Does Peer Support Enhance Recovery Outcomes: A Rapid Realist Review Informed Design

by

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Committee Approval

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Abstract

My research question was "How, why, for whom, in what contexts and to what extent does peer support contribute (if at all) to recovery outcomes for people with first episode psychosis?" People who have experienced first episode psychosis show benefits from having a mental health peer support worker in clinical programs. A finding is that the peer support role impacts the client, the team including the peer support worker, and the organization. Peer support is shown to be a benefit over cost in administrative costs, likely in recovery outcomes for the client and positive impacts on decreasing stigma in the workplace and clinical settings. More research is needed to explore mental health peer support relationship at a client to peer support level although there appears to be benefit from the early evidence.

Keywords: First Episode Psychosis, Peer Support, Mental Health, Recovery, System Transformation, Realist
Chapter 1. Introduction

1.1 Background

I have over 20 years of experience working in the mental health field and have a specific interest in the area of peer support and those with psychosis. My areas of study were interdisciplinary and included psychology, business and leadership.

At present, I am the Executive Director of the British Columbia Schizophrenia Society, Victoria Branch (BCSS Victoria). BCSS Victoria is a charitable non-profit society which provides counselling, public education, peer support, self-management workshops and consultation. That work experience is complimented by my past involvement with several projects for the Mental Health Commission of Canada. Further, for the last five years, I served on the board of Psycho-social Rehabilitation/Readaptation Psycho-sociale Canada (PSR/RPS Canada) with the endorsed psycho-social principles. Finally, I am a champion for recovery-oriented practice and also for involvement and leadership in mental health programs from people with lived experience (PWLE) of their own mental health issue.

Recovery-oriented practice is a paradigm. It promotes an overall view of becoming more well in spite of a mental illness than does the traditional bio-medical focus. Recovery uses a biopsychosocial frame of reference. Recovery does not necessarily mean cure. Recovery may be known as a process or outcome. As a process, it may represent the outlook of living well despite a mental illness. Conversely, as an outcome, recovery may speak to specified end goals such as symptom abatement.

There are various terms for the PWLE who receives mental health services including peer, consumer, client, patient and service user. A PWLE need not only be a recipient of service
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but a provider. This is not to say a PWLE should be limited to peer support roles. Indeed, if a PWLE chooses to support others, in a range of ways, it may be an option.

Research shows that Peer Support has many different definitions. But according to the Mental Health Commission of Canada (MHCC) *Making the Case Peer Support* (2010) report, peer support is broadly described as “support provided by peers, for peers, or any organized support provided by and for people with mental health problems.” The literature review in the MHCC report (2010) provides an overview of varied definitions, frameworks of peer support structures and processes, effectiveness and outcomes of peer support, values, involvement of marginalized and minority consumers/survivors, in peer support, and areas for future research. Peer support is gaining momentum in research literature although comprehensive reviews remain limited. The MHCC report (2010) stated that peer support remains a valued resource for recovery, for many people, who experience mental illness and distress, researchers and advocates alike support ongoing research and evaluation (Centre for Research and Education in Human Services, 2004; Hardiman et al, 2005).

Peer support is considered a complex intervention. As such, it is ideally reviewed with an approach called a realist review. My personal experience with this includes an examination of peer support as an intervention with exploration of its application in a narrowed scope of population known as First Episode Psychosis (FEP) which I define in a later section. Evidence demonstrates that early intervention in youth and young adults experiencing FEP promotes improved clinical and functional outcomes. (Craig et al., 2008). Peer support is used as an intervention broadly in mental health and, as a more recent development, with the FEP population.
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1.2 The Research Question

"How, why, for whom, in what contexts and to what extent does peer support contribute (if at all) to recovery outcomes for people with first episode psychosis?"

1.3 Justification of Review

Why is it important to identify peer support strategies for youth and young adults?

While peer support research is an emerging area in Canada (and a few leading innovator countries) there is building evidence that peer support provides hope to people with mental health problems as evidenced in the report *Making the Case for Peer Support* (MHCC, 2010). Hopefulness is considered an ingredient towards greater personal wellness and advancing the recovery process and outcomes. The MHCC outlines varied approaches to peer support that span from informal peer support (usually naturally occurring) to a clinical/conventional mental health system based peer support (MHCC, 2014).

Emerging literature outlines benefits for peer support but little exists for the actual implementation of peer support. Considerations for implementation include a perception of risk to institutional settings which most often rely on professional bodies (such as the College of Registered Nurses of British Columbia or the British Columbia College of Social Workers) to minimize professional risk. Peer Support Accreditation and Certification Canada (PSACC) has a standardizing body which includes certification for peer supporters. While a national guideline for practice and training of peer support has been developed, the training modules are being developed broadly throughout regions outside of PSACC.

My research provides an international update and recommendations for those interested in implementing peer support, including the local health authority of Island Health.
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In building on the Canadian perspective, I use key documents in guiding the approach including these Mental Health Commission of Canada (MHCC) key guiding documents: *Guidelines for the Practice and Training of Peer Support* (2014), *Guidelines for Recovery-Oriented Practice* (2015) and *Making the Case for Peer Support* (2010). This research also includes international perspectives in subject matter from leading countries such as the United Kingdom, New Zealand, United States and Australia.

1.4  What is First Episode Psychosis?

First episode psychosis (FEP) refers to the first time someone experiences symptoms of psychosis or a psychotic episode. Sometimes the person with a first episode may not understand what is happening to them. The symptoms can be very disturbing and unfamiliar to the person which may leave the person confused and distressed. Early psychosis speaks to the first psychotic episode and further isolates three distinct areas outlined for psychosis (Yale School of Medicine, 2017).

The three areas are termed the prodromal period, the acute and the recovery from the psychosis. In this instance, recovery is an outcome and not necessarily a process definition. I speak further to recovery as a process in my next section. The prodromal period is marked with symptoms that can be viewed with other symptoms such as depression and cognitive decline. The acute period occurs when a person has a break from reality as we would know it. They may experience seeing and hearing things others do not. They may also believe things to be true, that are not, called delusions (Yale School of Medicine, 2017).

It is important to note that 3% of the population experiences a psychotic episode in their lifetime according to the British Columbia Early Psychosis Intervention Program (2017).
For the purpose of this paper, I chose a western world view that comes from a bio-psychosocial perspective. This means exploring FEP as a distressing and treatable mental health issue from which recovery is expected. A bio-psychosocial view also notes that treatment and recovery should be a holistic approach (and include biological, psychological and social processes) and not simply a reductionist approach where it is simply a biological issue for which medication is the only tool used for treatment. Medication may be needed but there are many psychosocial approaches that assist a person seeking recovery.

Who experiences FEP? According to Yale Medicine, Males between 14 and 25 years of age and females between the ages of 25 and 35 are most prevalent for FEP. As well, some individuals will experience one FEP and may not go on to develop a psychiatric diagnosis such as schizophrenia, schizoaffective or bipolar disorder. Finally, it was stated by Yale Medicine that early help can assist with prognosis (2017).

One accepted and leading model of reviewing vulnerability to psychosis is the stress-vulnerability model (Zubin, 1977; Agius et al, 2010). This model stresses that people experiencing psychosis get help early in their onset to improve recovery outcomes. This model may also be helpful in outlining other factors of stressors (such as trauma or substance use) as additional impacts on a person with underlying vulnerability to psychosis. Concurrent substance use adds complexity in assisting a person in their recovery as use of substances, notably cannabis, has been shown to contribute to symptoms of psychosis -specifically in the developing brain and for those with a family history of mental illness (Schizophrenia Society of Canada, 2011). The use of cannabis and its impact on psychosis is out of scope for this paper.
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As a person shows signs of psychosis they are often referred to an Early Psychosis Intervention program or FEP program where specialized treatment is provided to this young population. One treatment area present in some programs is formalized peer support which I explore in this paper.

1.5 Recovery

The term recovery has strong roots flowing from the lives of people with lived experience (PWLE). Some literature refers to the recovery movement as being founded in the substance use 12-step group model used by Alcoholics Anonymous and later embraced by the consumer/psychiatric survivor movement as greater levels of independence were sought. Other historical accounts trace recovery back to the 1700’s moral treatment era with the Abstinence of US native tribes and Pussin in the 1790’s (Sherman, 2017, p. 5).

Recovery is defined with two main definitional elements: outcome or process orientation. Outcome definitions are primarily seen in the clinician definitions and attempt to describe tangible outcomes such as symptom abatement or attainment of a specific functional goal (such as paid employment or no further need for a hospital stay). Early advocates from the consumer/psychiatric survivor (PWLE) definition seem to prefer process definition.

Outcome oriented definitions tend to ignore that recovery may be more of a lifestyle outlook of someone with a mental illness. One popular definition of recovery was coined by Dr. Anthony: “A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles ...recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness." (1993). Later, the Substance Abuse and Mental Health Services Administration (SAMHSA) defined recovery for both mental
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health and alcohol and substance abuse as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” (2012).

In the Canadian mental healthcare policy context, Canada was the last G8 country to develop a national mental health strategy. The strategy is named Changing Directions, Changing Lives (2012) and was formed by the Out of the Shadows at Last (2006) cross-Canada consultation report led by the Standing Senate Committee on Social Affairs, Science and Technology. The work led to major policy research and amplification of the recovery movement in mental health. The first of the recommendations of the Lost in the Shadows report (2012) was to develop a commission tasked to advance mental health care in Canada and thus, the Mental Health Commission of Canada (MHCC) was established. The MHCC worked to develop Canada’s first National Mental Health Strategy in 2012. Two strategic directions from that strategy and now aligned with this paper are that to:

1. advance the recovery and well-being for people with mental health problems and illnesses; and

2. include a full range of services, treatments and supports including peer support.

From that time, important research and policy guideline works have been created and will be quoted in this paper. Three major relevant works by the MHCC include the Making the Case for Peer Support (2010), Guidelines for the Practice and Training of Peer Support (2013) Guidelines for Recovery-Oriented Practice (2015).

From this exploration of recovery basics we move on now to locate peer support in the context of a recovery-oriented paradigm.
1.6 Peer support

Peer support grew out of early advocacy efforts and has many definitions which will be explored in detail in the literature review. For the purpose of a brief insight into peer support, one accepted definition is that by Sherry Mead which says “Relationships built and nurtured through shared experiences. People who have liked experiences can better relate and can consequently offer more empathy and validation” (Mead, 2003, p. 1). Another peer support definition provided by the Ontario Peer Support Initiative (OPDI) occurring in the complete form as requested by OPDI:

“Peer Support is a naturally occurring, mutually beneficial support process where people who share a common experience meet as equals, sharing skills, strengths, and hope; learning from each other how to cope, thrive and flourish. Formalized Peer Support begins when persons with lived experience, who have received specialized training assume unique, designated roles within the mental health system to support an individual’s expressed wishes. Specialized Peer Support training is peer developed, developed and endorsed by Consumer/Survivor Initiatives. Peer Support Organizations, and Patient Councils, and is rooted in principles of recovery, hope and individual empowerment.” (OPDI, 2016)

The table below, developed by MHCC (MHCC, 2013), illustrates, with great clarity, the gradients within peer support. This table provides not only seven distinct levels of peer support but also outlines examples of peer support work environments a peer support worker may
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include. Peer supporters may offer a range of services from an informal peer support level to greater levels of clinical care environments as demonstrated in Table 1.6.1.

