

# What supports the emotional well-being of peer workers in an NHS mental health service?

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## Abstract

**Purpose** – This study aims to explore the experiences of peers working in a range of roles within a single NHS mental health service. This study also aims to provide evidence of the impact of existing support, organisational structure and culture around peer working and provide recommendations for a Good Practice Guide for Peer Working. Peer roles require lived experience of mental health conditions and/or services. While the impact on them of using their own lived experience is not fully understood, anecdotal evidence suggests that peer workers may experience a greater emotional impact than other mental health workers. Burnout and retention are particular concerns.

**Design/methodology/approach** – This was a two-stage study using focus groups and reflexive thematic analysis in Stage 1. The key themes formed the basis of the Stage 2 workshop, which provided recommendations for a Good Practice Guide. The study team consisted of peer researchers with lived experience, supported by a Lived Experience Advisory Panel.

**Findings** – There is a perceived lack of support and an increased peer burden for peer workers. Recommendations included relevant ongoing training and development; support and supervision; and organisational cultural change.

**Originality/value** – Working within a peer-led co-production framework, this study contributes to the development of the evidence base for peer emotional labour. Based on the findings, a Good Practice Guide for Peer Working is being developed to promote good practice for the development of future peer worker roles.

**Keywords** Mental health, Emotional labour, Well-being, Peer workers

**Paper type** Research paper

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## Background

Peer worker roles within mental health services all share a requirement for lived experience of mental health conditions and/or services (own or as a carer) – as opposed to roles where the individual may have lived experience but it is not required. Not all peer roles have a peer in their job title, and peer worker participants in this study included peer support workers, peer trainers, experts-by-experience, patient and public involvement (PPI) advisors and peer leads.

As an NHS provider of mental health services, [Sussex Partnership NHS Foundation Trust \(SPFT\) \(2023\)](#) employs over 70 peer support workers and 25 peer trainers (Recovery College). SPFT also engages with experts-by-experience to *help shape the design, development, delivery and evaluation of [its] services* via its participation team (SPFT, 2023), and over 100 PPI advisors and over 100 youth PPI advisors via its Research and Development department.

Health-care workers report higher rates of absence because of workplace burnout than workers in other sectors (Cohen *et al.*, 2023), and anecdotal evidence suggests that peer workers may experience an increased emotional impact from their job because of “the emotional work of using and embodying lived experience, and aspects of the working environment” (Faulkner and Thompson, 2023). However, the impact on peer workers of using their own lived experience in the work is not fully understood (Gillard *et al.*, 2022; Watson, 2017; Mancini and Lawson, 2009).

Emotions are unavoidable during the interactions between service-sector workers and service users (or colleagues). Hochschild first used the term “Emotional labo[u]r” to describe the impact of managing emotions resulting from interactions in the workplace (Hochschild, 1983). Previous studies have explored the emotional labour of specific groups of peers across different organisations: mental health research (Faulkner and Thompson, 2023); a literature review of the mechanisms underpinning peer support (Watson, 2017); experts by experience (Lewis, 2012); and US peer providers (Mancini and Lawson, 2009).

Focusing on involvement and co-production in mental health research, Faulkner and Thompson (2023) identified a number of key areas: negotiation of and impact on identity and the multiplicity of roles and intersectional complexities of identity (cf. Robertson *et al.*, 2019 and Robertson *et al.*, 2017); alienation experience of peers who bring their lived experience into unprepared workplaces; and structural factors that mitigate against successful integration. Watson (2017) also identified that peer support workers inhabit a liminal space between the service user and the providers of the service, with a resultant tension between the two identities.

## Purpose

The peer emotional labour (PEL) study sought to explore the experiences of the different groups of peer workers (and non-peer managers/supervisors of peers) in an NHS mental health service delivered by SPFT. PEL aimed to provide evidence of the impact of existing support, organisational structure and culture around peer working. Based on the findings, a Good Practice Guide for Peer Working is being developed to promote good practice for the development of future peer worker roles.

## Design and methodological approach

PEL was a two-stage study:

*Stage 1* used five focus groups to capture peer workers’ and non-peer managers/supervisors’ experiences of working in an NHS mental health service.

