A reflection on the development and delivery of a community peer support service for clients experiencing anxiety and depression

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Abstract

Purpose – *The purpose of this paper is to describe the development, implementation, delivery and evolution of a community-led, comprehensive, peer support service, including co-production approaches, peer support worker role development, outcomes, acceptability and lessons learnt over a five-year timeframe.*

Design/methodology/approach – *This case study presents a reflection on a charity's peer support service development along with outcomes to highlight client progress.*

Findings – *Improvement in well-being as measured through the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) was evidenced along with demonstrating that the peer support service offers complementary support to Improving Access to Psychological Therapies (IAPT) services.*

Research limitations/implications – *There was limited quantitative data, and that which existed was analysed on a service-wide basis as opposed to looking at individual components of the service.*

Practical implications – *This paper demonstrates the value of peer support provision as part of an overall primary care, community-based mental health service, including findings that suggest that for some individuals, where IAPT services did not help them as much, a peer-based service appeared to be more suitable.*

Social implications – *The peer support service provided a complementary and alternative service to conventional primary care mental health services whilst offering individuals with lived experience to gain volunteering, employment and development opportunities.*

Originality/value – *Whilst peer support services have been well documented in the literature for clients experiencing serious mental illness, research on the use of such approaches in the management of common mental health difficulties including anxiety and depression is not as well established. The aim of this paper is to detail the experiences of a user-led charity in developing and delivering peer support services, including challenges encountered. Furthermore, this paper describes a peer support service that has been integrated with a co-existing low intensity IAPT service, reporting recovery rates for clients that have accessed both peer support and IAPT services.*

Keywords *Peer support, Lived experience, Recovery, IAPT, Peer mentoring, Anxiety, Depression, Co-production, Volunteering*

Paper type *Case study*

Introduction

Peer support is increasingly being incorporated into mental health service provision internationally (White *et al.*, 2020) with a growing evidence base, though there is a need for high quality research (Bellamy *et al.*, 2017) and further investigation into the implementation of peer support services (Mutschler *et al.*, 2021).

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In England, peer support services have received renewed attention, with Peer Support Worker (PSW) roles featuring in mental health workforce plans (Health Education England - HEE, 2017). Furthermore, a Competence Framework for Mental Health PSWs has recently been developed (HEE, 2020), and the Mental Health Implementation Plan (NHS England, 2019) details opportunities for the growth in peer support roles until 2024.

Peer support however is nothing new and has a long history of being used in services (Faulkner and Basset, 2012), providing opportunity for those with lived experience of mental health difficulties to support the mental health recovery of others. PSWs are individuals with lived experience of mental health difficulties who are paid or unpaid workers that become professionally active in recovery and support services for clients with mental health problems (Nissling *et al.*, 2020). The sharing of personal experiences of recovery from mental health difficulties by PSWs has been shown to instil hope in clients, with PSWs also acting as role models (Solomon, 2004; Mahlke *et al.*, 2017). It has been postulated that clients become empowered because PSWs share their experiences of mental health recovery (Solomon, 2004; Rogers *et al.*, 2007) and that peer support services address isolation issues affecting clients through provision of social support (Dennis, 2003; Solomon, 2004). PSWs are believed to benefit from helping clients via the helper-therapy principle and in doing so, increase their confidence, self-esteem and management of their own mental health issues (Solomon, 2004).

The organisation concerned operates across the Northwest of England and was established in the mid 1990s as a user-led organisation, run by and for, individuals with lived experience of mental health issues. Peer support has always been integral to the organisation's service delivery offer. This is of importance as it is known that having a clear, shared organisational understanding of the values informing peer support is critical to the successful implementation of peer support services in practice (Gillard *et al.*, 2013), as is having specific training for PSWs (Tse *et al.*, 2014) and regular support and supervision (Cabral *et al.*, 2014), all of which are in place in the organisation concerned.

As an Improving Access to Psychological Therapies (IAPT) provider, the organisation offers evidence-based therapies to clients experiencing common mental health problems, such as depression and anxiety as well as an extensive range of other non-clinical, peer-support focussed services.

In 2014, the organisation developed a comprehensive peer support service, funded by the Big Lottery, for individuals experiencing common mental health difficulties, chiefly anxiety, and depression. The service operated for five years and comprised several components including a 1:1 peer mentoring service, 1:1 peer connect service, 'Rough guide to staying well' course and a co-production group (see Table 1).