Figure 1 MHCC Spectrum of Types of Peer Support (MHCC, 2013, p.16)

<table>
<thead>
<tr>
<th>INFORMAL PEER SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naturally occurring, voluntary, reciprocal relationship(s) with peers one-to-one or possibly in a community</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>CLUBHOUSE/WALK IN CENTRE</th>
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</thead>
<tbody>
<tr>
<td>Maintains psychosocial and social recreational focus with peer support naturally occurring among participants</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>SELF-HELP, MUTUAL PEER SUPPORT</th>
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<tbody>
<tr>
<td>Consumer operated/run organizations/activities/programs, voluntarily, naturally occurring reciprocal relationships with peers in community settings e.g. housing, social/recreational, arts/culture, traditional/spiritual healing, recovery/education/work, anti-discrimination/education/work, human rights/disability rights/education/work</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FORMALIZED/INTENTIONAL PEER SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer run peer support services within community settings (either group or one-to-one) focusing on issues such as education, employment, MH systems navigation, systemic/individual advocacy, housing, food security, internet, transportation, recovery education, anti-discrimination work, etc.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>WORKPLACE PEER SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace-based programs where employees with lived experience are selected and prepared to provide peer support to other employees within their workplace</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>COMMUNITY CLINICAL SETTING PEER SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer support workers are selected to provide support to patients/clients that utilize clinical services, e.g., Outpatient, A.C.T teams, Case Management, Counseling</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLINICAL/CONVENTIONAL MH SYSTEM-BASED PEER SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical setting, inpatient/outpatient, institutional peer support, multidisciplinary groups, recovery centres, or Rehabilitation Centres Crisis response, Crisis Management, Emergency Rooms, Acute Units</td>
</tr>
</tbody>
</table>

1.7 Mental health peer support in Canada

Mental health peer support in Canada evolved with the development of a national peer support certification body growing from the efforts of the MHCC. The Peer Support Accreditation and Certification Canada (PSACC) was established in 2011 and became a non-profit with its own aims and goals. An important national document was created by the MHCC named Making the Case for Peer Support (2013). From that document, a follow up document was created called The Guidelines for the Practice and Training of Peer Support (2013). Work
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS continues to grow across the country to develop training programs in regions to develop peer supporters to work within formal programs. This does not mitigate the fact that peer support is practiced in areas across Canada outside of formal training. I would note however, that published works such as *Making the Case for Peer Support* (2013) and *The Guidelines for the Practice and Training of Peer Support* (2015) have built a foundation from which training programs are developed. The PSACC body credentials peer support workers and provides a standardizing body to oversee peer support work as its own specialty.

### 1.8 Peer support is a complex intervention

Peer Support work is deemed a complex intervention as the “components tend not to act in a linear fashion, complex interventions are reliant on people carrying out the intervention and are highly dependent on the context in which they take place” (Greenhalgh 2009. p. 8). Traditional Cochrane studies are used to determine the effectiveness of linear approaches to treatment. For example, a Cochrane study would be used in medication trials where the answer sought is whether a treatment works or not. But the variability in people-based interventions and the contexts in which they are performed do not lend themselves to a simple ‘either/or’ scenario. As such, realism is a desirable option to study the complex intervention of peer support.

### 1.9 Aims and objectives

The aims of this paper were to explore how, why, for whom, in what contexts and to what extent peer support contributes (if at all) to recovery outcomes for people with first episode psychosis (FEP). A realist approach was used because peer support is a complex
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intervention. I used the literature review to explore the current knowledge in this area and conducted an analysis of interviews to uncover the answers to the question.
Chapter 2. Literature Review

2.1 Method

Realist synthesis and evaluation leading expert, Gill Westhorpe, (personal communication, June 17, 2016) recommended that I conduct a Rapid Realist Review (RRR) design for this literature review. The RRR design seeks to define a comparatively smaller scope to literature review and is meant to give decision-makers a quick review of the area of study. On her advice, I invited four subject matter experts to provide the top five favoured articles and readings from peer support literature. The subject matter experts chosen had three qualities. First, all were knowledgeable of a wide variety of peer support literature including peer reviewed and other literature. Second, all were leaders in the field who were people with lived experience of mental health issues. Third, all were leaders within the Canadian field. I received 20 submissions including peer reviewed literature, gray material, a video, a blog entry and a PowerPoint presentation. The items were reviewed and synthesised. A brief summary of the submissions was included in Table 1.

2.2 Summary of Literature

Mead (2006) published a peer reviewed article which identified that peer support (PS) provides mental health related support and offers practical strategies through itself. The article went on to say that mental health PS is unique in that its foundational roots were political and grounded in the civil and human rights movement around negative mental health treatment. It also identified the following constructs: critical ingredients of PS, critical learning, mutuality, language use, mutual responsibility and shared risk taking. Mead further suggested that PS be
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measured through narrative measurement strategies. Overall, Mead’s paper added to the definitions, historical and critical ingredients of PS including that in the political sphere.

The Pfeiffer et al (2011) peer reviewed article outlined that PS was helpful in reducing symptoms of depression. It added that we need to explore its effectiveness in primary care and other settings with limited mental health resources. The article noted that challenges to increasing peer support have been related to a traditional anti-formal system stance and the challenge of working together from this standpoint. A number of mechanisms were identified that promote the value of PS. Points in the discussion section included the need for characterizing the mechanisms by which peer support may provide therapeutic benefit.

Jones (2015) published a technical guidance manual which focused primarily on peer involvement at the organizational and regional levels. The guide provided an exploration of program development, policy and planning, direct service delivery, public outreach and stigma reduction, clinician education, and quality improvement/evaluation. It also included discussions on how persons with lived experience involvement at these levels can promote and strengthen social and individual involvement and wellbeing. The guide further described and discussed a range of ways in which peers can influence, improve and inform First Episode Psychosis (FEP) services for system transformation and FEP service peer support.

Pat Deegan (2006) is a leader in the psychiatric survivor movement. Her thoughtful blog and PowerPoint were shared during the literature review. Her blog post featured an overview of historical component of peer support from the perspective of a psychiatric survivor and advocate. In particular, she shared that peer support work often takes place in traditional behavioural settings such as ACT teams and hospitals. She noted that as work takes place within
traditional settings, there is room for innovation in new settings developed and led by people with lived experience. Deegan (2013) then shared an example in the work of Dr. Pinel, often noted as the father of modern psychiatry, from the 1700s. Pinel reportedly sought to release people with mental illness from iron shackles in asylums and initiate new, more humane approaches. However, Deegan notes this was indeed a myth. It was actually Pussin, a former patient of Pinel’s who returned to work at the asylum and encouraged new manners of more humane and helpful approach. These included encouraging kindness, inspiring hope, providing a focus on vocational activity, and other approaches. Deegan encouraged us to recall that our modern peer support ventures are not the first attempts of reformation and support. Rather, there is a historical path from which current initiatives and system transformation can be inspired.

The Davidson et al (2005) article was shared by two subject matter experts. The published report defined peer support and reviewed four randomized control trials which demonstrated comparable outcomes by conventional non-peer support and peer support as a mental health service provision. There were three categories of peer support provided in the article including mutual aid, participation in peer-run services, and the use of peers as providers of service and support with an expected one-directional benefit to the peer client. There was caution that more research was needed to explore how one functions as a peer support provider, as a differentiator or as a service.

Davidson et al (2012) was shared by two subject matter experts. That policy paper asserted that while mental health peer support commenced in the 1990s it actually had roots in the 18th century with Pinel and Pussin in France during the moral treatment era as shared by
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Pat Deegan. It further made a case that peer support is effective in the engagement phase, reducing hospital and emergency rooms and reducing substance use with those who have co-occurring substance use. Among other positive aspects, there was also a shown decrease in depression and psychosis. This article also provided an overview of commonly asked questions by non-peer practitioners in organizations about the implementation of peer support and an overview of implementation strategies.

Solomon (2004) was a published article that defined different types of peer support such as self-help internet online groups, peer delivered services, peer-run services, peer partnerships and peer employees. It also explored the underlying five psychosocial processes each of which include social support, experiential knowledge, helper-therapy principle, social learning theory and social comparison theory. The benefits were illuminated for peer-providers, peer-recipients and the mental health system. Peer provided services were found to be as effective as non-peer-provided services. Improved self-efficacy railed against feelings of stigma and overall improved quality of life. Benefits to the system included reduced hospital stays for peer recipients and providers and the relative cost to benefit analysis showed positive savings. Another benefit is listed as combatting stigma within the mental health service community. Finally, those who are opposed to engagement with the traditional system have increased engagement with peer support services. Critical ingredients of peer provided service elements included use of the experiential learning process, use of mutual benefit, use of natural social support, voluntary nature of the service and primary control of the service by individuals who have lived experience of psychiatric disorders. Characteristics of peer providers included experience with the mental health service delivery system, stable and in recovery, not a
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currently one who abuses substances or dependent on substance. Finally, the article cited that characteristics of an effective mental health service delivery system included diversity and accessibility of peer provided services that reflected the cultural diversity of the community. It also noted there must be availability of adjunctive and alternative peer provided services.

Repper et al (2011) was shared by two subject matter experts. In this article, he reviewed the literature of peer support workers who are paid to provide peer support; gave a description of the development of paid peer support work within clinical posts of statutory systems; and informed its implementation in the United Kingdom. It was noted that current published literature is mostly qualitative studies often with small sample sizes. The findings considered the definition of peer support, efficacy of peer support, benefits for service users, empowerment score level, social support and social functioning, empathy and acceptance, stigma reduction, hope, befits for the PSWs, and the challenges such as boundaries, power, stress for PSWs, accountability, and maintaining PSWs role. Initially, the scope of PSW literature and research showed minor difference. However, when a broader range of literature was reviewed, the following benefits were illuminated: promote hope and belief in the possibility of recovery and other outcomes of empowerment, increased self-esteem, self-efficacy and self-management of difficulties and social inclusion and engagement in and increase of social networks. The central tenets of recovery were listed as hope, control/agency and opportunity.

While there were challenges in the introduction of peer support, it was recognized that the literature is still new.

One subject matter expert shared a United Kingdom web video titled “Mental Health: In our Own Words” (n.d.). This video highlighted questions posed to thirteen 18-25 year-olds
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about their mental health problems and how they cope. This video provided a view into the grey literature and was an example of persons with lived experience who are youth. Remember that youth are the population likely considered for FEP. So the video was helpful to demonstrate the power of such media to share and inspire people with lived experience, clinicians, planners and most importantly youth about the importance of sharing voice to break down stigma and inspire early help and hope.

PeerZone is a peer-led training program website and service delivery package shared by one subject matter expert. It is an example of a peer-created and led resource and is undergoing study at present (personal communication May 2016). The training program is unique and offers insight into a program being offered for people with lived experience of mental health issue for others. It is inspiring to note that an example of peer leadership and voice is in every aspect of the program.

While much of the research within the literature review focused on articles citing peer support as an intervention and its’ implementation, Trachtenberg (2013) published a report for the Centre of Mental Health in the UK with an additional vantage point. It self-identified as a first attempt to assess if PS is good value for money. Specifically, it focused on the reduction of hospital bed use. It compared six studies in the research literature and found that the benefits of employing PSWs did exceed the costs. In some cases, it was by a substantial margin though it did recommend more research as the evidence is limited both qualitatively and quantitatively. There was also a note for research to be conducted to increasingly examine the effects of PSWs as the current literature showed some inconsistency. The authors further noted that replication was a challenge and the quality of the evidence method was poor. There was variability in the
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initial, up-front training of PSWs as well as in the nature and frequency of peer support between service users. Therefore, the interventions evaluated showed inconsistent results. There were benefits noted for the PSWs themselves. Finally, there was a note about the very positive impact the PSWs brought to the organization to drive recovery orientation. However, the authors found that finding was not formally investigated. The cost to benefit ratio compared value of bed-days saved per PSW to cost of peer support through a full-time employee equivalent. While the costs savings were apparent in the report, the authors noted that they did not factor in the positive impact on outcomes that PSWs provided on mental health and quality of life. The authors noted four limitations of the studies which were limited scale and quality of evidence base; variation of peer support as an intervention; only scale for cost benefit was bed day usage and the cost for peer support may be offset by increased community mental health costs; and geography used was external to the United Kingdom which may have contextual differences.

Frost et al (2011) explored the benefit of an employer learning community model for providers and people with lived experience to explore (through a team approach) the value of recovery-oriented practice and having people with lived experience in peer support roles. It outlined the difference between the traditional medical model and recovery-oriented mental health services. The employer learning community included participation from all 38 mental health authorities in Texas as they sought to develop and implement peer specialist programs. Each member was to sign the application and confirm commitment to purpose. Four members were signed up from each organization and were a combination of clinicians, administration, and at least one person with lived experience represented. There were six requirements which
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included the following in brief: conduct a recovery self-assessment staff survey; participate in a 3-day kick off conference, encourage employed peer specialists to apply for the certified training, participate in monthly conference calls, conduct an anonymous six-month recovery self-assessment staff survey, and attend a wrap-up conference. The lead staff in the study recognized the need for recovery education and consultation in many of the organizations. One of the main findings was that the learning community for providers was a promising tool to guide organizations through the adoption of a recovery-oriented service with certified peer specialists. This article spoke to the impact of system transformation and peer support implementation. The value in the article was surely the feature of implementation itself being transformational.