The five peer groups identified for the study were:

1. Peer support workers – support service users/carers within multi-disciplinary teams.
2. Peer trainers – psycho-educational and well-being courses (e.g. Recovery College).
3. Experts by experience (EBE) (service provision) and PPI members.
4. Peer leads – managerial and supervisory roles.
5. Non-peer managers/supervisors of peers – included because they influence the work, structure and culture of the peer worker’s working environment.

Reflexive thematic analysis was used to determine key themes (Braun and Clarke, 2019). Reflexivity allowed theme development and analysis to be contextualised (i.e. what did the theme actually mean to the individual?).

The key themes formed the basis of the *Stage 2* workshop topics. The workshop enabled the co-researchers to present the emergent themes and then work with the workshop

participants to determine key recommendations, which then informed the Good Practice Guide for Peer Working in SPFT.

HRA ethics approval [313635] was granted for this research, and written consent was obtained from participants for their data to be used in the study.

## Patient and public involvement

PPI was at the heart of PEL:

- Extensive PPI consultation, which helped shape the study design and methodology.
- The PEL Lived Experience Advisory Panel (LEAP) provided support, evaluation and governance throughout.

The study team co-facilitated a “Thinking about peer research” meeting (Approaches in Recovery (AIR) theme group members, peer leads, peer workers), where the need to capture the experiences of SPFT peer workers was recognised. Further consultations took place in various SPFT forums (e.g. the 2020 AIR Theme Conference, Positive Experience Committee, Participation Leads Group, PPI Café and the Lived Experience Advisory Forum [LEAF]) and with external stakeholders such as the McPin Foundation and Applied Research Collaboration Kent Surrey Sussex (ARC KSS).

Results of these discussions included:

- Acknowledging that many people have lived experience, but peer workers are asked to draw upon their lived experience appropriately to support their work.
- Focusing on peer groups in SPFT, but could be expanded in the future to peer workers elsewhere in our region and beyond and in third-sector organisations.
- Including managers and supervisors of peer workers, as they impact the work environment and therefore have an important contribution to make.
- Methodology – focus groups are more dynamic than interviews. To facilitate focus groups for each peer group (potential for more honesty and to explore the commonalities and differences between groups).
- Meaningful output co-produced in an active manner (workshop event). We wanted to ensure that the results contributed directly to how peer workers are supported to provide “the support, promotion and development of the peer workforce, including ensuring that there are development pathways and leadership progression in place” ([Holland, 2021](#)).

## Recruitment

The PEL study team received consent for 37 participants to take part in the focus groups, with a total of 28 participants attending the five focus groups. It was a difficult process to translate the consent into participation in the focus group because of participant availability, etc. This meant that, apart from the non-peer managers focus group, the other focus groups were more mixed than previously intended. The topic guide was emailed to people who could not attend a focus group. All email contributions received were also added to the data set.

There were 17 participants at the online workshop (March 2023) – four of whom had not taken part in Stage 1 (including two study stakeholders).

Given that some participants and/or LEAP members could be considered as “vulnerable adults” ([Lathlean et al., 2006](#)), there were important and sensitive ethical considerations. These include recruitment (using gatekeepers); working with co-researchers and LEAP

members (using a LEAP co-ordinator) to ensure safeguarding, non-coercion and appropriate support (SPFT, EBE and PPI policies) throughout all aspects of the study.

A study flyer was developed to recruit participants to the focus groups. Focus group recruitment was through gatekeepers (i.e. peer lead, people participation lead and AIR theme co-ordinator) who had access to the people identified in these groups. There were additional recruitment routes (particularly aimed at non-peer managers and supervisors) using the SPFT intranet, research network, Twitter, the PPI café and the PPI youth café (Thomson *et al.*, 2022).

### ***Stage 1: focus groups***

Various parameters were determined for co-facilitating the focus groups, including up to a maximum of 8–10 participants; on Zoom; ran for 90 min (including a check-in and check-out); were recorded and transcribed *verbatim* by an external transcribing service; and were conducted in worktime (so that participants were paid or got time off in lieu). The study paid for PPI and EBE people's time. Others' time was covered by SPFT salary.

