U.S. for many years and forms an important part of mental health support, alongside traditional services. It is interesting to note that the Scottish experience above was made possible through central funding. To date, this has not been the case in the rest of the UK.

There are numerous terms and definitions used and trying to lever some organisations into a single category is problematic. Corrigan (2008) breaks them down into two major groups.

Table 1: Major types of peer support

Mutual support or self-help groups	Peer provided services
<p><i>Face to face</i> A group of people sharing a similar problem who meet regularly to exchange information and to give and receive psychological support. Small to medium, informal, usually free of charge or small fee. Organised by peers in a non-hierarchical way. Can include groups affiliated to a larger organisation, e.g. GROW in the USA and MDF the Bipolar Organisation in the UK.</p>	<p><i>Peer operated services</i> Services which are controlled, operated and staffed by peers <i>Peer partnership services</i> A non-peer organisation has legal responsibility, administration & governance are shared, peers have primary control.</p>
<p><i>Internet</i> Some are open to anyone. Others are private and need an application to the owner of the group.</p>	<p><i>Peer employees</i> People employed by non-peer organisations to provide services to other peers, e.g. Scottish project</p>

Mutual support or self-help groups

Participation

Such information as exists indicates that mutual support groups are used by up to one third of potential participants. More women than men attend and people often need encouragement to join. Of those who do attend, the majority drop out by four months. The main reasons for non-attendance appear to be negative experiences from other group members and people's own illness. However, there appear to be benefits for those who remain as outlined below.

Evidence of benefits of participation

1. Studies with a comparison group

The following is based on an earlier review by Davidson (1999) and a recent systematic review by Pistrang et al. (2008) of 12 studies examining the effect of participation in peer groups supporting chronic mental illness, depression / anxiety and bereavement on measures of psychological and social functioning. Positive changes related to group membership were found in seven studies, including two randomized trials suggesting greater cost effectiveness for the peer support groups compared to professional interventions. Cost effectiveness was inferred from the finding that the outcomes were equally beneficial if the intervention was delivered by a mutual support group or by a professional. Highlights of these two reviews include the following:

- Improvement on symptoms of chronic mental illness and social adjustment over a one year period, plus the finding that giving help was associated with improved functioning, but receiving help was similarly associated only for people who reported higher group integration.
- Compared to recent group members, longstanding group members used less medication and treatment services, had higher levels of well-being and less neurotic distress. It has been pointed out that the longstanding members tended to be group leaders and were probably a select group, making the benefits in general difficult to estimate. Longer participation is positively associated with having larger social networks; increased perceptions of self-esteem; better decision-making skills and improved social functioning; more members pursuing educational goals and finding employment; and collective political action.
- People who were introduced to a group for depression or manic depression by an experienced group member were three times more likely to attend the group. At one year, there was no difference between self-help members and no-intervention

controls on either daily functioning or illness management but there was a positive relationship between the *amount of group involvement* and improved illness management.

- In a study of internet-based support groups for chronic depression, 34% of participants had resolved their depressive symptoms by 12 months, with frequent users of the support groups more likely to have resolution. These groups were mostly socially isolated women in treatment for depression at the start of the study. The authors adjusted their analysis to take account of severity of depression at the start of the study. Frequent users were not less depressed than non-frequent users.
- The importance of group integration and involvement was mentioned in six of the studies. It is important to remember that statistical links between group attendance and improved outcomes cannot be taken to determine cause. There will be an element of ‘horses for courses’ in terms of the nature of the group, closeness of social fit and factors such as sociability and social skills. It is said that Alcoholics Anonymous is 85% effective – for the 5% that attend it, although I have not been able to find a reference for this.

2. Descriptive findings of benefits based on surveys, qualitative studies, personal accounts or complex interventions

By and large, the essentially voluntary nature of participation in a mutual support or self-help group makes the topic unsuitable for study using RCTs in which people would be randomly assigned to take part in a mutual support group or not. Therefore, most of the literature consists of descriptions of the benefits of peer support, many of which reflect important elements of personal recovery. These benefits include:

- valuing the meetings and the broader mutual support experience;
- an instillation of hope and greater self-understanding;
- changed perceptions in terms of identity, life narrative reconstruction, spiritual development and a sense of feeling cared about;
- personal empowerment.