This paper describes the components of this peer support service, key milestones in the development of the service (including the role of co-production), outcomes for clients accessing the service, challenges encountered and the evolution of the service to the current offer in existence.

Method

The peer support service operated between 2014 and 2019, comprising a number of components undertaken by individuals performing a range of roles in both paid and unpaid capacities (see Table 1). Element of the service's provision still exists today and has been further developed in other parts of the organisation.

Participants – those receiving the service

Referral source. In total, 433 clients attended at least one session of peer support (1:1 peer mentoring/1:1 peer connect/peer support structured course). Most referrals were internal,

Table 1 Description of the components of the peer support service and target client group

Service component	*Description of service component*	*Role type service delivered by*
1:1 Peer mentoring	Peer mentoring support for people experiencing common mental health problems (chiefly anxiety and depression) over a four-to-six-month period, usually one hour per week	Provided by 20 volunteers and 2 paid PSWs with lived experience of mental distress ranging from common mental health problems to more complex experiences such as personality and bi-polar disorder. Some also had experience of substance misuse and addiction. Many were previously clients of the organisation
1:1 Peer connect	Peer navigation service providing short-term information, advice and guidance to help clients access the right help needed, with a home visit element. Universal access criteria for anyone experiencing mental distress. Clients received a maximum of four sessions of one hour per week; one or more sessions could be home visits. Telephone appointments also provided	Provided by two, part time, PSWs employed on a casual/sessional basis with experience of common mental health problems, such as anxiety and depression
'Rough guide to staying well' course	A peer-designed and delivered well-being course largely suitable for people experiencing common mental health problems, though due to a flexible intake process, some clients with more complex presentations were enrolled onto the course	Each course was co-facilitated by two individuals with experience of mental health problems employed as PSWs on a casual/sessional basis. These individuals had a range of experiences of mental health problems including depression, anxiety, bi-polar and personality disorder as well as experience of long-term conditions and substance misuse/addictions. All facilitators were previously volunteers in the service
Whole service coordination		The service was supported by an administrator, a project coordinator, a manager and a trainer/facilitator. These roles were undertaken by people with experience of mental health difficulties of different types

received from other areas of the organisation, with self-referrals the second largest referral source. External referrals received came from voluntary sector organisations. Some referrals were also received from GPs and primary care mental health services (see Table 2).

Participants – those delivering the service

Twenty peer support volunteers operated in the service at any time. Ten sessional PSWs delivered the 'Rough guide to staying well' course, four peer support staff delivered the peer connect service and two peer support staff delivered the peer mentoring service.

For an overview of each of the roles (paid and unpaid) involved with the delivery of the peer support service see Table 1.

All staff and volunteers involved with the delivery of the service were comprehensively trained. See Table 3 for details of training provided:

Table 2 Referral sources for clients attending at least one session of peer support

Referral source	*No.*	*(%)*
Self	133	30.7
Internal	240	55.4
External	60	13.9
Total	433	

Table 3 Description of the training components of the peer support service

Training component	*Description*
Volunteer induction	A one-day induction covering boundaries, safeguarding, lone working and other essential requirements for volunteers and staff
Peer support training – (internal)	A one-day training on peer support, developed and delivered by staff in the first year of the service, for volunteers undertaking any peer support role
Peer support training – (external) IMH/Open University	An 11-day training course on peer support, initially delivered by the Institute of Mental Health (IMH), Nottingham, and then co-delivered with internal staff. Learners received accreditation of 20 credits with the Open University
The peer sessions – (internal)	IMH and the organisation worked in co-production to develop this shorter three-day training course
Train the Trainer – IMH/Open University	A five-day training course on facilitating adult learning/training for individuals with lived experience in peer support contexts. Learners received accreditation of 20 credits with the Open University

Participants – clients. Clients were assessed and triaged as depicted in Figure 1.

Table 4 details measures taken in the peer support service.