The plan was to co-facilitate five distinct focus groups for each identified peer/non-peer group. We thought that this would allow for a freer discussion. The final focus group ended up being “mop up” for those unable to attend their “designated” specific focus group. Given the study time constraints, apart from the non-peer group, in practice, it was impossible to be dogmatic about who was in each focus group – being able to consent, attend and contribute was more important than holding strict boundaries around membership.

Co-facilitation from an “insider” perspective was a fundamental part of PEL. Each group was co-facilitated by two co-researchers who work in peer roles in SPFT, with one co-researcher leading and the other monitoring well-being and the zoom chat room. SR co-facilitated all focus groups (plus either HL-P or AT) apart from the peer leads focus group. As this focus group had participants who SR line managed, it was appropriate that SR did not take part in this focus group and so HL-P and AT co-facilitated this one.

The focus group topic guide was developed as part of the co-production process with the LEAP. It included the following topic areas (and was adapted for non-peer managers/supervisors) (Box 1):

<b>Box 1</b>
What does the peer understand by the term's “peer” and “peer work”?
What does emotional labour mean?
In what ways does being a peer/peer work support your well-being?
... Challenge your well-being?
In what ways do you feel supported at work by SPFT?
... Not supported at work by SPFT?
What do SPFT and other employers need to consider when employing and working with peers?

Note: Emotional labour was introduced to participants at the start of the focus groups as a concept that could be helpful when describing the emotional impact of their roles, but participants were not directed to use it whilst discussing their experiences.

The LEAP group suggested that contributing in a focus group setting would not suit everybody, so we needed to think about other ways that people could contribute. After each focus group, the co-facilitators stayed on line for 30 min. This allowed participants to talk to us privately. This facility was used in all focus groups, apart from the non-peer one. These conversations were added to the data collected. We made it clear that participants could contribute via email instead of or in addition to attending a focus group.

### *Stage 2 workshop to develop a good practice guide*

After the co-researchers presented the emergent themes to the workshop participants, the participants were randomly allocated to three break-out rooms for the discussion. Each group had two co-facilitators – one who facilitated the group and the other to monitor the chat-box and scribe. SR did not join a single break-out room but was available to look after anyone who might have become distressed by the discussion. This precaution was not needed.

Each group discussed each question and determined their practical recommendations. Roughly 45 min were allocated to this activity. Each group's recommendations were then fed back to the whole workshop by one of the group's co-facilitators to determine workshop consensus.

On reviewing the emergent themes from Stage 1, the study team and LEAP decided to direct the workshop discussions towards considering training needs, support (reduced isolation) needs and organisational change (Box 2):

#### Box 2

Discuss and determine practical recommendations for:

What training/development opportunities would help peers and all other staff?

What was needed to support initial "team readiness" and ongoing support for peer workers and their teams?

What organisational change was needed?

## Findings

Braun and Clarke's (2006 and 2019) reflexive thematic analysis process was used to make sense of the data. The key themes were determined by the study team and the LEAP by grouping sub-themes together to form and name each key theme. Figure 1 shows the key themes that emerged from the thematic analysis of the focus groups.