Evidence of harm

I have not found any reports of harm, but that is not to say that they do not exist, particularly as there is a publication bias in favour of positive results. The most I have found is that there is no difference between members of mutual support groups and non-members in terms of various outcomes such as symptoms. Authors have tended to conclude in general that group participants do not do worse.

Harm may not be reported for obvious reasons but there is anecdotal evidence of possible harms which will be included in the later section concerning the practicalities of supporting peer support.

Peer employees

Mike Slade (2009) suggests the following list of benefits:

1. *For the peer employee:* They have a job, with all the accompanying benefits. Lived experience is valued, which can be a transformative reframing of an illness experience. Giving to others is an important component of healing.
2. *For other staff:* having peer employees around makes other staff more aware of their personal values and is a challenge to ‘them and us’ attitudes
3. *For other peers:* peer employees provide positive role models and generate hope.

The pros and cons of employing peers in mainstream mental health services are outlined below. They are based on research summaries provided by Solomon (2004), Corrigan (2008) and Slade (2009), plus the Australian study mentioned above.

Descriptive accounts of the gains to be had from peer employees

For the peer employee:

- Fewer hospital admissions & shorter stays

Based on qualitative research:

- Increased confidence, self-esteem, sense of empowerment & hope
- Better illness coping strategies
- Practice own recovery, self-discovery, build own support system, engage in professional growth & moving towards a career goal
- Improved quality of life

For other peers:

- Have successful coping strategies
- Engage well & fewer unmet needs re. daytime activity, company, finances, transport and access to benefits.
- Provide positive role models & hope
- Perceived as more helpful than other staff
- Fewer hospital admissions & shorter stays
- Improved discharge experience this time compared with other admissions

- Functioned better in community without help from MH system
- Better quality of life
- More positive self-image and outlook
- Gains in social support

For recovery based practice:

- Facilitate culture change by having less stigmatising attitude, challenging prejudices & providing role model for staff in terms of relationships with clients

Concerns about peer employees based on descriptive research reports

- Staff prejudice
- Need for additional support & accommodations such as job sharing
- Some peers do not want support from a peer employee because of perceived lack of expert status.
- Some peers fear that peer employees will be influenced by professionals and lose their peer identity in favour of a professional identity

For the peer employees

- Role strain (qualitative study of the experiences of 5 peers in New Zealand)
 - Super cool (unable to express a normal range of emotions at work)
 - Super normal (felt the need for conservative appearance and behaviour)
 - Super person (felt they had to be experts in every area of mental health)
 - Unskilled (felt they were seen as unskilled & only qualification was lived experience)
 - Voyeurism (staff wanted to know details of illness & admission)
 - Remuneration (lack of proper pay scales to reflect their work)

The New Zealand peers identified the following ways of dealing with the above strains: humour, their own peer support, being open, a thick skin, long term perspective (the goal of changing the culture) and supervision. Other research has reported similar and additional strategies including setting boundaries, practicing self-care, self-monitoring and using medications strategically, personal supports and accessing supervision.

The following ethical concerns, most of which would also apply to non-peer staff have been described by Mike Slade. He and others suggest some possible solutions.

Ethical concerns	Possible solutions
Boundary issues arising from friendships, dual relationships, role conflict	Having policy guidelines, clear understanding of roles and responsibilities. Acknowledgement, openness and discussion. In some cases not peer-working with that person. Training for 'non-peer' staff to create a supportive & open environment & help them accept peer-workers as equals.
Confidentiality issues due to access to records, conversations	Peer workers are in the same position as other employees. Clear written protocols and training on confidentiality. Openness between peer workers and their friends about the need for confidentiality. Openness and the opportunity to discuss issue with other staff, peer workers
Sex	?? No-one has suggested a solution as far as I know.
Safety (some peers may be damaging to those with whom they work)	Appropriate recruitment and selection with policies in place to deal with unacceptable behaviour

The Scottish experience (Scottish Recovery Network)

A one year pilot project of having paid peer support workers in a variety of NHS and voluntary settings has been taking place from June, 2008. Within the NHS this included both inpatient and community work. The project has lasted longer than one year due to different start dates. An evaluation undertaken by an external body should be ready soon and will be available via the SRN website. There is also a dissemination event planned. The following summary is taken from an informal telephone conversation with Simon Bradstreet in late June.

How did it go?