We analysed quantitative data for clients attending at least one session of peer support collected routinely as part of service delivery. The data pertains to demographics, referral sources, measures (WEMWBS), recovery goals and an exit questionnaire. In total, 433 clients attended at least one session of peer support, with 306 clients attending at least two sessions of peer support. There are a total of 131 paired WEMWBS scores (short WEMWBS was used for earlier clients, long WEMWBS was used for later clients). Although this number is only 30% of those clients who completed two or more sessions, the percentage rises to 79% for clients completing six or more sessions (107/135). We mapped initial and final

Figure 1 Peer support service: assessment and triage

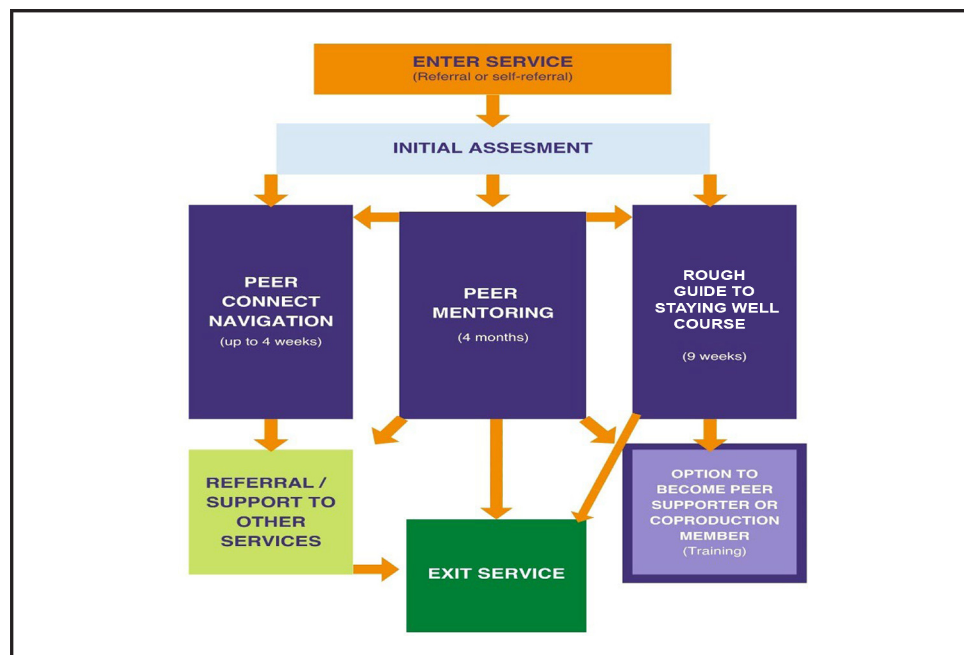

Table 4	Measures taken
WEMWBS	The WEMWBS (WEMWBS, 2008) is a tool developed to enable monitoring of well-being. There are two versions of the scale; the long version has 14 questions, and the short version has seven questions. Short and long versions of this measure were used in all areas of the service at different stages of the five years. This measure was selected as it is strengths/recovery based, has an evidence base for its usage and is used widely by other peer support services in England
Recovery Star	Used for a short time in peer mentoring; felt to be effective as it was strengths/recovery based and had been developed in co-production with service users, however it proved to be time-consuming to deploy in services and acted more as a case work tool than an outcome measure. For this reason, it was not used in every session and was largely discontinued after year three of the service. No recovery star data is presented in this paper
PHQ-9 and GAD-7	PHQ-9 (depression) and GAD-7 (anxiety) are two measures used to monitor symptom severity in IAPT services for people experiencing common mental health problems. Comparison of initial and final PHQ-9/GAD-7 scores is used to measure recovery in IAPT mental health services. These measures were not used widely in the peer support service as they were not considered sufficiently recovery/strengths focused. However, to facilitate comparison of recovery rates for peer support clients accessing the organisation's IAPT service, with recovery rates for all clients accessing our IAPT service, it was necessary to use these measures
Exit questionnaire	An in-house produced, exit questionnaire completed by all clients at the end of receiving peer support. Questions include: (1) client experience of the service, (2) recovery, (3) progress on goals, (4) improvement in mental health, (5) connection with the community, (6) self-understanding, confidence and implementation of positive coping strategies
Case studies	Some written case studies were provided by clients in response to requests from peer supporters and/or were given freely. Volunteers also provided self-case studies that focussed on the impact of their role on their mental well-being. Elements of these were used in reports to the funding body

WEMWBS scores into high, average and low mental well-being categories using the published cut-offs (the raw WEMWBS scores were transformed to metric values), and compared the initial and final distributions with a non-clinical distribution (Tennant *et al.*, 2007; Ng Fat *et al.*, 2017).