Oades et al (2013) provided a range of definitions on mental health peer support, aims of peer support initiatives and the psychological underpinnings. A case example provided further demonstrated differences between peer support types of intervention. This article also examined the political context in which peer support programs may be nested. That ranged from conservative to radical and whether the person’s view of self was more aligned with the survivor/ex-patient philosophy. There was consideration of power differential when providing peer support and whether the work was paid or unpaid. As psychiatric survivors often sought alternatives to the traditional mental health system, they tended to choose more of the unpaid peer support. Peer support programs can sit within traditional community based psychosocial rehabilitation services as a peer partnership model (Solomon, 2004).

The research report prepared by Forchuk et al (2002) for the Canadian Health Services Research Foundation outlined a study of 390 people with chronic mental illness as they
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

transitioned from hospital to community. Two key elements included peer support for one year from former clients and an overlap of inpatient and community staff for up to one year. The report led to nine key implications for decision makers and six overall recommendations/implications. While the focus was not on early intervention specifically, the article provided a cost benefit argument for implementation of the new model of treatment outlined in the research study. This important work provided insight into cost benefit analysis and implementation. Overall, the benefits outweighed the costs although the authors noted that more research had to be conducted.

Mead (2003) explored in a brief paper the definition of peer support built on giving and receiving help based on key principles. The key principles were mutual respect, agreement on what is helpful and shared responsibility. This was counter to the development of self-concepts based on disability, diagnosis and trauma. Mead’s paper was based on the internal and interpersonal relationship while it investigated power and choice in greater self-awareness. The paper further identified the additional value of peer support programs and the critical analysis they may bring to transform conversation and systems of care. Mead’s work helped to explore and define peer support. The article spoke to system transformation.

The Taylor Newberry Consulting (dated November 2014) unpublished report was prepared for the Ontario Peer Development Initiative (OPDI) and the Self-Help Alliance. The report provided a definition of peer support and conducted a project to explore the facets of peer support in contemporary organizations and systems. Facets such as context of workplaces, wages and challenges were identified through surveys, focus groups, and analysis. It was shared
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

that a community of practice would be developed. This work provided a working definition of peer support, geographic context and experiences of peer supporters.

2.3 Themes


Peer support definitions shared the view that peer support was reciprocal and mutually offered, rather than being based on clinical knowledge. Mead and the Taylor Newberry Consulting report further asserted that peer support in mental health has a political frame of reference given that it grew from the civil and human rights movement. The literature over the last two decades showed momentum for providing further dissections of types of peer support. Reper (2011) shared three levels of peer support from the work of Davidson (1999) within the literature review which were informal peer to peer, peers as service users in peer run programs and peers participating in peer programs in traditional services. The most contemporary work which outlined the spectrum of peer support and provided examples was in the Guidelines for Practice and Training in Peer Support by the MHCC (p.19, Figure 1, 2013). Included in that table was a spectrum of peer support from friendship level to clinical care. There were seven gradients - three informal and four formal. The table was a novel approach that clearly outlined the types of mental health peer support. Of limited discussion in the definitions of peer support were whether or not similarity of diagnosis or symptoms had to be similar for peer support. A question does occur when providing peer support for early psychosis youth; must the peer
support provider have experienced a psychosis and be a youth in order to provide peer support to a youth experiencing FEP?

There was a limited range of FEP literature provided by the subject matter experts. However, the singular submission of Jones (2015), was both contemporary and rich. It contained information for decision makers, practitioners and peer supporters alike specific to the FEP peer support area from planning to peer support to evaluation. An additional aspect of this paper was that it pointed to the importance of peer involvement and leadership in FEP services. The chapters explored planning policy and oversight, direct services, public outreach and stigma reduction, clinician education, quality improvement, evaluation, and research. Jones shared that the importance of FEP programs were two-fold: to intervene as early as possible and to help the young person remain active and engaged in their community. Peer involvement was examined at four different levels: individual, social or interpersonal, organizational or program-level and regional. On an individual level, Jones referenced a randomized control study in which peer support documented statistically significant improvements in symptoms, well-being and treatment self-advocacy (Cook et al 2012). As well, peer interaction was shown to decrease internalized stigma and lower self-expectations (Cook et al 2012).

One submission from the subject matter experts (Davidson, 2012) noted that people with psychosis were a benefactor of peer support based on presented evidence. Several authors noted gaps which stated the literature was still new (Repper, 2011) and more research was needed (Davidson, 2005; Pfeiffer, 2011; Repper, 2011; Trachtenberg, 2013). Two submissions included the cost benefit analysis that demonstrated a positive return on
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

investment for peer support and considerations for future research (Forchuk 2002 Trachtenberg, 2013). A very recent literature review on peer support, provided by Repper (2011), also indicated a need for future research. There were suggestions on measurement methods by Mead (2006) and Pfeiffer (2011). One article provided an in-depth view on theoretical underpinnings (Solomon, 2004). Finally, it should be noted that two submissions were a video of youth with lived experience of a mental health issue (2013) as well as a peer-led and developed program (PeerZone, n.d.).

2.4 How does the literature review illuminate the research question?

The answers of how, why, for whom, in what contexts and to what extent does peer support (if at all) contribute to recovery outcomes for people with FEP were explored in the literature review. While the definition was explored, a greater clarity was found in the gradients of peer support offered therein. There was support for the how, for whom, contexts and extent for FEP but the literature is still new for this area. The question of why was less clear. There was a good overview of the organizational context and benefits of PS with implementation recommendations. I noted that there was limited information on the mechanisms of peer support to answer the question of why?
Table 1. Overview of subject matter expert literature

<table>
<thead>
<tr>
<th>Subject Matter Expert (SME)</th>
<th>Article</th>
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<tbody>
<tr>
<td>SME 1</td>
<td>Repper, J., &amp; Carter, T. (2011). A review of the literature on peer support in mental health services. <em>Journal of Mental Health</em>, 20(4), 392-411</td>
<td>Repper et al (2011) was shared by two subject matter experts. This article was a review on the literature of Peer Support Workers (PSWs) who are paid to provide peer support (PS), a description of the development of paid peer support work within clinical posts of statutory systems and to inform its implementation in the United Kingdom. It was recognized that the literature was still new.</td>
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<td>Davidson, L., Bellamy, C. B., Guy, K., &amp; Miller, R. A. (2012).</td>
<td>Davidson et al (2012) published a policy paper which made a case that PS was effective in the engagement phase where it reduced hospital and emergency room stays and reduced substance use among those who have co-occurring substance use. Among other positive aspects, there was also a demonstrated decrease in depression and psychosis. Finally, there was an overview of commonly asked questions by non-peer practitioners in organizations about the implementation of PS complete with implementation strategies.</td>
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<td>SME 1</td>
<td>Mead, S. (2006). Intentional Peer Support: What Makes it Unique. <em>International Journal of Psychosocial Rehabilitation</em>, 10(2), 29-37</td>
<td>Mead published a peer reviewed article which identified that PS provided mental health related support, offered practical strategies through itself, and was unique in that its foundational roots are political and grounded in the civil/human rights movement. It also identified the following constructs: critical ingredients of PS, critical learning, mutuality, language use, mutual responsibility, and shared risk taking. It further suggested that PS be measured through narrative measurement strategies.</td>
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<td>SME 1</td>
<td>Pfeiffer, P. N., Heisler, M., Piette, J. D., Rogers, M. A., &amp; Valenstein, M. (2011). Efficacy of peer support interventions for depression: a meta-analysis. <em>General Hospital Psychiatry</em>, 33(1), 29-36</td>
<td>The Pfeiffer et al (2011) peer reviewed article outlined that PS was helpful to reduce symptoms of depression. But it also said there was a need to explore its effectiveness in primary care and other settings with limited mental health resources. Some challenges to increased peer support have been related to traditional anti-formal system stance and challenge working together from this standpoint. A number of mechanisms were identified that promoted the value of PS. The discussion section touched on the need to characterize the mechanisms by which peer support provided therapeutic benefit.</td>
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<td>SME 1</td>
<td>Jones, N. (2015). <em>Peer involvement and leadership in early intervention in psychosis services: from planning to peer support and evaluation.</em></td>
<td>Jones (2015) published a technical guidance manual which focused primarily on peer involvement at the organizational and regional levels. It also included discussion on how involvement at these levels can promote and strengthen social and individual involvement and wellbeing. The guide described and discussed a range of ways in which peers can influence, improve and inform First Episode Psychosis (FEP) services.</td>
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Table 1. Overview of subject matter expert literature (continued)