The overall response has been positive, even in places where there were many difficulties and challenges. E.g. in one area, the project stopped because both peer workers became ill, but people are still supportive of the idea.

- There are ongoing issues around **funding** – same as with other posts – subject to the current economic climate. There are also difficulties with balancing the benefits issue for peer workers who only work a few hours – especially if this is in a stressful environment.
- In the NHS settings, there were some **managers** who were *determined* not to treat the peer workers any differently from other workers, so there was probably not enough support or attention to the fact that these posts were *different* in that peer were employed for their lived experience and this brought particular challenges to a system which had previously offered support. There could be a refusal to discuss the person's mental health as though that might be wandering into the territory of therapy. Life for the peer worker was made more difficult if there was not a wellness culture in the organisation.

I asked Simon if any peer workers had 'gone native' and adopted the norms of the environment, e.g. did they adopt an 'us and them' stance. He thought not. The 'us and them' was more about the peer workers (us) having a recovery focus and the 'them' (regular staff) not having this focus.

What did they learn?

- **Careful placement** is very important. It is much better to place the peer worker in a 'good', i.e. recovery supportive environment. There were examples of peer workers being placed in 'bad' environments in order to change the culture – however this led to them becoming unwell. It would be best to start in a good place – possibly one ward - and expand out. This is better than spreading the peers too thinly where mutual support between peers is limited.

- It may be too stressful to start with acute units, a community based setting might be better. A good use of peer workers would be during the *transition phase* from discharge to home or indeed periods of transition generally.
- There should be **more than one** peer worker in one place because they need peer support themselves.
- There needs to be more emphasis on getting the right peer. Some were too ‘hand-picked’. A **normal application procedure** is important.
- **Preparation and readiness for work** is vital (some had not worked for very considerable periods).
- **Training** needs to be UK applicable. SRN used trainers from the US where various types of peer support form a major part of mental healthcare provision. The US training is inspirational but does not necessarily prepare participants adequately for the realities of the NHS system - a system which itself is undergoing change. Some peer workers had unrealistic expectations of what they could achieve, leading to frustration and disappointment when things did not change as quickly as they might have wanted.
- **Clear role definition** This applies to both the peer worker and existing managers and staff on the ward.
- **Leadership** and supervision from **managers** is very important and the newly appointed peer worker should be clear as to what they should be doing – therefore preparation for their arrival should occur!
- **Supervision** Needs to be a clear understanding of what supervision is about, especially in regard to boundaries. SRN’s supervisors went on a training course provided by the same company that did the peer support training. It might have been better if the supervisors had more training in relation to the peer worker role as some were unclear and did not feel confident to challenge or help define the role.
- **When a peer worker becomes unwell** Need to think and plan for this possibility very seriously. Possibly contentious but peer workers need to be robust. Simon referred to a report by RAND which said that peer workers should have had good periods of wellness before starting. (*Glenn suggested a WRAP plan which Simon thought was a good idea*)

- **SRN's own training course** This is progressing. Simon thinks it will be in 3 parts. The award will fit in the Scottish Credit and Qualifications framework. A stakeholder group which includes good representation from peer graduates and workers is leading the development of awards and materials.

Peer support work from Sutton Mental Health Foundation & South West London & St. George's NHS Mental Health Trust

Sutton Mental Health Foundation (SMHF) was launched in 1987 as a mental health self-help support group. It became a registered charity in 1994, and a limited company in 1998. It employs 12 part-time staff. One of SMHF's important developments in recent years is its unique peer support service, based on the model of 'intentional peer support' developed in the US by Shery Mead. Funded largely through a one-year grant from Skills for Care, SMHF sent four people – two staff and two peer support workers – to the US to train as peer support work trainers with Shery Mead and her partner, Chris Hansen. They now have their own training programme for peer support workers in the borough, led by SMHF development worker John Nurse. They have so far trained about 20 people, and run regular peer support sessions on the local acute psychiatric admission ward – under a service level agreement initially with South West London and St George's NHS Mental Health Trust and now with Sutton and Merton PCT – and a Sunday peer support drop-in at a community venue in Sutton. SMHF would like to extend the peer support service into the community, and to set up a peer-run crisis centre and a safe house in the borough. Ultimately, they would like to establish the service as an independent social enterprise.