The peer support service operated alongside other mental health services delivered in the organisation: (eTherapy, IAPT Psychological Wellbeing Practitioner service [PWP], sanctuary crisis service). 55% of those who attended at least one peer support session were referred by another service within the organisation. In total, 92 people accessing the peer support service also completed an intervention with a PWP. We compared their PWP outcomes (recovery rates via initial/final PHQ-9 and GAD-7 scores) with the overall outcomes for the PWP service.

Co-production. Co-production was an integral part of the peer support service throughout its lifespan. It largely comprised a co-production group – 'Design of New Unique Therapeutic Services – DONUTS', which met quarterly/bimonthly comprising clients, volunteers, staff and other stakeholders.

Results

Table 5 details the key milestones in the peer support service's evolution.

Table 5 Timeline of the peer support service's evolution

Year	Event
2014	■ Vision came originally from national, user-led, condition-specific organisation which recognised the need to expand the service's remit beyond anxiety disorders and for a local service to be developed
	■ Funding bid to National Lottery Big Lottery Fund successful. Service launched in April
	■ Formation of co-production group, DONUTS
	■ Development of first in-house training course
	■ Initial provision of 1:1 peer mentoring on a volunteer basis in community locations across Manchester and Trafford
2015	■ First cohort of volunteers complete accredited peer support training and train the peer trainer training
	■ Co-production of 'Rough guide to staying well' course based on lived experience commenced
	■ Peer Connect – navigation element launched
2016	■ DONUTS extended to all aspects of peer support service
	■ Second cohort of volunteers complete accredited peer support training
	■ Eight PSW roles created, allowing for development in role of peers (peer connect, course facilitators, etc.)
	■ Two employed part-time PSW roles created (peer mentoring); one focused on supporting clients with more complexity
	■ Development of in-house peer support training and train the peer trainer to meet national standards (co-produced with IMH)
2017	■ Provision of peer support training to external organisations
	■ Change in referral criteria for clients in volunteer peer mentoring towards more defined "common" mental health problems. Continuation of universal criteria for peer connect service
	■ Provision of further reflective support for peer volunteers and PSWs introduced – peer support group and reflective practice
	■ Accreditation of service with Mentoring and Befriending Foundation
	■ Development of two PSW roles in the organisation's IAPT service, specifically working with client with long-term conditions
2018	■ Co-production process leads to development of social and creative activities for all involved in the service including clients and staff
2019	■ Termination of service due to funding ending

Demographics

The ethnicity, age and gender breakdowns are given in Tables 6–8. Comparison with ONS (Office for National Statistics) (2016) population denominator data for Manchester shows that while the percentage of white-British clients (58.4%) is in line with the population in the local area, males and older adults are under-represented in the service (ONS – using the 2016 file for people aged 16 and above, the following percentages are obtained for Manchester: white-British 60.7%, male 50.7%, 66 and above 10.9%).

Table 6 Ethnicities of clients attending at least one session of peer support

Ethnicity	*No.*	*(%)*
White	285	65.8
Mixed	27	6.2
Asian/Asian British	72	16.6
Black/Black British	26	6
Chinese/other	7	1.6
Not known/not stated/no data	16	3.8
TOTAL	433	

Table 7 Gender of clients attending at least one session of peer support

Gender	*No.*	*(%)*
Male	146	33.7
Female	220	50.8
Other	2	0.5
Not known/not stated/no data	65	15.0
TOTAL	433	

Table 8 Age of clients attending at least one session of peer support

Age	*No.*	*(%)*
16–25	51	11.8
26–35	102	23.6
36–45	94	21.7
46–55	106	24.5
56–65	58	13.4
66 and above	19	4.4
Not specified	3	0.6
TOTAL	433	

Initial and final WEMWBS

For the 131 clients for which there are paired scores, the distribution of initial and final scores, categorised into low, medium or high well-being, is shown in Table 9 below

These distributions are compared with a non-clinical sample in the graph below – see Figure 2.

Table 9 WEMWBS Scores for 131 people where there are paired scores mapped to low, average and high well-being

Well-being level	*Initial*	*Final*
Low	96	51
Average	33	72
High	2	8
Total	131	131

These results show that the initial well-being distribution is more heavily weighted towards low well-being than a sample population distribution. Furthermore, there is a significant improvement in well-being between the initial scores and the final scores with the percentage of people with a low well-being WEMWBS score decreasing from 73% to 39%.