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<td>SME 2</td>
<td>Davidson, L., Chinman, M., Sells, D., &amp; Rowe, M. (2006). Peer Support Among Adults With Serious Mental Illness: A Report From the Field. <em>Schizophrenia Bulletin</em>, 32(3), 443-450. doi:10.1093/schbul/sbj043</td>
<td>Davidson et al (2006) was shared by two subject matter experts. The journal report defined PS and reviewed four random control trials which demonstrated comparable outcomes by conventional non-peer support and PS as a mental health service provision. There were three categories of PS described in the article; mutual aid, participation in peer-run services and the use of peers as providers of service and support with an expected one-directional benefit to the peer client. There was caution that more research was needed to explore how the PS operates as service differentiator.</td>
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<td>Davidson, L., Bellamy, C. B., Guy, K., &amp; Miller, R. A. (2012).</td>
<td>Davidson et al (2012) published a policy which made the case that PS was effective in the engagement phase, in the reduction of hospital and emergency room use, and in substance use reduction with those who have co-occurring substance use. Among other positive aspects, there was also a shown decrease in depression and psychosis. Finally, there was an overview of commonly asked questions by non-peer practitioners in organizations regarding the implementation of PS complete with implementation strategies.</td>
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<td>SME 2</td>
<td>Solomon, P. (2004). Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients. <em>Psychiatric Rehabilitation Journal, 27</em>(4), 392-401. doi:10.2975/27.2004.392.401</td>
<td>Solomon (2004) defined different types of PS such as self-help internet online groups, peer delivered services, peer-run services, peer partnerships and peer employees. It also explored the underlying five psychosocial processes of each. The benefits were illuminated for PS, recipients and the mental health system. Peer provided services were found to be as effective as non-peer-provided services. Finally, characteristics of mental health service delivery system included diversity and accessibility of types of PS services. The services were to reflect cultural diversity of the community and there should be an availability of adjunctive and alternative peer provided services.</td>
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<td>Repper, J., &amp; Carter, T. (2011). A review of the literature on peer support in mental health services. <em>Journal of Mental Health, 20</em>(4), 392-411</td>
<td>Repper et al (2011) was shared by two subject matter experts. This article was a review on the literature of PSWs who are paid to provide PS. It also described the development of paid PS work within clinical posts of statutory systems and informed its implementation in the United Kingdom. It was recognized that the literature was still new.</td>
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<td>SME 3</td>
<td>Mental Health: In Our Own Words [Video file]. (n.d). Retrieved from <a href="https://www.youtube.com/watch?v=_y97VF5UJcc@sns=em">https://www.youtube.com/watch?v=_y97VF5UJcc@sns=em</a></td>
<td>A United Kingdom web video “Mental Health: In our Own Words” (n.d.) highlighted questions posed to thirteen 18-25 year-olds about their mental health problems and how they coped. This video provided a view into the grey literature.</td>
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<td>SME 3</td>
<td>PeerZone</td>
<td>Peer-led Mental Health Workshops, Consultancy, and Online Tools. (n.d.). Retrieved from <a href="http://www.peerzone.info/">http://www.peerzone.info/</a></td>
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<tr>
<td>SME 3</td>
<td>Trachtenberg, Marija. (2013). <em>Peer support in mental health care: Is it good value for money?</em></td>
<td>Trachtenberg (2013) published a report for the Centre of Mental Health in the UK. It self-identified as a first attempt to assess if PS is good value for money, notably through the reduction of hospital bed use. It compared six studies in the research literature and found that the benefits of employing PSWs was good value for money. The cost to benefit ratio compared value of bed-days saved per PS to cost of PS full-time employee equivalent. (see Appendix 2).</td>
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<td>Frost, L., Heinz, T., &amp; Bach, D. H. (2011). Promoting recovery-oriented mental health services through a peer specialist employer learning community. <em>Journal of Participatory Medicine, 3, e22.</em></td>
<td>Frost et al (2011) study explored the benefit of an employer learning community model for providers and people with lived experience to explore the value of recovery-oriented practice and having people with lived experience in peer support roles. It outlined the difference between the traditional medical model and recovery–oriented mental health services. One of the main findings was that the learning community for providers was a promising tool to guide organizations through the adoption of a recovery-oriented service with certified peer specialists.</td>
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<td>SME 3</td>
<td>Oades, L., Deane, F. P., &amp; Anderson, J. (2013). Peer Support in a mental health service context. <em>Manual of Psychosocial Rehabilitation</em>, 183-193. doi:10.1002/9781118702703.ch 14</td>
<td>Oades et al (2013) published a chapter which provided a range of definitions on mental health peer support aims of peer support initiatives and psychological underpinnings. This article further examined the political context in which peer support programs may be nested. They ranged from conservative to radical and whether the person’s view of self is aligned with the survivor/ex-patient philosophy. There was a consideration of power differential when providing peer support and whether the work was paid or unpaid. Finally, recommendations were provided that included actions to avoid or enact.</td>
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<td>Canadian Health Services Research Foundation. (2002). Therapeutic Relationships: From Hospital to Community.</td>
<td>The research report prepared by Forchuk et al (2002) for the Canadian Health Services Foundation studied 390 people with enduring mental illness as they transitioned from hospital to community. Two key elements were PS for one year from former clients and the overlap of inpatient and community staff for up to one year. The report led to nine key implications for decision-makers and six overall recommendations and implications. While the focus was not on early intervention specifically, the article provided a cost benefit argument for implementation of the new model of treatment outlined in the research study.</td>
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<td>SME 4</td>
<td>Mead, S. (2003). <em>Defining peer support</em>. Retrieved from <a href="http://www.mhepinc.org/images/stories/peer-support/DefiningPeerSupport.pdf">http://www.mhepinc.org/images/stories/peer-support/DefiningPeerSupport.pdf</a></td>
<td>Mead (2003) explored in a brief paper the definition of peer support built on giving and receiving help based on key principles. The key principles included mutual respect, agreement on what is helpful and shared responsibility. It was counter to the development of self-concepts based on disability, diagnosis and trauma. Rather it was based on the internal and interpersonal relationship while investigating power and choice in greater self-awareness. The paper identified the additional value of PS programs and the critical analysis they may bring to transform conversation and systems of care.</td>
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<td>SME 4</td>
<td>Deegan, P. (2013). <em>The historical roots of peer support</em> (<em>PowerPoint retrieved from personal communication</em>). Pat Deegan PhD &amp; Associates, LLC.</td>
<td>Deegan’s (2013) PowerPoint presentation provided an example of the historical roots of hope and recovery through the work of Dr. Pinel and his former patient, Pussin, in the Parisian hospital as Pinel ordered the removal of the chains from people who had been in psychiatric asylum.</td>
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<td>Frost et al (2011) explored the benefit of an employer learning community model to explore the value of recovery-oriented practice and having people with lived experience in peer support roles. It provided an outline of difference between the traditional medical model and recovery-oriented services. A main finding was that the learning community was a tool to guide organizations through the adoption of a recovery-oriented service with certified peer specialists.</td>
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<td>SME 4</td>
<td>Taylor Newberry Consulting (2014) <em>Investigating the state of peer support work in Ontario.</em> Unpublished report.</td>
<td>The Taylor Newberry Consulting unpublished report was prepared for the Ontario Peer Development Initiative (OPDI) and the Self-Help Alliance. The report provided a definition of peer support and conducted a project to explore the facets of peer support in contemporary organizations and systems. Facets were identified through a survey, focus groups and an analysis. It was shared that a community of practice would be developed.</td>
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Chapter 3. Methods

3.1 Why Realism?

I attended a realist synthesis and realist evaluation week of study at the University of Saskatoon with international experts in realism led by Dr. Gil Westhorpe in the summer of 2016 to explore the philosophy and methods used in realism. As identified, in this paper, realist perspectives have been used in contemporary study to explore complex interventions. At a master level study, considering budget and time resources, Dr. Westhorpe recommended the Rapid Realist Review (RRR) approach. According to Saul (2013), a realist synthesis can be used to inform policy makers with a transferable theory to express whether a program is bound to be helpful. RRR is especially helpful when exploring programs merit in emerging areas or when timing is sensitive. Involvement of knowledge users and external experts help ensure the usability of the product or program under review. It should be stated that realist lead expert shared that other approaches to synthesise evidence have merits and drawbacks. For example, he stated that meta-analytical approaches fail to understand how programs work while the narrative approach may lack the ability to transfer over other settings or under different circumstances (2002, 2006).

3.2 Rapid Realist Review (RRR) Framework

I used the rapid realist review (RRR) design approach to synthesize evidence to identify how, why, for whom, in what contexts and to what extent peer support contributes to recovery outcomes for people with First Episode Psychosis (FEP). While there is a standards protocol for realist synthesis and realist evaluation, RRR protocol has not yet been developed. I used current published research, the RAMESES website and hosted list-serve to assist in my work. The realist review method is outlined in the RAMESES training material by Geoff Wong and colleagues.
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(http://www.ramesesproject.org/). Greenhalgh states (2004) that an intervention may never be implemented in an exact manner and that successes may not be transferrable over differing settings which can present as a challenge to implement evidence-based policy. Peer support is considered a complex intervention. Its complexity lies within its non-standardized approach and the fact that it is offered through a variety of infrastructures, institutions, interpersonal relationships and individuals. The realist review allows for intervention exploration including such factors as policy timing, organizational culture and leadership, human and financial resources, and regional planning.

3.3 Description of Methodology

I used a rapid realist review (RRR) method which included a qualitative method approach with three subjects in a semi-structured interview. The realist research cycle of theory, refinement and development started with the recommendations informed by the literature review and were recorded in the form of context-mechanism-outcomes (CMOs) as per a realist review approach. Finally, I used the lens of trans-theoretical model of change theory to examine change as it applied to both person and organization.

There are seven steps to describe my research design of the realist review. First, the scope of my review targeted peer support interventions for the FEP population. The purpose was to identify efficiencies for recovery oriented outcomes for the approach. In addition, the local health authority viewed the results to inform local practices. Key theories surrounding the efficacy of peer support were identified and explored. Second, I conducted a thorough review of grey and academic peer reviewed literature to explore the research question which was
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limited to subject matter experts chosen from my network of professional contacts. This sampling method was recommended by Gil Westhorpe, realist expert during the realist review training I attended at the University of Saskatoon in June 2016. I limited search terms to set parameters on the study and including “peer support for early psychosis” and “peer support for first episode psychosis” from peer support leads in Canada in accordance with rapid realist review protocol. Third, I used a semi-structured interview technique with managers of three early psychosis programs that use formalized peer support. I used this technique as it is a fast method for gaining information that can be compared and analyzed. Through an opportunity sampling method, three prospects were identified using a scan of existing programs in Canada, Australia, and the United Kingdom. These countries were selected because they demonstrated evidence development in this area and speak English. Three countries were chosen in this study versus three Canadian regional locations due to the paucity of Early Psychosis Intervention programs in Canada that use peer support. I received confirmation from the Royal Roads University ethics department to conduct the study. Nine prepared questions were given to the three interviewees and a 45 minute appointment was made to discuss the questions over VOIP. Each interview was digitally recorded to aid in transcription with consent. The transcripts were reviewed by the interviewees for accuracy and to aid in transparency. Each participant was offered a copy of my completed thesis. After I conducted the three interviews and had them transcribed, I thoroughly reviewed each transcript to seek realist perspective configurations. Each configuration contained a context (C), a mechanism (M) an outcome (O) and was calculated as C+M=0 (Rycroft-Malone, 2012). This analysis was designed to examine underlying mechanisms that may be outside of the observable in a traditional intervention study. The
realist approach is used in social sciences and indicated especially in complex social interventions such as peer support. From the three interviews, I identified 18 CMO configurations. They are shown in Table 4.1.

While I sought interviewees to speak about First Episode Psychosis (FEP), the program delivery method in each area showed three different peer support (PS) formulations. In one instance, the FEP Peer Support Worker (PSW) program was on hold due to human resource issues. The second program interviewee indicated that PSW were employed and worked throughout FEP and general adult program. The third program was voluntary PSW and considered group based PSW as funding was limited. I would like to add here that my initial scan of Canadian FEP PSW programs illustrated a desire for PSW in the FEP programs but there was no funding at the time to operate a PSW FEP facet to the program, thus further demonstrating the scarcity of FEP PSW. None of the interviewees made funding decisions and all were in a clinical coordinator role. Fourth, I carefully reviewed the interview transcripts and extracted information provided by the experts that was relevant to my research question. The experts spoke about the impact that peer support had on programs, service delivery teams and the clients. I selected information from the materials using an iterative approach, specific to realist review design. I categorized the information based on these three areas of impact which was congruent with my research question and the purpose for my study. I expressed the information as a CMO configuration in accordance with the realist method. The data extraction method to select CMO configurations included a complete review of each interview, identification of the context and mechanism and the outcome. The information was recorded as configurations and illustrated in a table. This method is a hallmark of realist review. In
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accordance with the ethics review, the interviews and analysis were stored in a locked file
cabinet while my electronic work was stored on a password protected computer. Fifth, I
integrated program theory findings. I selected the Transtheoretical Model (TTM) of change to
explore the research question within the micro, meso and macro levels. Sixth, I will make
recommendations geared toward implementing peer support for the FEP population. And
lastly, I will share my findings with interested stakeholders.
Chapter 4. Results

4.1 Themes

Analysis of the CMO’s revealed many themes which I grouped into three main areas depending on who or what was influenced by the inclusion of a peer supporter. The first area included the impacts of peer support on the program. The second area was the impact on the team delivering service which includes the PSW. The third area was for the client of the service.

Table 2. Realist review CMO configuration

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<th>Context (C)</th>
<th>Mechanism (M)</th>
<th>Outcome (O)</th>
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<tr>
<td>Client with early psychosis linked to PSW who was in recovery.</td>
<td>Client identified with PSW and was more hopeful about their future.</td>
<td>Client engagement in the program improved.</td>
</tr>
<tr>
<td>Budgetary restraints required prioritization of interventions.</td>
<td>Program Manager saw PSW as less important than other interventions.</td>
<td>Limited access to PSW.</td>
</tr>
<tr>
<td>Recruitment of PSWs that prioritized lived experience of mental illness results in workers who needed more training and support.</td>
<td>Program manager realized importance of PSW wellbeing to job performance.</td>
<td>Program included additional ongoing training and support for PSW.</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Context (C)</th>
<th>Mechanism (M)</th>
<th>Outcome (O)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSW embodied negative aspects of lived experience (such as weight gain from psychotropic medication).</td>
<td>Client felt negative about own recovery future.</td>
<td>Client did not engage with PSW.</td>
</tr>
<tr>
<td>Unstable funding of PSW positions resulted in lack of opportunities for career progression.</td>
<td>PSW frustrated by lack of recognition of work.</td>
<td>Low morale resulted in poor job performance and decreased effectiveness of PSW.</td>
</tr>
<tr>
<td>Client socially isolated because her circle of support was alienated due to recurrent hospitalizations. Connected with PSWs.</td>
<td>Client enjoyed visitors and felt less lonely.</td>
<td>Client in recovery and became a PSW.</td>
</tr>
<tr>
<td>Former client of program joined team as PSWs.</td>
<td>Program clinicians felt their role in client’s recovery was significant and that they were part of a success story.</td>
<td>The PSW was considered a valuable member of the team.</td>
</tr>
<tr>
<td>Context (C)</td>
<td>Mechanism (M)</td>
<td>Outcome (O)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PSWs saw themselves as</td>
<td>Increased confidence.</td>
<td>Pursued further education</td>
</tr>
<tr>
<td>success cases.</td>
<td></td>
<td>including credentialed helping</td>
</tr>
<tr>
<td></td>
<td></td>
<td>roles (nursing, psychologists,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and social workers).</td>
</tr>
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Table 2. Realist review CMO configuration (continued)