A report of their work can be found as Appendix 2. It includes a brief summary of the project which ran on Jasper Ward. Peer workers trained in intentional peer support worked on this inpatient ward. People supported by these workers were interviewed and there were also comparisons made between those who had spent time with a peer worker and those who had not. From the material available, I cannot tell which of the following are statistically significant but the report states that those with peer worker support were more likely to report that:

- they had been helped to settle in and told what would happen and what they could expect;
- they had the opportunity to discuss their feelings, worries and receive support when distressed;

- they had received help in their recovery and their hopefulness about being able to do the things they wanted to do in life had increased over their stay on the ward

Those interviewed were overwhelmingly positive about their experience of spending time with peer support workers, particularly appreciating spending time with someone who had experienced similar things – which helped them to feel more like a person and less like a patient. The peer workers seem to have been positive role models in terms of recovery ideas.

Comments from John Nurse on matters they found to be important:

- Careful preparation of ward staff and their managers
- Peer support to inpatients being provided by an independent organisation – this comment is related to accountability, safeguarding, fidelity to the IPS model, co-supervision that is not hierarchical)
- A background of a recovery culture worked on for several years
- Inpatient wards not really the best place to start – too stressful
- Providing peer support to in-patients is highly demanding and you really do need to have your co-supervision solidly built in. Even with that the turnover rate is very high. (There's some research from NZ that bears on this.)
- It is important that the peer support work/scheme/programme belongs genuinely to the people who are doing it. Otherwise it's not 'peer'. So supervision on the lines that professionals do it is not a good idea.

**The mental health peer supported hospital-to-home service (Adelaide, Australia)
Sharon Lawn, Ann Smith & Kelly Hunter**

Both a literature review and extensive consultation with people who used mental health services identified the first two weeks following discharge from hospital as a critical time when people feel most isolated and vulnerable to relapse. This 3-month pilot project employed peer workers to support the discharge process and avoid re-admission. An estimated 300 bed days were saved and positive feedback was received by all the stakeholders – ‘consumers’, carers, mental health staff, GPs and peer support workers. A copy of the full report was sent as a separate attachment with this document.

Comments made by Sharon Lawn following the project:

- Clear management support essential
- Secure clear human and financial resources to provide support and mentoring

- Have clear person from within the service to coordinate, protect, trouble shoot, navigate, build acceptance etc. (someone who can navigate management and worker layers)
- Build support that is not just vested in one person to avoid services where managers can just tick that box. Often use of peers is about whole of service saying something new about itself and the way it works and sees the role of service users

Common themes from the ‘lived experience’ of these peer support projects & the literature

Perhaps the first thing to say is that any peer support system is only worth setting up if it is well thought through and therefore likely to succeed and prove valuable. The key messages are:

- **Funding!**
- **Management support & subsequent preparation of ward staff**
- **Recruitment:** normal application procedure
- **UK applicable training & preparation for work:** including the demands of the NHS system. Possibly training for ‘non-peer’ staff to create a supportive & open environment & help them accept peer-workers as equals
- **Careful placement:** inpatient wards may be too stressful, periods of transition such as returning home after hospital admission or community work may be more appropriate
- **Clear role definition:** for both peer workers and staff
- **Peer workers need peer support:** so more than one in the same place
- **Supervision* & support:** needs to be flexible and geared towards the peer worker role - probably different to that normally given in NHS setting. Support needed in navigating the professional culture. Possibly a project support person to navigate management and work layers, protect, trouble-shoot, build acceptance
- **Plan for possible period/s of being unwell:** WRAP

*John Nurse strongly advocates co-supervision, which fits with the Intentional Peer Support approach used by Sutton Mental Health Foundation.

UK training possibilities

Intentional peer support: there is some local knowledge on this approach devised by Shery Mead. A 5-day residential course was run by Shery in Devon in 2007 and has been further developed by Mind in Exeter and East Devon. This course is currently being piloted in two places and the tutors, David Cooke and Georgina Lynch both attended Shery's 5-day course. Richard Brabrook told me that the course isn't accredited as such at the moment, but is part of the Recovery Approaches module that is part of the new Support Time and Recovery Course that is accredited with the National Open College Network at Levels 2 & 3. The module is currently locally accredited, but they are working with the NOCN to get it nationally recognised. Currently the IPS course is funded through the European Social Fund and Learning Skills Council as a one off, which is enabling them to adapt the course Shery Mead wrote, for the UK system, and pilot it in Exeter and South Devon.