Goals

Of the 306 clients who completed at least two sessions, 120 set recovery goals. Of these, 116 clients achieved more than 50% of their recovery goals.

Exit questionnaires

The results of exit questionnaires are tabulated – see Tables 10 and 11 below:

In total, 203 out of 206 (98.5%) people were satisfied with the service.

Psychological Wellbeing Practitioner service

As implied above, many clients who accessed the peer support service also accessed other mental health services within the organisation. In total, 92 of these clients accessed a low intensity IAPT intervention with a PWP. The recovery rate as per the standard IAPT definition using the PHQ-9 and GAD-7 measures [The National Collaborating Centre for Mental Health (2021)], for these clients was 37%. This is significantly lower than the recovery rate for all PWP interventions, in this period, 51% (*N* = 11,446) – implying that the peer support service provides an alternative provision for clients who fare less favourably in IAPT services.

Figure 2 WEMWBS scores categorised into low, medium or high well-being for initial, final scores and a sample non-clinical population

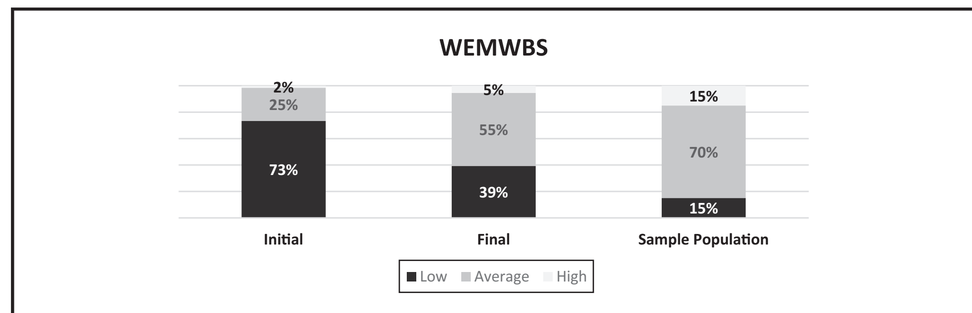

Table 10 Exit questionnaire results

Exit questionnaire questions	*Yes*	*No*	*NA*	*% Yes*
I have increased self-understanding and confidence in managing my mental health	184	23		88.9
I have learned and begun to use new positive coping strategies	173	31		84.8
I have increased my community and social connections/activities	147	55		72.8
I feel that my mental health has improved	148	54		73.3
I feel less anxious	120	68	11	63.8
I feel less depressed	129	58	10	69.0

Table 11 Learning derived from delivery of the peer support service

Service area	*Learning*
Peer mentoring/connect	The service from the outset attempted to offer flexible access and assessments in keeping with principles of peer support such that initially peer support volunteers providing six months of mentoring were given a wide range of client presentations to support. The progression/improvement of clients was found to be inconsistent, and therefore within the first two years, the service structure evolved so that volunteer peer mentors only supported clients with common mental health problems (anxiety and depression). The subsequent creation of the peer connect service as a navigation element was developed to specifically meet the need of a wider range of clients so that the service access criteria for this element of the service was wide. The development of PSW roles also enabled the service to offer mentoring to individuals experiencing greater complexity – provided by staff with similar lived experiences. Sadly, funding applications to expand this area of service provision were unsuccessful
Training and differing experience of volunteers	During the first year of the service, it became apparent that a one-day induction and training course on peer support was insufficient to equip peers with necessary skills and learning to be effective in role. Some volunteers came to the service with previous experience of undertaking training and supporting others, whilst others had no prior experience. Providing a more in-depth training experience was crucial in helping to level these differences, providing clients and volunteers with a better support experience. Linked to this was the differing lived experience of many peer supporters, and the extent that mental distress may still have been current in their life. Ensuring training included a strong element of self-reflection was essential as was providing ongoing support and reflection opportunities for peer supporters
Co-production	Achieving a greater balance/representation of clients, volunteers, staff and other stakeholders was essential in improving the legitimacy of the co-production process as was supporting all through training and other methods to contribute equally. Transparency in the limitations around decision making and more objective, skilled facilitation of the co-production process, helped improve the effectiveness of the group. The co-production element helped to innovate new developments in the service throughout the five years of its existence
Courses and other meetings	The development of the ‘Rough guide to staying well’ course, co-produced by people with lived experience, was found to be a valuable, unique aspect of the service. Clients accessing the course reported that they had never experienced anything like it before in terms of the subject areas the course covered and its relevance to people experiencing mental distress. Another positive aspect of the well-being courses and co-production meetings was the creation of a community of people that were using lived experience in a positive way, involving clients, volunteers and staff

Discussion

Peer support is clearly here to stay and is set to form a larger component of mental health services in the future.