<table>
<thead>
<tr>
<th>Context (C)</th>
<th>Mechanism (M)</th>
<th>Outcome (O)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer support was championed by the highest levels of organizational governance.</td>
<td>Clinicians learned about the value of PS.</td>
<td>PSW was included in FEP program.</td>
</tr>
<tr>
<td>When client became a PSW the roles for clinician and client changed.</td>
<td>PSW and clinician experienced sadness due to loss of previous relationship.</td>
<td>Role ambiguity for peer support worker and clinician.</td>
</tr>
<tr>
<td>Recruitment decisions favour PSWs who have made a “classically full recovery” because clinicians felt that people who relapsed/ experienced symptoms should not be PSWs.</td>
<td>Stigma.</td>
<td>Discriminatory hiring practices and homogeneity of PSWs.</td>
</tr>
</tbody>
</table>

(continued)
Table 2. Realist review CMO configuration (continued)

<table>
<thead>
<tr>
<th>Context (C)</th>
<th>Mechanism (M)</th>
<th>Outcome (O)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client engaged in intervention(s) with PSW in addition to a clinician.</td>
<td>Client felt empowered.</td>
<td>Client made choice in accordance with individual needs.</td>
</tr>
<tr>
<td>PSWs in a psycho-educational group setting were open about own recovery journeys.</td>
<td>Clients identified with PSWs.</td>
<td>Increased client hopefulness and engagement.</td>
</tr>
<tr>
<td>Unionized work setting introduced constraints in selection of PSWs based on client variables (age, ethnicity, class, gender).</td>
<td>Clients did not relate to PSW.</td>
<td>Reduced effectiveness of PSW intervention.</td>
</tr>
<tr>
<td>PSW worked long term with client who was stable and living in the community.</td>
<td>Client vision of recovery grew beyond symptom control.</td>
<td>Client actively pursued own recovery beyond just stability.</td>
</tr>
</tbody>
</table>
Chapter 5. Discussion and Conclusions

5.1 Summary of findings

In exploring my research question, I analyzed the content of the three interviews to extract the context, mechanism and outcome (CMO) configurations to get at underlying mechanisms in peer support (PS). While peer support work (PSW) mechanisms were explored, it was found in the literature review that where PSW exists, and the voice of the persons with lived experience and recovery-oriented values were held, system transformation appeared to be linked. After the following impacts are discussed, I will apply a change lens of Transtheoretical Model (TTM) to the three layers at work to identify more about the contexts in which PS can contribute to recovery outcomes. I chose the TTM for the applicability to the micro, meso and macro levels of analysis.

5.1.1 Impacts of peer support on the program:

The program area underscored issues related to funding, priorities, innovation and human resources. Funding issues were discussed by each of the interviewees. Financial resources are required for a PS program to be implemented and sustained. All interviewees shared that there have been challenges in the sustainability of peer support in their programs. Funding has not been provided or was limited in the three cases. I also noted that all three interviewees saw the benefit of PSW and I will share their thoughts in the areas related to team and direct client benefit. Funding is allocated according to the priorities of an organization. Priorities are ascertained through various types of information which should be informed by evidence and population health. Priorities can also shift given socio-political context or innovations based on new evidence. One of the biggest innovations to impact mental health
services is that of the shift away from the traditional illness focused medical-model of mental health service provision towards a strengths-based recovery-oriented paradigm. Recovery-oriented services are being increasingly viewed as effective and efficient (Frost et al, 2011). During this time of system transformation, statutory and professionally led systems of care are faced with a great deal of organizational change. It should be noted that the recovery-orientation is part of a larger social transformation our communities are building (Frost et al, 2011). I recognize that within my collegial working circles, the advancement of recovery-oriented service has been emphasized as a desirable direction. It is additionally captured in leading Canadian policy work as championed by the Mental Health Commission of Canada Guidelines for Recovery-Oriented Practice (MHCC, 2015).

While there is a recognition in the literature of the cost-benefit of employing peer supporters, the evidence for PS underlying mechanisms is still considered newer in the academic literature and more research is needed on peer support (Pfeiffer et al, 2011; Trachtenberg, 2013). However, there is still a cost-benefit argument to be made in the cost-savings of service delivery when calculating bed days per full time equivalent PSW (Trachtenberg, 2013). Trachtenberg did outline that bed savings were only one method used to quantify cost savings and that other measures may be researched such as the evidence for positive impact on outcomes of mental health and quality of life for those using the service (Trachtenberg, 2013).

Another area that ranked high was issues related to human resources. These issues included concerns about job descriptions, training, support and job performance. I included the discussion of these items in the impact on the team section in 5.1.2.
5.1.2 Impacts on the team delivering service which includes the PSW:

The team skills area includes the PSW, noted relationships of PSW to team members, and role clarity versus lack of clarity. This area is most probably a human resource issue as it relates directly to training, leadership and organizational culture. One qualitative study from Australia identified the following challenges faced by peer support workers in various mental health services: lack of role clarity, stigma from colleagues, challenges with self-disclosure, lack of adequate supervision, and heavy workload expectations (Kemp & Henderson, 2012). The challenges were reviewed and a team in Canada sought to enhance practices to improve experience. That team found there was apprehension towards peer support staff, role conflict and confusion, poorly defined jobs, inadequate training and lack of communication to non-peer staff (Balderson et al, 2016). Of interest, through a private sector grant, the peer supporters were hired and the program implemented. There was a question as to the sustainability of the program were the grant not renewed.

The six items outlined by the Kemp and Henderson study (2012) and the six items outlined by the Balderson study spoke to the need for more preparation for job descriptions (including time used to measure expectations), additional role clarity and preparation of peer and non-peer staff to work together as a team on the unit. The study also revealed the need for more communication to be facilitated with non-peer staff. While the study is yet to be published, the PowerPoint and presentation illustrated that the implementation of peer support could not be done in a vacuum. There must be preparation from multiple organizational departments and staff members including the members of the team, varied
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

levels of management and human resources. In addition, according to the interviews, unions must also be included in the preparation and implementation to seek greater success in such areas as staff “fit”, or to reflect the mentoring needs of the persons who are users of the service.

Finally, as the peer support work tends to be interlinked with the recovery oriented paradigm and culture, the organization must prepare for organizational change. Such change will include substantial alterations to language, procedures, risk, behavioural norms related to beliefs as well as attitudes and values throughout the organization (and more widely throughout the systems of care and service). It is through the work of the Peer Support Accreditation of Canada that some aspects of peer support implementation may be enhanced, such as adoption of the peer support credential through the PSACC accreditation body. That step will assist managers and human resources in gaining greater confidence that a standard has been met by the peer supporter which in turn will increase organizational confidence.

5.1.3  Impacts on the client of the service:

The client of the team will experience benefits such as increased hope, recovery, empowerment, engagement, growth and improved social relationships. One interviewee shared an experience from the front line stating “...our peer support workers literally embody recovery themselves”. Repper et al, (2011) conducted an literature review on PS in statutory or professionally led services which noted that the employment of PSWs was a recent development and that PS implemented outside of their UK study area were showing promise in facilitating recovery. One part of the realist review research, conducted by Pawson (2006), is that of youth mentoring and specifically, youth engagement. The inner mechanisms explored
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

are how PS works, why, for whom, in what contexts and to what extent does PS work, if at all.

And the larger question of how those mechanisms contribute to recovery outcomes for people with FEP must be examined by CMO’s. Pawson does clearly explore youth engagement and breaks -down parts of the model although it is with adult mentors through outlining nine studies. However, none of the nine studies focus on mental health peer support. An important distinction to mental health peer support versus other peer support is the stigma, discrimination and prejudice people face when diagnosed with a mental health condition as identified in the literature review. Mental health peer support is recommended versus non-mental health lived experience peer support (Mead 2006).

5.2 Implications of Findings on Macro, Meso and Micro Level Decision Making

I sought to locate three levels of change within the presentation of impact areas. The three levels are used within social sciences. Namely in the micro-level which include the staff, client and PSW, the meso-level which is the organization level and the macro-level which is represented as the larger shift in mental health care to the recovery oriented paradigm. I chose to explore the topic with the Transtheoretical Model (TTM) as developed by Prochaska and DiClemente (Prochaska et al, 2001) in the late 1970’s. TTM is a stage based model focused on behaviour change. Later studies explored the use of TTM for organizational change (Prochaska et al, 2001). As the research question is inextricably linked with organizational and system transformation, I focused the discussion on the changes that would be required in the context of the person. Those changes include the client, staff (including the PSW), the organization and as a broader system to enhance peer support uptake and generate recovery outcomes as per the research has shown in my paper.
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

Prochaska and DiClemente’s TTM is a health and behaviour change model that highlights six stages of change including pre-contemplation, contemplation, preparation, action, maintenance, through to termination. In each of the six areas, targeted strategies are used to assist a person in moving through them. The TTM is also applied as a theory to help with organizational and system change so its framework is applied to the culture change of organization. The more recent work of Schein (2010) provides detailed assistance in the steps of movement in organizational change which would assist in the movement towards adoption of the recovery oriented culture and PS also as a compatible stage based model. Schein (2010) provided three stages of organizational culture change.

On the macro level, we experience a large system wide shift from a bio-medical focused mental health system of care to that of a recovery-oriented system of care. In TTM, with the leadership of like-minded advocacy and self-help organizations, a groundswell of people with lived experience and the MHCC, we are hearing more about mental health than ever before. More people are sharing their stories about mental health journeys and illuminating the barriers and enablers to leading more fulfilling lives. The demand for change is a growing movement and is accelerating across Canada and other leading countries in the G8. Using the TTM we are able to posit that we are no longer in a pre-contemplation stage of change. People with lived experience, families and other supporters, organizations and systems are hungry for evidence which proves what helps not only alleviate suffering but what can also help people overcome painful mental health challenges and gain the life being sought. I would posit that our nation and G8 partners are seeking evidence and to implement changes within our living, healing and working spaces. We have seen from the evidence supported in this paper that PS is
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

interlinked with system transformation. PS also demonstrates benefit over financial cost and is showing recovery outcomes. I would argue that recovery outcomes have not been as thoughtfully measured. Yet there is progress on that front through a study being conducted and early research outcomes to be released. As Schein illustrates in his model of change, we are between the first and second stage of change for seeing large system wide reform. It is indeed an exciting time.

On the meso, or organizational, level we recognize that organizations are part of larger systems. We can formally seek to audit how recovery orientation is being embraced, or not if it is in the earlier stages of transformation. As noted by Schein (2010), change is represented by three stages: the unfreezing stage which created the motivation to change; the learning new concepts, new meanings for old concepts and new standards stage; and the internalizing new concepts, meanings and standards stage. Each stage has its own steps to stimulate change. As TTM stated, there are tools which can assist with the uptake of recovery-oriented care. And, as leaders in our fields of practice, we can also apply Kotter’s steps to leading change. These steps are establishing a sense of urgency, creating the guiding coalition, developing a vision and strategy, communicating the change vision, empowering employees for broad-based action, generating short-term wins, consolidating gains and producing more change, and anchoring new approaches in the culture. Through the implementation of these steps within the TTM framework and application of the more detailed steps of Schein’s work, we can influence change to increase the uptake of peer support.

One the micro-level, we have seen the client be assisted by the peer support worker (PSW) through the introduction of new attitudes and beliefs related to stigma and nurturance
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

of hope. The PSW related with the client and further enhanced one’s own recovery. The clinical team and organizational staff is further inspired in the advancement of a recovery role model and the positive effects the PSW had on the client and within the environment.

5.3  Strengths and limitations of Review

5.3.1.  Strengths of the review

The strengths of the review indicate there is strong evidence to be used for the value of peer support and that there is evidence to utilize peer support not only as an intervention for clients but also as a vehicle for system transformation. I have outlined financial and recovery based benefits for the implementation of peer support.