The sessions run from 10am to 4pm for the first two and 10am to 2pm for the remaining 5 giving the whole course around 25 Guided Learning Hours plus an evening meal and get together after session 1. The sessions are spread so the first two are delivered a fortnight apart and the remaining 5 on a monthly basis with learners encouraged to meet up in between sessions to develop their peer relationships.

Sutton Mental Health Foundation

They have quite a history of sending people to the US for Shery Mead's training, including four people who have done Shery's training course for IPS trainers. They now have their own IPS course which is accredited.

Scottish Recovery Network

This is progressing and will be made available to any interested parties. It will fit in the Scottish Credit and Qualifications framework and is likely to be in three parts. It is being developed by peer graduates amongst others.

Training content

The following is an excerpt from a forthcoming book chapter written by Sharon Lawn and colleagues. Reproduced with her permission.

“(iii) Content of training

The underlying philosophy of training is the promotion of respect and autonomy for the person with mental health issues. Training emphasizes personal development, preparing for work and skills development while on the job.

Peer training often involves dedicated courses that may begin with introductory 4-6 week programs in which groups of 8-12 peers come together weekly for 2-3 hours to share and discuss specific topics such as telling your story safely, preparing for work and sharing understandings of mental health issues. Beyond this, peers may undertake formal accredited adult learning programs over 6-12 months part-time or full-time, usually with a placement component. Specific examples in Australia, New Zealand and the USA range from 80 to 820 hour training programs (Mind and Body 2009; TAFE 2009; US Psychiatric Rehabilitation Association 2009). Key components of the training include understanding the work environment, its philosophy, policies and procedures, relevant legislation, administrative aspects of keeping records, timesheets and other practical aspects of the role.

Further key components of training relate more directly to work with patients and include:

- Ethics and boundaries
- Communication skills
- Empowerment
- Advocacy
- Harm, suicide, vicarious trauma, risk assessment
- Co-morbidity and dual diagnosis
- Wellness Recovery Action Plan (WRAP)
- Supporting behaviour change and motivation
- Telling your personal story safely and constructively”

What now?

The research overall is encouraging and the experiences of others invaluable to any of the peer support projects which we may undertake. My own thoughts are that we have quite a bit going for us in Devon in terms of the enthusiasm of Recovery Devon for peer support initiatives, and the current drive for recovery orientation and practice within DPT and other organisations. Based on the knowledge and understanding derived from this summary and from other sources of expertise, it is now necessary to take this document forward by considering the various options in greater detail in order to prioritise proposals for local developments.

Over to you!

References

Copeland, M. E. & Mead, S. (2004). *Wellness Recovery Action Plan & Peer Support*. Brattleboro, VT: Peach Press. Also see: www.mentalhealthpeers.com

Corrigan, P. W., Mueser, K. T., Bond, G. R., Drake, R. E., & Solomon, P. (2008). Peer Services and Supports. In *Principles and Practice of Psychiatric Rehabilitation: An empirical approach* (pp. 359-378). New York: The Guilford Press.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. (1999). Peer support among individuals with severe mental illness: a review of the evidence. *Clinical Psychology: Science & Practice*, 6, 165-187.

Lawn, S., Smith, A., & Hunter, K. (2008). Mental health peer support for hospital avoidance and early discharge: an Australian example of consumer driven and operated service. *Journal of Mental Health*, 17, 498-508.

Lawn, S., Smith, A., Hunter, K., Smith, J., Hirst, N., Nanai, M. et al. (2010). Training Peers to Provide Low Intensity CBT Support: The Value of Personal Experience. In J. Bennett-Levy, H. Christensen, P. Farrand, K. Griffiths, D. Kavanagh, B. Klein, M. Lau, J. Proudfoot, D. Richards, L. Ritterband, J. White, & C. Williams (Eds.), *The Oxford Guide to Low Intensity CBT Interventions* (Oxford: Oxford University Press).

Pistrang, N., Barker, C., & Humphreys, K. (2008). Mutual help groups for mental health problems: a review of effectiveness studies. *Am.J.Community Psychol.*, 42, 110-121.

Slade, M. (2009). Peer relationships. In *Personal recovery and mental illness: a guide for mental health professionals* (pp. 103-113). Cambridge: Cambridge University Press.

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatr Rehabil.J.*, 27, 392-401.