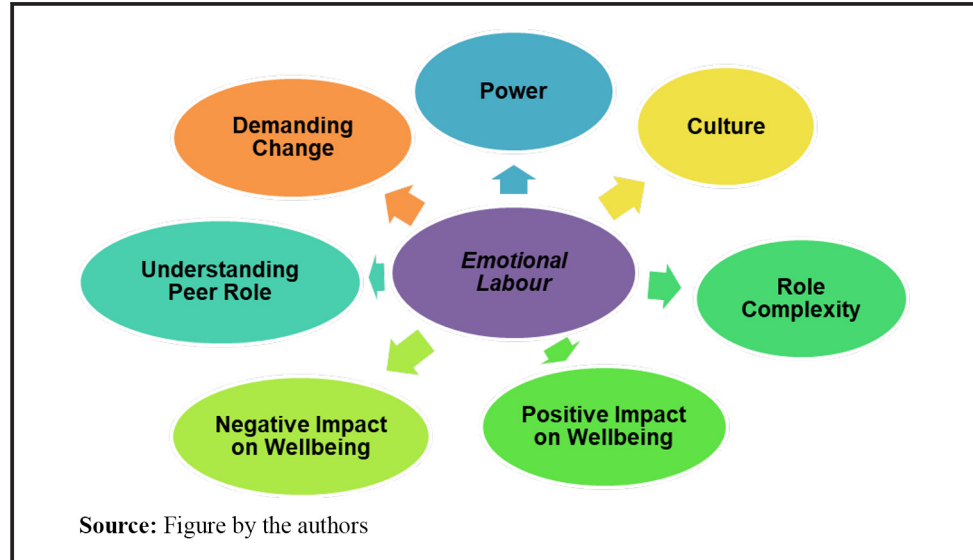
In terms of the themes with negative impact, the team identified that some of the factors raised had the potential to impact all workers, not just peer workers. Of those factors that impact all, factors that disproportionately impacted peer workers were identified and grouped as being because of lived experience, the newness of peer roles or a combination of both. Figure 2 shows this schematically and Table 1 summarises the themes with a negative impact on peer workers.

The emergent data from the focus groups suggested that the key considerations for the Good Practice Guide were: resistance to change; support and supervision given to peer workers; team readiness; and training for both peer workers and non-peers. These formed the basis of the workshop topics.

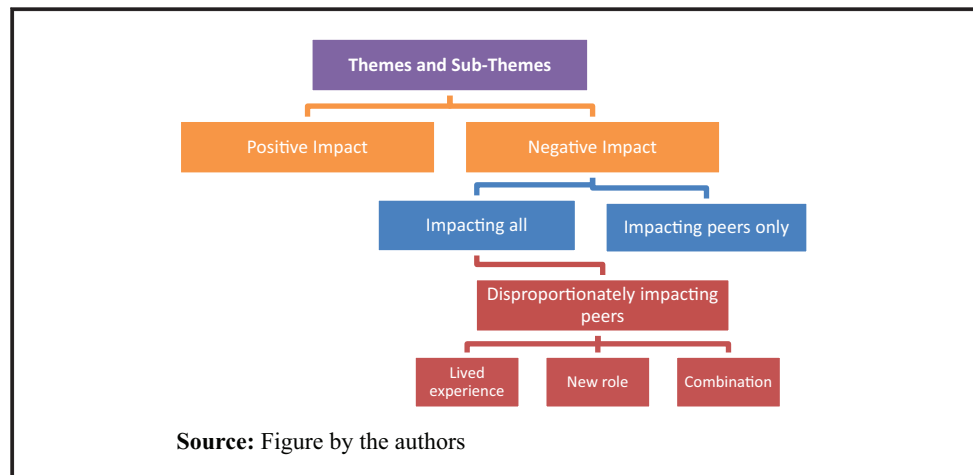
Some example comments are included below for illustrative purposes.

Others' understanding of peer roles:

**Figure 1** Key themes



**Figure 2** Themes and impact on peer workers



You have to understand what peer support work is, take your time to do that. You also have to consider how they are going to fit in your team. They're not just going to slot in, it is a different role and they are going to need different considerations for somebody with lived experience.

Being "othered":

And people are just getting about their work and then it's almost like there's a sense sometimes that we're seen as the annoying PPI people because people go to a meeting and they're like, oh my God, this is brilliant, oh what a good idea, oh isn't this lovely. And then there's one of us sitting there going, oh, actually, we don't.

Negative feelings around treatment in job:

[...] my employment experience was not valued at all, and I feel I have been actively discriminated against, bullied and harassed as a result of my own lived experience, despite lived experience being listed an essential criterion for the role.