5.3.2.  Limitations of the review

The primary limitation of the review is its wide scope. While the original question sought to explore the direct impact of PS on the PSW and the client, the literature review broadened the question to include the implementation issues, in particular, on the organization. While I explored the client, PSW and organizational aspects, the study scope included many vantage points which became too broad for a pure rapid realist review approach. Therefore, I explored the question with a nod towards the design of rapid realist review.

Transtheoretical models of change have recently been challenged as an approach. One limitation noted by Brug et al (2004) was that while stage based interventions have shown some promising results, further research is needed to explore complex health behaviour. The limitation would suitably be addressed through exploring behaviour change through realist review, as this paper has already made the case that complex behaviour interventions are best suited to realist approaches. According to West (2005), another factor that TTM did not
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

incorporate were that the lines between stages can be arbitrary. There had been no readiness tools developed at that point to explore even the pre-contemplative individuals. Another concern noted by West was that TTM assumes that individuals always make coherent and logical plans in their decision-making process. However, in the recovery-oriented paradigm, we have sought to measure change. One new measure of recovery outcomes is the Personal Recovery Outcomes Measure (PROM) (Barbic, 2016). The PROM is utilized at a micro and meso level and could be applied at a macro level. It is exciting to explore measurement in recovery as the personalized approach to exploring how satisfied one may be in one’s own recovery and how programs and larger systems could advance recovery as self-defined by person with lived experience voice. As recovery-oriented measures are still considered new, more research needs to be completed to explore how the TTM could interface with changes one makes in their recovery journey and the role of stigma in the micro, meso and macro levels of change.

5.4 Recommendations for future research

The following recommendations are not exhaustive but were identified as questions for further research through gaps I identified in research during my review.

1. **Labour standards**: Determine how programs can recruit peer support role models without violating current human rights legislation

2. **Psychosis and peer support**: Determine if it is aligned with evidence to have people who have experienced early psychosis to be the peer supporter for those with early psychosis in a clinical program

3. **Realist review on mental health peer support**: Explore the benefit of peer support for first episode client
PEER SUPPORT AND FIRST EPISODE PSYCHOSIS

4. **Evaluation and measurement of change models and recovery outcomes** need further research, in particular as aligned with recovery-oriented practice at micro, meso and macro levels.

5.5 **Conclusions and Recommendations**

The research question was “How, why, for whom, in what contexts and to what extent does peer support contribute (if at all) to recovery outcomes for people with first episode psychosis?” During my thesis, I learned that more research needs to be done to explore the question at a micro-level, meso and macro level. I believe the question of context has been addressed more fully in this paper. However, the research shows promise and early success with the implementation of peer support in the literature.

Island Health, a local health authority in Victoria, British Columbia, is considering increased uptake of PS within its programs and services. I recommend the following for their consideration:

1. **Thesis Review:** Review this thesis to provide foundation on the field of PS and implementation of barriers and enablers.

2. **Inclusive Committee:** A PS committee be developed inclusive of people with lived experience that mirror the demographics they seek to serve.

3. **Peer Specialist Employee Community Development Model:** Consider adoption of the Frost et al (2011) employee community development model in collaboration with the Island Health Recovery-Oriented Practice Peer Support Committee subcommittee and consider involvement of the Recovery Education subcommittee.
4. **FEP Pilot Project:** Conduct a peer support pilot research project in the Early Psychosis Intervention program.

5. **Measures and Evaluation:** Develop evaluation and measurement practices with tools to advance recovery oriented practice, measures and evaluate outcomes in collaboration with the Island Health Recovery-Oriented Practice Framework Monitoring and Evaluation subcommittee. Consider the PSR/RPS Canada competencies in this work.

6. **Certification:** Consider the Peer Support Accreditation and Certification Canada (PSACC) credential for peer support workers; Consider the Certified Psychosocial Rehabilitation and Recovery (CPRRP) certification for mental health workers, clinicians, policy-makers and administration through PSR/RPS Canada.
References


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https://www.mentalhealthcommission.ca/sites/default/files/MHCC_RecoveryGuidelines


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Appendices
Appendix 1 Ethics Declaration Form
Request for Ethical Review  
For Research Involving Humans  

Approved by RRU Academic Council  
September 20, 2012  

If your research involves human participants then it most likely requires an ethical review by the Royal Roads University Research Ethics Board (or one of its subcommittees). Please refer to the Royal Roads University Research Ethics Policy for specific guidance on identifying research that requires ethical review.

The Royal Roads University Research Ethics Policy will assist you in understanding the questions below and will help you formulate your responses. If you have additional inquiries, contact your Project Advisor or Academic Supervisor or the Research Ethics Coordinator.

Research involving human participants cannot be initiated until the Request for Ethical Review has been approved. (This includes sending out invitations for participation, as well as any data-gathering.)

Incomplete requests for Ethical Review will not be considered – all questions must be answered and all requested attachments provided.

Please do not delete any of the questions or prefatory materials. If you need more space than provided, please attach additional blank sheets. Please remember to note the number of your response.

Please have your academic supervisor submit the completed form, via email, to ethicalreview@royalroads.ca. Please allow four weeks for the decision of the Research Ethics Board.

### I. PRINCIPAL INVESTIGATOR

<table>
<thead>
<tr>
<th>Name:</th>
<th>Hazel Meredith</th>
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<tbody>
<tr>
<td>Faculty / Program:</td>
<td>MAIS</td>
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<tr>
<td>(Please specify)</td>
<td>□ Faculty</td>
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<td>Other (Please Specify):</td>
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### A. CONTACT INFORMATION

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<td>City:</td>
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Please use the current email address which you check regularly. Correspondence and/or approval will be sent to this address.
### Request for Ethical Review
For Research Involving Humans

#### If Student, specify:
**FACULTY PROJECT ADVISOR / ACADEMIC SUPERVISOR**

- **Name:**  
- **Office Phone:**  
- **E-Mail:**  
- **Supervisor:**

**Faculty Members Only - Specify Your Supervisor:**

#### If applicable, specify:
**SPONSOR / CLIENT**

- **Name:** N/A  
- **Company:**  
- **Office Phone:** (_____) ____________  
- **E-Mail:**  

#### If Faculty member, specify:
**SUPERVISOR AND SCHOOL/FACULTY**

- **Name of Supervisor:** N/A  
- **Office Phone:** (_____) ____________  
- **E-Mail:**  

**Faculty Members Only - Specify Your Supervisor:**

- **Your School/ Faculty:**

#### CO-INVESTIGATORS (If Any)
Name, position, affiliation with other institution, mailing address, email address, and telephone.

N/A
B. CONFLICT OF INTEREST

Provide full details of any actual, perceived, or potential conflicts of interest (economic, family-related or otherwise) on the part of the principal investigator and/or co-investigators. For example, if you plan to incorporate into your research staff whom you employ, students whom you teach, or fellow employees, this constitutes a conflict of interest. Because the researcher has power over potential participants in areas outside of the research, such individuals may perceive their participation to be coerced, and are therefore not fully free to refuse participation in your research, regardless of your best intentions. Please indicate how you would acknowledge and address this issue. What measures would you take to ensure research participants are aware of potential or actual conflict? Any and all conflicts of interest must be disclosed in your consent documentation (as outlined in Question IX).

One area of perceived conflict of interest: I am the executive director of BC Schizophrenia Society Victoria Branch (BCSS Victoria). I am performing the study as a student outside of my full time work role as executive director. Although I have the benefit of having an excellent network of people through my work through which I will reach out for interviews, I will not be conducting the research in my work role.

Do you supervise or have influence over individuals in the study? If so, please explain how you would minimize undue influence over these individuals?

No

Is there any possibility that the activities or results of your study could impact negatively on the organization?

Yes ☐ No ☒

If Yes in what ways might the activities or results of your study impact negatively on the organization? If this is a potential outcome, please explain how you would mitigate this impact.
Request for Ethical Review
For Research Involving Humans

II. SHORT TITLE OF PROJECT

Project Title: (10 Words Max.)
A rapid realist review of peer support for those with early psychosis

1. Rapid Realist Review (RRR)

Provide 4 keywords / phrases that describe the project:
2. Peer Support
3. Early Psychosis
4. Mental Health

III. SUMMARY OF PROPOSED RESEARCH

Provide a brief but complete description, in non-technical language, of the purpose, objectives and research questions of the project. Use no more than one page.

A. Purpose – [Why are you conducting this research?]

Peer support is considered a complex intervention and thus, is suitable for a rapid realist review (RRR). Peer support has gained momentum in the mental health area and our local health authority is interested in implementing peer support as an intervention. The early psychosis intervention area is being targeted for research due to its smaller scope of age, for 19-35 years of age, and for its smaller program size. This area has not been reviewed from a realist review perspective and a RRR approach provides a foundation for future research from this perspective.

B. Objectives – [What do you hope this research will accomplish?]

The study will explore the research question using a Rapid Realist Review approach which will provide a foundation of study into peer support for the early psychosis population including recommendations to move forward in this area if it is found to be a helpful intervention.

C. Research Questions:
Request for Ethical Review
For Research Involving Humans

The study will examine how, why, for whom and in what contexts and to what extent peer support (if at all) contributes to recovery outcomes for people with first episode psychosis.

IV. SUMMARY OF METHODOLOGY AND PROCEDURES
Provide a brief but complete description, in non-technical language of the methodology and procedures. Use no more than one page.

Note: Attach to this application a copy of your questionnaire, interview guide, survey, test instrument, or other research instrument (for each method). If any instrument, informed consent, or letter of invitation is incomplete; or if you plan to finalize your instruments after you begin your research, then please submit your “best draft”. When your final instrument is available, please submit it to your faculty Project Advisor or Academic Supervisor for approval. Your Supervisor will forward your final version to the RRU Research Office to add to your file. If there are significant changes between initial and final submissions, approval may be required from the REB or from the appropriate subcommittee that monitors amended submissions, or you may be asked to resubmit a Research Ethics Request Amendment (see Section VII. Research Project Details, Part D).

Attached: interview questions, letter of invitation and informed consent form

Methodology:
I will be utilizing a rapid realist review method which will include a qualitative method approach with 3 subjects in a semi-structured interview. The realist research cycle of theory, refinement and development will start with the recommendations informed by the literature review and will be recorded in the form of context-mechanism-outcomes (CMOs) as per a realist review approach. Finally, I will be using the lens of trans-theoretical model of change theory as it will apply to both person and organization. The following seven steps are outlined to describe the research design of a realist review: First, the scope of the review is targeting peer support interventions for the FEP population. The purpose will identify efficiencies for recovery oriented outcomes for the approach. In addition, the local health authority is interested in viewing the results to inform local practices. Key theories surrounding the efficacy of peer support will be identified and explored. Second, I will conduct a thorough review of grey and academic peer reviewed literature to explore the research question. Third, I will limit search terms to set parameters on the study and they will include “peer support for early psychosis” “peer support for first episode psychosis” from peer
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support leads in Canada in accordance with rapid realist review protocol. I will use a
standardized open-ended interview technique with managers of three early psychosis
programs that use formalized peer support. I will use this technique as it is a fast
method of gaining information that can be compared and analyzed. Through an
opportunity sampling method, three prospects will be identified through a scan of
existing programs in Canada, Australia, and the United Kingdom. These countries have
been selected because they have demonstrated evidence development in this area and
speak English. A list of nine prepared questions will be circulated to the three
interviewees and a forty-five minute appointment will be made to discuss the questions
over VOIP with a recording function to aid in transcription. The transcripts will be
included in the thesis appendix. Each participant will be offered a copy of my
completed thesis. Fourth, I will select information from the materials using an iterative
approach, specific to realist review design. Fifth, I will integrate program theory
findings. Sixth, I will make recommendations geared toward implementing peer
support for the FEP population. Finally, I will share the finding with interested
stakeholders.

V. DESCRIPTION OF POPULATION

A. How many participants will be required for this study? What is the total
sample size?

As there are few peer support programs for those experiencing early psychosis, I will select 3
sites and interview the coordinator or manager. The total sample size is 3.

B. Who will be recruited and what are the criteria for their selection? (Justify any
exclusion of research participants on the grounds of attributes such as race, sex,
age, culture, race, and mental or physical disability).