This paper demonstrates that a community-based comprehensive peer support service can achieve positive well-being outcomes as demonstrated quantitatively through increased WEMWBS scores post intervention and qualitatively through the exit questionnaire results. The literature is sparse for evidence at primary care level for peer support and also for

improvement in clinical outcomes (White *et al.*, 2020). This study therefore goes some way to address this gap, and that of acceptability, which also exists.

Where relevant, analysis of client recovery rates demonstrated that this service may assist clients who when accessing IAPT services, achieved lower recovery outcomes than typically reported for the service. This implies that the peer support service is a useful component of mental health services that can be viewed as complementary to IAPT and other mainstream support services. Furthermore, the peer support service provides a unique, alternative provision to currently commissioned, mainstream primary care mental health services, such as IAPT.

As the organisation is a provider of IAPT services, this aided signposting to the peer support service and supported collaborative working between both services. Post project, this has led to the peer support service further evolving to include workers operating alongside IAPT services and with a step 1 service which operates as part of an integrated IAPT Plus service.

White *et al.* (2020) report that it is important to explore the heterogeneity in the implementation of peer support. This has been addressed in this paper through providing detailed descriptions of several peer support interventions deployed, along with information on training provided, key milestones and the overall evolution of the service.

One of the most significant learning points is that of the development and improvement of all components of the service stemming directly from the co-production process. This included refinement of volunteer peer mentoring (referral criteria, intervention length), mentoring support for clients with greater symptom severity and complexity, improvement in the mentor–mentee/client matching process, provision of a universal peer connect service with home visit element for isolated individuals and improved training for peer supporters. The effectiveness of the DONUTS co-production group was enhanced as all involved grew more experienced and confident with co-production methods. This included responding to service challenges reported through outcome data, recovery questionnaires and case studies, through which collectively solutions were found.

An unintended “soft” outcome from the DONUTS group was the creation of a community of people with lived experience of mental health difficulties positively engaging in the peer support service which resulted in increased satisfaction and improved confidence. This is linked to a wider outcome of the service which pertains to the general journey of clients with lived experience, from that of being supported by the service to becoming people who contributed to the success of the service (either by attending DONUT meetings or by becoming volunteer or paid/professional peer supporters themselves).

Some of the challenges encountered in the development and implementation of the service included: clients presenting with a wider range of issues than that which was represented in the service’s peer support workforce and peer supporters having differing levels of training and experience prior to coming to the service, which may have resulted in an inconsistent client offer. The latter however is to be expected as lived experience is not a homogenous concept and peer support services are not manualised.

Furthermore, it is also worth noting that the value and credibility of the peer support service was not initially shared by wider stakeholders, therefore significant work had to be undertaken to socialise and educate clinicians and services managers in this regard.

Finally, Table 11 details other learning derived from the delivery of the service.

Limitations to the study

The study had several limitations. Firstly, different outcome measures were deployed at different times which impacted on sample size and limited the number of pre-post

outcomes available for analysis. In addition, part way through service delivery, there was a change of use of outcome measure from the long WEMWBS to the shortened version. In addition, results were combined to gain a sufficient sample size with outcomes reported for aggregated elements of the peer support service as opposed to on an individual service component basis. To support client experience, measures were not taken on a sessional basis, therefore the number of paired outcomes was not maximised. The study's conclusions therefore must be viewed through a broad lens.

Implications of the findings

The implications of this study are that peer support services should be publicly funded and commissioned as part of mainstream primary care mental health services, in addition to stand-alone, bespoke services.

Next steps

The elevated profile of peer support services, arising from, but not limited to, the Competence Framework for Mental Health Peer Support Workers (HEE, 2020) is welcomed, however a requirement exists for the standardisation of peer support service outcome measures and collection frequency, both of which would aid implementation of services, scaling up and more detailed evaluation. It is therefore recommended that future evaluations compare the effectiveness of different peer support intervention models as well as benchmarking service quality.

References

Bellamy, C., Schmutte, T. and Davidson, L. (2017), "An update on the growing evidence base for peer support", *Mental Health and Social Inclusion*, Vol. 21 No. 3, pp. 161-167, doi: 10.1108/MHSI-03-2017-0014.