**Table 1** Themes: negative impact of peer working

<i>Impacting all (peers/non-peers)</i>	<i>Impacting peers only</i>	<i>Disproportionately impacting peers because of lived experience</i>	<i>Disproportionately impacting peers because of a newish role</i>	<i>Disproportionately impacting peers combination of both</i>
<ul style="list-style-type: none"> <li>• Power imbalance</li> <li>• Banding hierarchy – how hierarchical the NHS is</li> <li>• Job role – tensions created by job role</li> <li>• Working with others – how colleagues often don't understand lived experience (LE) at all</li> <li>• Negative feelings around treatment in the job – feeling unvalued and discriminated against</li> </ul>	<ul style="list-style-type: none"> <li>• Medical model as dominant narrative – peers unique in not coming from this angle</li> <li>• Embodying recovery model – feel a lot of pressure to be models of wellness and recovery</li> <li>• Bridging gap – difficulty at times of being seen as having a foot in both staff and service user camps</li> <li>• Informal peer work – a lot of intensive, informal &amp; unnoticed peer work</li> <li>• Being “othered” – seen as annoying/irritating when you have to challenge the status quo</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of understanding – tendency to blame peer's mental health when things go wrong</li> <li>• Triggers – work can be really triggering</li> <li>• Environment – can also be triggering, especially if you have had bad previous experiences there</li> <li>• Toxic positivity – constantly being expected to project wellness and happiness is exhausting</li> <li>• Stigmatising language – other staff sometimes use very stigmatising language to talk about patients like us</li> <li>• Representation and advocacy – having to advocate for others in a powerful system can be exhausting and frightening</li> <li>• Tokenism – leaves peer's feeling not listened to and not valued</li> <li>• Connections and relationships – peer work can undermine relationships if seen as representing an organisation that has caused harm to other peers</li> </ul>	<ul style="list-style-type: none"> <li>• Place in organisation – peers can feel like (and be treated as if) they don't really sit within a team</li> <li>• Definition of a peer role – confusion over definition, but we see as people asked to use our lived experience as part of our work</li> <li>• Other's understanding of our role – lots of confusion, especially in teams, over what peer work is and how the work should be done</li> <li>• Structural issues – peer roles, which need to be, by definition, flexible, don't fit easily into the rigid structure of the NHS</li> <li>• Managing peers – requires compassion, understanding and knowledge of lived experience</li> <li>• Responsibility – weight of responsibility of managing your own LE when, as a peer worker, you are working yourself with someone with lived experience</li> <li>• Accessibility of support – not having anywhere to take the difficulties and pain that have arisen during the working day when relating to other people's LE</li> </ul>	<ul style="list-style-type: none"> <li>• Organisational culture – sometimes it feels as though other staff think peers are deliberately putting obstacles in their way because they are in a very different headspace about the work</li> <li>• Need to challenge – really tension between having to challenge the status quo but also knowing that challenging could affect my job and make my life a lot harder</li> <li>• Policing the system – people who organise peer work are responsible for dealing with problems with it; peers have nowhere else to go with complaints or issues</li> <li>• Imposter syndrome – tend to have negative beliefs about self as they are, and so many challenges within the system tend to feed those</li> <li>• Unrealistic goals – need to temper unrealistic goals and understand that we are not going to revolutionise system</li> <li>• Barriers and obstacles – lived experience is still not being taken seriously enough, marginalised</li> <li>• Boundaries, risk and safeguarding – peers don't have clear boundaries like other workers and are being asked to bring our LE, so it is not clear where we set those boundaries</li> </ul>

Source: Table by the authors



Embodying recovery model:

We're meant to be further along our recovery journey and models of wellness at times.

I felt there was a lot of pressure for me to appear emotionally incredibly well compared to other colleagues.

Toxic positivity:

I am having a tough time but need to be careful not to project that I'm not coping with my role to my colleagues, especially my manager and supervisor so early on in the role.

Workshop discussion and recommendations are shown in [Table 2](#).

## Discussion

The PEL study was not aimed at investigating the validity of peer work or the role it plays in a peer's recovery journey. This is the reason why many of us with lived experience do peer work ([Robertson et al., 2019, 2017](#); [Leamy et al., 2011](#); [Bird et al., 2014](#); and [Slade, 2009](#)). However, within peer work spaces (e.g. including peer supervision, peer well-being, peer-to-peer support and PEL focus groups), the positive aspects of peer work are often taken for granted, and discussions concentrate on practical issues that are more relevant to the functional role and its impact on a peer's emotional labour.