The interviews will target professionals in managerial or program coordinator role of the early
psychosis peer support program. I will not be targeting service recipients in this study as I am
hoping to gain a perspective from management position. I hope that my future study work will
include direct service user perspectives and/or peer support workers.
Request for Ethical Review
For Research Involving Humans

VI. RECRUITMENT AND WITHDRAWAL
Provide a brief but complete description, in non-technical language, of the purpose, objectives and research questions of the project (Use no more than one page).

A. How will the participants be recruited?

☐ By letter (enclose a copy)
☒ By telephone or other online electronic medium? (Complete the Telephone or Online Electronic Contact Form)
☐ By advertisement, poster, flyer (enclose a copy)
☐ Other (explain):

B. How and when are participants informed of the right to withdraw?

The participants will be informed of the right to withdraw in the initial recruitment contact by phone or email. They will also be informed in the letter of introduction and as part of the consent form. Finally, I will provide a reminder of the right to withdraw at the outset of the interview.

C. What procedures will be followed for participants who wish to withdraw at any time during the study?

I will advise the person that they have the right to withdraw without consequence. If records have been created from the contact with the person, they will be destroyed by shredder if in hard copy, or deleted from my electronic files. I will thank them for their interest in the study and offer to provide a copy of my thesis for their interest at no cost to them.

VII. RESEARCH PROJECT DETAILS
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A. Where will the project be conducted?
The project will be conducted through electronic means from my personal residence at 1-1327 Arm Street. I will conduct my VOIP (i.e WebEx) interviews from home.

B. Does your sponsoring organization (or any of the organizations involved in your research) require an ethical review in addition to the RRU review?
I do not have a sponsoring organization.

C. Conducting Research Outside of Canada:
   a. Research conducted outside Canada may require additional (formal or informal) approvals. Have you addressed this requirement?
      Yes ✘ No ☐ N/A ☐

      If such approvals are required, please describe your intended process:
      I will be interviewing persons in Canada, Australia and England. No vulnerable person will be interviewed, as such, denotes a low risk to the study.

   b. If applicable, describe cultural, political, and/or legal differences that are likely to create a challenge in your study and how you plan to address them. (For example, how will you respond if participants abroad depart from the common interpretation of the Tri-Council Guidelines in their understanding of applicable research ethics?)
      I believe there will be minimal differences considering the three countries are developed countries, share similar approaches to mental health services and are Anglophone.

D. Is this an amendment of a previously approved protocol?
   Yes ☐ No ✘ Date of previous approval:

VIII. INVOLVEMENT OF ABORIGINAL INDIVIDUALS OR COMMUNITIES
Will the research involve aboriginal individuals?
   Yes ☐ No ✘

If yes, do any of the following statements apply? (Provide a brief
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Explanation and indicate how approval of the community as a whole will be obtained.

- Property or private information belonging to an aboriginal group as a whole will be studied or used.
- Leaders of the group will be involved in the identification of potential participants.
- The research is designed to analyze or describe characteristics of the group.
- Individuals are selected to speak on behalf of, or otherwise represent, the group.

IX. FREE AND INFORMED CONSENT

Evidence of free and informed consent by the participants or by authorized third parties should ordinarily be obtained in writing. (See Checklist for Consent Form and include a copy of the Consent Form or other document with which you will obtain consent in writing). Obtaining informed consent from your research participants is mandatory; however, the method by which the informed consent is obtained may vary. For example, on a survey form a preface or a preamble could include the same information found in a consent form.

A. Have you included, attached to this "Request for Ethical Review," a sample consent form for each method in this research?

   Yes ☒   No ☐

   If no, document the procedure by which free and informed consent will be obtained.

B. Will the participants face any impediment to giving free and informed consent? (Consider physical or mental condition, age [e.g., under 18], language, incarceration or other barriers.)

   Yes ☐   No ☒

   If "Yes", please provide details [e.g., for minors, two signatures are required: one from the participant and one from the legal guardian.]

N/A
C. Research Involving Vulnerable Participants

The Criminal Code of Canada Section 122 (1) Subsections 6.3(1) defines a vulnerable person as “a person who, because of his or her age, a disability or other circumstances, whether temporary or permanent,
(a) is in a position of dependency on others; or
(b) is otherwise at a greater risk than the general population of being harmed by a person in a position of trust or authority towards them.”

As a Canadian university, Royal Roads University abides by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans and the Canadian Laws protecting potentially vulnerable participants. As a RRU sanctioned researcher, if you involve participants under 18 years old or other vulnerable persons, you will be subject to a Vulnerability Sector Search.

**VULNERABLE SECTOR SEARCH**

A VS search is initiated by the local police in the jurisdiction where you live. The police will use the Canadian Police Information Centre (CPIC) system as well as their own database to conduct a background search based on your name, gender and date of birth. If your gender and date of birth match a pardoned sex offender record, you will be asked to provide fingerprints to confirm your identity. ([http://www.rcmp-grc.gc.ca/cr-ct/vuln/index-eng.htm](http://www.rcmp-grc.gc.ca/cr-ct/vuln/index-eng.htm))

In BC, the VS Search is accomplished through a Criminal Records Check – Children and Vulnerable Adults, as mandated by the BC Criminal Review Act ([http://www.pssg.gov.bc.ca/criminal-records-review/index.htm](http://www.pssg.gov.bc.ca/criminal-records-review/index.htm)).

RRU International students resident and/ or conducting research overseas with vulnerable populations are also required to provide their supervisor with a criminal records check on themselves from their country of citizenship and from their resident location (if this differs from their country of citizenship). **Please note: if you feel this requirement poses a risk, you should discuss your concern with the Research Ethics Office before proceeding ([ethicalreview@royalroads.ca](mailto:ethicalreview@royalroads.ca)).**
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☑ I do not plan to involve Vulnerable Participants in my research (or practicum)

OR

☐ I intend to involve Vulnerable Participants in my research (or practicum); and I have reviewed the RCMP information on Vulnerable Sector Search, the BC Criminal Review Act as it pertains to the process for Criminal Records Checks in BC, and the specific offences that will be subject to review.

☐ I have already completed a Criminal Record Check (Please provide a copy to your supervisor/advisor)

☐ I have applied for a Criminal Records Check – Children and Vulnerable Adults. Researchers can find the link at http://www.pssg.gov.bc.ca/criminal-records-review/apply/index.htm. Or I have applied for an equivalent Vulnerability Sector Search through my local police force.

☐ The costs of the Vulnerability Sector Search/Criminal Record Checks are my sole cost as the researcher (check to confirm understanding).

☐ The results of the Vulnerability Sector Search/Criminal Records Checks will be provided to my Project Advisor/Academic supervisor and Program Head before any human interaction with Vulnerable Persons is undertaken (check to confirm understanding).

Note: If a criminal record is found, your research proposal will be reviewed. This may result in (1) denial of your proposed research, (2) limitations imposed on your Research’s methods or scope, or (3) imposition of additional specific conditions set by RRU and the Academic Supervisor.

X. RISKS

A. Does the research in your view conform to the standard of “minimal risk”?  

“Minimal Risk”:

“For the purposes of this [TCPS] Policy, “minimal risk” research is defined as research in which the probability and magnitude of possible harms implied by participation in the research is no greater than those encountered by participants in those aspects of their everyday life that relate to the research”. [Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010, p. 23]

Yes ☑ No ☐

If no, please explain how it exceeds minimal risk.

N/A

B. Describe the potential and anticipated risks of the proposed research.

N/A
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C. What inducements (monetary or otherwise) will be offered to prospective participants? If payment is to be made, provide details such as amounts and payment schedules.

No payment will be offered to participants. There is an offer to provide a completed copy of the thesis.

D. How much time will a participant be expected to dedicate to the project?

45 minutes to 1.5 hours

XI. BENEFITS

A. Benefits to Researcher:

I will be contributing to the fields of peer support and early psychosis intervention. I will also be seeking completion of the thesis for requirement of a Masters degree.

B. Benefits to Participants:

Participants will be provided with a copy of the completed thesis which may be of benefit to their current and future work.

C. Benefits to Sponsor:

N/A

D. Benefits to Society:

There is little research on peer support from a realist perspective in particular for the early psychosis population. This study will be a contribution to the field of work. It will also help provide some recommendations and perspectives of peer support for the local health authority to review and use for their program development. It is my hope that it will benefit people experiencing early psychosis and the contexts in which peer support is provided. An integrated
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Knowledge translation approach, with specific information on users, is being used. I hope to publish my results in the Canadian Journal of Community Mental Health and/or Implementation Science.

<table>
<thead>
<tr>
<th>XII. PRIVACY, CONFIDENTIALITY AND ANONYMITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. For some researchers, depending on the nature of your research, your client/sponsor or the sponsoring organization will require you to sign a research privacy agreement. The responsibility is yours to ensure that your research adheres to all privacy legislation and regulations in the jurisdiction where you will conduct your research. Please check with your client/sponsor or sponsoring agency, to see if they will require a research privacy agreement.</td>
</tr>
</tbody>
</table>

**Does your client/sponsor require a research privacy agreement??**

| Yes ☐ [Skip to XII.b] | No ☑ |

If “No”, have you completed some other form of agreement to protect the personal information of participants?

| Yes ☑ | No ☐ |

If “Yes”, please describe the agreement.

I have provided an anonymity clause in the introduction letter and consent form.

If “No”, please describe how you have explained to your client/sponsor the RRU and Tri-Council Guidelines for maintaining participant confidentiality:
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B. Will the project obtain private information from research participants? (For example, will names linked to opinions, views, etc. be collected?)

Yes ☒ No ☐

By marking "No" you confirm that you will obtain information only from public sources (e.g., publications from Statistics Canada).

If "Yes", please describe "a" through "f" below and respond to "g":

a. The type of information you will collect.

I will be interviewing research participants for their opinions and views from a realist perspective on successes and challenges of peer support programs for the early psychosis population.

b. The purpose for which the information will be used.

The information will be used to explore peer support from a realist perspective to help isolate context, mechanisms and outcomes while seeking commonalities and differences among them. The interviews will be themed and compared to the literature base obtained from subject matter experts to inform my study.

c. The limits in place on the use, disclosure and retention of the information.

Study records will be used for the purpose of this research project. The interview transcripts will not be included in the final published paper to maintain confidentiality. I will maintain my interview records for up to 5 years and will dispose of the material by shredding if in hard copy and I will delete electronic material by that point in time. The interviewees direct views and opinions will remain anonymous but I will thank them for their contribution of time in the study.

d. The safeguards in place for confidentiality and participants' security (Note: If you warehouse data on US servers or a subsidiary of a US company manages your information you should notify your research participants that US authorities are legally entitled to access that information under the Patriot Act. Typically, this can be done in the Request for Informed Consent document).

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The interviews will be kept on a password protected computer. Transcribers will have access to the interviews and will maintain confidentiality of the participant interviewees. Transcribers will sign a confidentiality agreement.

e. Any media you may collect such as photographs, videos or sound recordings that allow identification of particular participants.

I will be using a VOIP method such as WebEx to conduct the interview and create an audio recording. The audio recording will be destroyed after the transcripts are completed and reviewed by the interviewee, with opportunity to comment or revise as desired by the interviewee. Follow up interviews if needed, will follow the same process.

f. Any anticipated linkage of your research data with other participant data in public or personal records.

There is no anticipated linkage of my research data with other data in public or personal records.

g. Do you plan the secondary use of individually identifiable data that you gather for: (1) non-research purposes, such as a journal article or conference presentation, or (2) as part of a subsequent research project?

Yes ☐ No ☒

If yes, please describe the following:

i. Why individually identifiable information is essential for this secondary use;

ii. What measures you will take to protect the private information of individuals;

iii. How you will obtain informed consent from those who contributed the data or from authorized third parties.
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XIII. FEEDBACK TO PARTICIPANTS AND DISSEMINATION OF RESEARCH

Participant Deception:

Does your research involve deception of your participants regarding the true nature of your research?

☐ Yes. Explain how and why this will be done.

☒ No.

If yes, will the participants deceived in your research be debriefed, and, if so, how and when will this take place?

Debriefing refers to the full disclosure of the research purpose and other pertinent information to participants who have been involved in research employing partial disclosure or deception. In other words, the study requires some degree of deception or omission so that the participants are not aware of the true nature, or all of the true nature, of the study. In such cases, debriefing is typically done after participation has ended, but may be done at any time during the study.