Cabral, L., Strother, H., Muhr, K., Sefton, L. and Savageau, J. (2014), "Clarifying the role of the mental health peer specialist in Massachusetts, USA: insights from peer specialists, supervisors and clients", *Health and Social Care in the Community*, Vol. 2 No. 1, pp. 104-112.

Dennis, C.L. (2003), "Peer support within a health care context: a concept analysis", *International Journal of Nursing Studies*, Vol. 40 No. 3, pp. 321-332.

Faulkner, A. and Basset, T. (2012), "A long and honourable history", *The Journal of Mental Health Training, Education and Practice*, Vol. 7 No. 2, pp. 53-59, doi: 10.1108/17556221211236448.

Gillard, S.G., Edwards, C., Gibson, S.L., Owen, K. and Wright, C. (2013), "Introducing peer worker roles into UK mental health service teams: a qualitative analysis of the organisational benefits and challenges", *BMC Health Services Research*, Vol. 13 No. 1, pp. 1-13.

Health Education England (2020), "The competence framework for mental health peer support workers", available at: www.hee.nhs.uk/

Health Education England (2017), *Stepping Forward to 2020/21: The Mental Health Workforce Plan for England*, Health Education England.

Mahlke, C.I., Priebe, S., Heumann, K., Daubmann, A., Wegscheider, K. and Bock, T. (2017), "Effectiveness of one-to-one peer support for patients with severe mental illness–a randomised controlled trial", *European Psychiatry*, Vol. 42, pp. 103-110.

Mutschler, C., Bellamy, C., Davidson, L., Lichtenstein, S. and Kidd, S. (2021), "Implementation of peer support in mental health services: a systematic review of the literature", *Psychological Services*, Vol. 19 No. 2, doi: 10.1037/ser0000531.

National Collaborating Centre for Mental Health (2021), Improving Access to Psychological Therapies Manual, available at: www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual-v5.pdf

Ng Fat, L., Scholes, S., Boniface, S., Mindell, J. and Stewart-Brown, S. (2017), "Evaluating and establishing national norms for mental wellbeing using the short Warwick–Edinburgh mental well-being

scale (SWEMWBS): findings from the health survey for England", *Quality of Life Research*, Vol. 26 No. 5, pp. 1129-1144., doi: 10.1007/s11136-016-1454-8.

NHS England (2019), *NHS Mental Health Implementation Plan 2019/20–2023/24*, NHS England, London.

Nissling, L., Fahlke, C., Lilja, J.L., Skoglund, I. and Weineland, S. (2020), "Primary care peer-supported internet-mediated psychological treatment for adults with anxiety disorders: mixed methods study", *JMIR Formative Research*, Vol. 4 No. 8, p. e19226.

ONS (Office for National Statistics) (2016), available at: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/adhocs/008781populationdenominatorsbybroadethnicgroupandforwhitebritishlocalauthoritiesinenglandandwales2011to2017

Rogers, E.S., Teague, G.B., Lichenstein, C., Campbell, J., Lyass, A., Chen, R. and Banks, S. (2007), "Effects of participation in consumer-operated service programs on both personal and organizationally mediated empowerment: results of multisite study", *Population*, Vol. 11, p. 12.

Solomon, P. (2004), "Peer support/peer provided services underlying processes, benefits, and critical ingredients", *Psychiatric Rehabilitation Journal*, Vol. 27 No. 4, p. 392.

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., Parkinson, J., Secker, J. and Stewart-Brown, S. (2007), "The Warwick-Edinburgh mental well-being scale (WEMWBS): development and UK validation", *Health and Quality of Life Outcomes*, Vol. 5 No. 1, p. 63.

Tse, S., Tsoi, E.W.S., Wong, S., Kan, A. and Kwok, C.F.Y. (2014), "Training of mental health peer support workers in a non-Western high-income city: preliminary evaluation and experience", *International Journal of Social Psychiatry*, Vol. 60 No. 3, pp. 211-218.

WEMWBS (2008), available at: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.

White, S., Foster, R., Marks, J., Morshead, R., Goldsmith, L., Barlow, S., Sin, J. and Gillard, S. (2020), "The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis", *BMC Psychiatry*, Vol. 20 No. 1, p. 534, doi: 10.1186/s12888-020-02923-3.

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