There was a sense of 'the luck of the draw' as to whether a peer worker was in a supportive team or not, largely dependent on the commitment of their team leader to support peer workers and prepared to go the extra mile to do this. There was also an underlying concern regarding the perceived lack of freedom to speak up because the process was not independent – the system policing itself. Peers being "othered" was also an underlying concern. Some of the negative burden of peer work could be attributed to the fact that the fundamental principles of peer work (e.g. mutuality and reciprocity) require flexibility; however, the systems and culture that peer workers have to work in are often rigid and slow to change.

As the purpose of PEL was to develop a Good Practice Guide based on the themes and key recommendations arising from focus group discussion around the emotional labour of peer workers, an inductive approach to thematic development and analysis was required. Themes were generated from the data, rather than using the data to fit a pre-existing range of themes (to match a theory). While exploring the consensus of emotional labour experience, it was equally valid to analyse any contradictions and idiosyncrasies that arose. Reflexivity was also needed to assess additional aspects emerging from the focus group process, such as the language used, silences and any difficulties within the focus groups and group dynamics. These were not captured by thematic analysis, but they added to the richness of the data and subsequent analysis. Reflexivity allowed theme development and analysis to be contextualised (i.e. what does the theme actually mean to the individual?).

In addition, because context and other factors such as mental health (stigma, identity and resilience); societal and organisational structures and culture; and focus group process dynamics were likely to be relevant to the analysis, it was important that the themes generated were reflexive too ([Braun and Clarke, 2006](#), p. 82, 2019). Reflexivity allowed theme development and analysis to be contextualised (i.e. setting the themes in the context of the peer worker role and world).

With co-production at the heart of this study, PEL was richer, felt more empowering and was more likely to contribute to change. Already, SPFT peers are reporting that they now have a common language and understanding, which helps them describe their emotional labour in peer supervision. Co-production also requires more time and resources for it to be meaningful and to be beyond tokenism. For co-production to be meaningful, the research



**Table 2** Practical recommendations that will inform the SPFT Good Practice Guide*Theme**Training/development*

What training/development opportunities would help peers and all other staff?  
Mandatory training needs to be for all staff, not just peers (as is current practice)

For non-peer staff:

- Staff training should include:
  - the different peer roles
  - integration into team – what peer support workers can and can't do (not expected to carry clinical loads).
  - how to support people in the peer role
  - the challenges involved in bringing lived experience to peer roles (power imbalance, how we fit in a biomedical role, how people are labelled, inclusion/exclusion based on diagnosis and how this can make people feel discriminated against)
- Training should incorporate trauma-informed and recovery-oriented approaches
- Training should be co-produced/delivered by peers
- Elements of training should be included in staff induction training so all new staff are aware of peer roles
- Ongoing training should be mandatory because all staff need training on all the different peer roles to raise awareness and increase knowledge. High staff turnover means peers are constantly having to explain their role to new staff

For peers:

- Peer training on:
  - managing triggers
  - peer emotional labour
  - what it's like being parachuted into a busy team and how to manage this
  - support with navigating peer roles
- Training needs to be longer than currently offered and consistent across the roles, with written guides to what the roles entail  
Training needs to be both before the role AND ongoing
- Training should be provided to peers to allow for progression with more supportive and development training as the role grows to cater to more experienced peer workers
- Peers should be trained by peers
- The peer training policy should be transparent so that all peers know what training they are entitled to and how to access it

*Support*

What was needed to support initial 'team readiness' and on-going support for peer workers and their teams?

- Creation of peer support development strategy
- Clinical supervision should be implemented for peers. There is a huge investment of emotional labour in bringing lived experience to work every day, but there is no clinical supervision for the role, and this gap has been identified as a major one in this research
- Reflective practice groups for all peers should be implemented as a commitment to shaping the service and principles of lived experience in the trust. Peer workers need space to talk about the problems created by this work
- Where practicable, peers should work in pairs and/or be offered peer mentors and/or buddies in their workplace (especially when part-time/casual working) to reduce isolation/separation
- Managers supervising peers should be encouraged to see recovery as a process, not an outcome and understand that a peer worker can still be effective while managing health fluctuations
- Replacement for peer workers should be prioritised when absent from the role rather than remaining vacant
- Reflective practice to be demonstrated in a newsletter in a similar way to "Safety Matters" for whole trust reflection and good practice?

*Organisational change*

What organisational change was needed?

- Peer work (such as clinical handover meetings)
- Establishment of an independent equivalent of the speak-up guardian for peer work – offering independent mediation/intervention for peers
- Development of a process that provides some mediation/communication/resolution process for peers with managers/leaders when decisions are made that have a significant effect/are in conflict with peer work
- Regular reviews in teams on what peer workers do as there is a general lack of understanding (links up with training)
- More organisational buy-in on peer roles to share information and increase awareness of peer support. More promotion across the Trust of peer roles and how they can enhance the service

(continued)

**Table 2***Theme*

- Creation of a peer accreditation team with a remit to ensure people with lived experience are embedded in the organisation. Knowledge of roles and responsibilities, quality of experience
- Recommend peers work in pairs. It relieves one person of the burden of solo working and helps give scope for flexibility. Organisational benefits of reducing cancellations of sessions because of sickness. Expansion model: take on 1.5 people for every FTE to provide capacity. This cares better for people and ensures management flexibility on staffing. Helps with the smooth running of meetings. Prevents overload of staff members.
- Widen the peer support network to include other peer roles, including R&D. Include all peer workers in reflective practice opportunities already granted to EBE members. Reflective practice groups run by independent practitioners.
- Debrief for all

Source: Table by the authors

team also needs to be receptive to challenges. Co-production meant greater emotional labour for the research team, especially SR.

As part of the study design and co-production process, SR ensured that the study team and the peer participants had support available. In all participant information at meetings and at the start of each focus group and workshop meeting, SR explained that she was there in her role as the chief researcher and not in her PPI lead role, and being clear of the boundaries was important. There were a number of occasions where this was ignored and SR was asked to deal with something that had been discussed in the focus groups, as PPI lead. SR did not include herself in this support mechanism, and the reality was that SR needed peer supervision, which was external to the study team and organisation. This was rectified by going back to the funder and asking to divert some funds for this external supervision. In all future PEL studies, this will be written into the grant application.

## Conclusions

Peer working and its emotional labour are nuanced, and “one-size-fits-all” systems and processes are not always helpful to individuals, particularly if they have lived experience of mental health difficulties. The emergent data also suggested that there is a perceived lack of support and an increased peer burden for peer workers. Translating these recommendations into practice will require time and commitment.

This PEL study provides evidence that relevant on-going training and development support and supervision and organisational cultural change are fundamental requirements for peer working and positive PEL. This in turn supports the recruitment and retention of peer workers and contributes to less absences and sicknesses. Given the mutuality and reciprocity nature of peer work, this should have a beneficial impact on the peers that peer workers are supporting.

## Limitations of study

This study is limited to one NHS mental health service, which may not be typical of other services.

Many peer workers have multiple roles (e.g. PPI advisor and peer support worker). We were also aware that there are other peer worker roles that were not captured as specific peer roles (e.g. Trust Public Governors, volunteer peer workers and learning-disabled peer workers). Some of the issues that peer workers face in these excluded groups were raised in the focus groups because many people had multiple roles.

Because the focus groups were more mixed in terms of different types of peer roles, it was not possible to isolate differences in the experiences of different peer worker groups.

## Next steps

The study team is working with SPFT's central peer leads to develop the Good Practice Guide based on the recommendations of the workshop.

As well as informing the Good Practice Guide for Peer Working, this study will act as a feasibility study for the next stage of PEL research: PEL2. In PEL2, we plan to work with three additional NHS sites; specifically concentrate on peer support workers; and explore in more detail the mechanisms that contribute to PEL.

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### Further reading

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