☐ Yes. Explain how this will be done.

☐ No. Explain why not.

XIV. RESEARCH DISSEMINATION

Please describe your process for reporting research findings and recommendations back to your participants and to key stakeholders in your research.

I will provide a copy of my thesis to the research interviewees and subject matter experts who provided the material for the literature review to thank them for their time.
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will also provide a copy of my thesis to the local health authority for their review and
consideration. The thesis will be provided electronically for their use.

XV. COMPLIANCE

I understand that the Royal Roads University Research Ethics Board may request from
me my research documentation and my research results to demonstrate compliance
with RRU Research Ethics Policy and to demonstrate my compliance with my
approved Request for Ethical Review.

Please check here to confirm acceptance: ☑

XVI. SIGNATURES

For electronic submissions, the researcher’s supervisor/advisor can email his/her
approval to ethicalreview@royalroads.ca or fax the signed signature page, attention
Research Ethics Coordinator, Office of Research, to 250-391-2500.

All applicants:
Principal Investigator

Co-investigator

If student:
Faculty Project Advisor/ Academic Supervisor

Date

Date

Date
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If faculty member or other:

Dean ___________________________ Date __________

Where the Dean is the Principal Investigator, or where the subject of the Research is an individual, program, or department within RRU the signature of the Vice President Academic is required.

Vice President Academic ___________________________ Date __________

APPENDICES

Checklist for Consent Form

Researchers can obtain free and informed consent by various means, such as having participants sign a Consent Form; by an explanatory letter accompanying a questionnaire; or by an introductory statement (preamble) at the beginning of a questionnaire. Whatever means is used, the burden is on the researcher to ensure that the participants understand what they are being asked to do and are giving their free and informed consent to participate in the project. The participants should retain a copy of the Consent Form (or other document) for their reference. You should convey the following information to participants. (Regardless of the means you use to obtain consent, please check each item on this form as you address it.)

☑ Give the title of Project.
☑ Identify the researcher and the University affiliation. Include contact name and telephone number for the Faculty Supervisor and/or School Director.
☑ Invite the individual to participate in a research project.
☑ Provide a clear statement of the research purpose.
☑ Describe the nature and duration of the participant’s involvement.
☑ Describe the nature of questions you will ask, especially if sensitive questions will be asked. (You can place warnings in the body of the interview itself.)
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Indicate how you propose to deal with sensitive items, if any, in your interview.

☐ State how you will record the information.
☐ Provide a statement about protection of privacy, confidentiality and anonymity.
☐ Describe any foreseeable harms and benefits to the participant, including any financial costs or benefits and/or inconveniences.
☐ Disclose any and all conflicts of interest.
☐ Assure prospective participants they are free not to participate and have the right to withdraw at any time without prejudice to pre-existing entitlements.

These assurances (which may come from third-parties) address conflict of interest issues. They apply especially to:

a. Students: Whether they choose to participate or not will have no effect upon their grades and standing.

b. Employees: Whether they choose to participate or not will have no effect upon their employment or advancement.

c. Public: Whether they choose to participate or not will have no effect upon medical care or services they receive or will receive, if applicable.

d. Dependent populations (e.g. prisoners, others in institutional settings): Whether or not they choose to participate will have no negative consequences.

☐ Address the possibility of any commercialization of research findings, and the presence of apparent, actual or potential conflicts of interest on the part of researchers, their institutions or sponsors.

☐ Offer to answer any questions before proceeding.

☐ Offer the name and telephone number of a person who can verify the authenticity of the research project. Investigators should provide a contact outside the research group if potential respondents request it.

☐ State that if the participant completes and submits an online or paper questionnaire, it is assumed that consent has been given.

☐ Describe how the research results will be published and how participants will be informed of the results of the research.

☐ If appropriate, have the participant or authorized representative sign and date the document.

The following statements relate to participant anonymity and record confidentiality. Please check those that apply to you and respond where requested.

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- The use of code numbers or pseudonyms to identify the results obtained from individual participants will protect anonymity.
- The participant's name will not appear on any final documentation (whether the report is published or unpublished).
- Any data collected will remain confidential; interview results and questionnaires will be kept in a locked cabinet.
- Loss of anonymity will occur for participants in a focus or discussion group, however, the researcher will still maintain participant confidentiality in any report.
- Only specified individuals will have access to raw data or identifying information.
- There is a record retention plan for this project. (If so, describe what will happen to all records and documentation once the study is complete (e.g., they are destroyed or archived). Describe when this will occur (e.g., immediately or after a certain number of years).
- In the event a participant leaves the study prematurely, there is a plan for handling that participant's information. (If so, describe what will happen to their information if a participant withdraws early? Note: with large-group data-gathering methods participants may leave the group, but their previously recorded comments remain in the data set as these comments cannot be separated out of a group recording)

The following statements relate to the audio, video, or photographic recording of participants. Please check those that apply to you and respond where requested.

- The researcher will secure the participants' permission for disposal of media and will specify how and when this will occur.
- A participant has the right to decline electronic recording. In this case the researcher may seek the participant's agreement for a different, anonymous data collection method.
- The media from this research will be further used after the project is completed. Additional permission is required if recordings, transcriptions of recordings, or photographs are used after the research is completed (e.g., in a public exhibition). Describe the required permission.

The following statements relate to participants who are not competent to give free and informed consent. If your research involves such participants, please identify their authorized representatives (e.g. parents or legal guardians), check the statements that apply to you and respond where requested.

- Describe how the free and informed consent will be obtained from the authorized representatives and how the participant's best interests will be protected.
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- Confirm (with check mark) that the authorized representative is not a researcher or any member of the research team.
- Describe how the continued free and informed consent of an authorized representative will be maintained during the course of the research activity, so long as the participant remains incompetent.
- If an individual understands the nature and purpose of the research, but full consent is not possible, describe how the researcher will attempt to ascertain the individual’s wishes.

*Note: If a participant becomes competent during the course of a project, his or her informed consent must be obtained as a condition of continuing participation.*

**TELEPHONE OR ONLINE ELECTRONIC CONTACT FORM**

The following statements relate to telephone or other electronically-mediated contact with participants. Please check those that apply to you and respond where requested.

- Initial contact with the participant is made by telephone or other electronic media. (Where such initial contact is made, if possible, please attach a text copy of your introductory words.)
- Contact with the participants in your project is solely by telephone or other electronic media. (This makes it impossible to obtain a signed record of consent, and necessitates a verbal, recorded consent.) If this is the case, indicate why you believe such contact is necessary to achieve your research objectives.
- Include a text copy of the proposed introduction for your telephone interview. Please check each item on the following list before submission to be sure your introduction covers as many of the normal consent items as possible.
  - Identification of researcher and the University affiliation.
  - Identification of fieldwork agency, if applicable.
  - Invitation to participate in a research project.
  - Clear statement of the research purpose.
  - Description of the nature and duration of the participant’s involvement.
  - Description of the nature of the questions to be asked, especially if there are sensitive questions. (Warnings may be included in the body of the interview itself. Indicate how you propose to deal with sensitive items, if any, in your interview.)
  - Statement about how information obtained over the phone will be recorded.
  - Description of measures for the protection of anonymity and confidentiality.
  - Description of any foreseeable harms and benefits.
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- Assurance that prospective participants are free not to participate. If they do, they have the right to withdraw at any time without prejudice to pre-existing entitlements.

- Statement on the possibility of any commercialization of research findings, and the presence of apparent, actual or potential conflict of interest on the part of researchers, their institutions or sponsors.

- Researcher's offer to answer any questions before proceeding.

- Offer to provide the name and telephone number of a person who can verify the authenticity of the research project. Investigators should provide a contact outside the research group, if potential respondents request it.

- Disclosure of any and all conflicts of interest.

- Description of how the research results will be published and how participants will be informed of the results of the research.

- Specific request for the participant's informed consent and willingness to proceed with the telephone or online interview.

- Indicate how interviewers are trained to answer respondents' questions.

ADDITIONAL APPENDICES
Please list (below) and attach all of the appendices of your Proposal, including your Letters of Invitation, Letters of Informed Consent, your Protocol and/or Questions for each method. Your documents should be presented in the sequence in which they would be used.

Introduction Telephone or Email Form

Letter of Invitation

Letter of Informed Consent

Interview Questions
Appendix 2 Peer Support Benefit and Cost

The following table provides the results of the six studies comparing benefit and cost ratio as presented by Trachtenberg (2013)

Table: Results of the six studies comparing benefit and cost ratio

<table>
<thead>
<tr>
<th>Study</th>
<th>Time period</th>
<th>Cost per peer support worker</th>
<th>Value of bed-days saved per peer support worker</th>
<th>Benefit: cost ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinman</td>
<td>6 months</td>
<td>£16,742.50</td>
<td>£142,989</td>
<td>8.54:1</td>
</tr>
<tr>
<td>Klein</td>
<td>6 months</td>
<td>£16,742.50</td>
<td>£41,679</td>
<td>2.49:1</td>
</tr>
<tr>
<td>Lawn</td>
<td>12 months</td>
<td>£33,485.00</td>
<td>£239,910</td>
<td>7.16:1</td>
</tr>
<tr>
<td>Rivera</td>
<td>12 months</td>
<td>£33,485.00</td>
<td>-£43,560</td>
<td>-1.30:1</td>
</tr>
<tr>
<td>Salzer</td>
<td>12 months</td>
<td>£33,385.00</td>
<td>£23,826</td>
<td>0.71:1</td>
</tr>
<tr>
<td>Sledge</td>
<td>9 months</td>
<td>£25,113.75</td>
<td>£130,018</td>
<td>5.18:1</td>
</tr>
</tbody>
</table>
Appendix 3 Summary of Studies: Peer Support and Hospital Bed Use

The following table provides a summary of studies giving data on peer support and hospital bed use by Trachtenberg (2013).

### Table: Summary of studies giving data on peer support and hospital bed use

<table>
<thead>
<tr>
<th>Author</th>
<th>Design</th>
<th>Sample Size</th>
<th>Study period</th>
<th>Nature of intervention</th>
<th>Estimated number of bed-days saved per full-time equivalent peer support worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinman et al., 2001</td>
<td>Non-randomized design; matched comparison group</td>
<td>Intervention group = 79; comparison group = 79</td>
<td>6 Months</td>
<td>Peer support provided after discharge from hospital, in order to prevent/reduce readmissions</td>
<td>433 over 6 months</td>
</tr>
<tr>
<td>Lawn, 2007</td>
<td>‘Before and after’ study; no comparison group</td>
<td>Intervention group = 230</td>
<td>12 months</td>
<td>Peer support service providing hospital avoidance and early discharge support to patients at risk of needing admission/re-admission</td>
<td>727 over 12 months</td>
</tr>
<tr>
<td>Sledge et al., 2011</td>
<td>Randomised controlled trial</td>
<td>Intervention group = 38; control group = 36</td>
<td>9 Months</td>
<td>Peer support service providing hospital avoidance and early discharge support to patients who have been hospitalised three or more times in the previous 18 months, in order to prevent or reduce re-admissions</td>
<td>394 over 9 months</td>
</tr>
<tr>
<td>Klein et al., 1998</td>
<td>Described in Pitt et al. (2013) as ‘quasi randomised’</td>
<td>Intervention group = 10; control group = 51</td>
<td>6 months</td>
<td>Peer support combined with intensive case management for dual diagnosis patients living in the community</td>
<td>126 over 6 months</td>
</tr>
</tbody>
</table>

(continued)
Table: Summary of studies giving data on peer support and hospital bed use (continued)

<table>
<thead>
<tr>
<th>Author</th>
<th>Design</th>
<th>Sample Size</th>
<th>Study period</th>
<th>Nature of intervention</th>
<th>Estimated number of bed-days saved per full-time equivalent peer support worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salzer et al., undated</td>
<td>Non-randomised design; matched comparison group</td>
<td>Intervention group = 106; comparison group = 378</td>
<td>36 months in study; data for first 12 months provided on request</td>
<td>Peer support combined with intensive case management for dual diagnosis patients living in the community who had been hospitalised at least once in the previous two years</td>
<td>72 over 12 months</td>
</tr>
<tr>
<td>Rivera et al. 2007</td>
<td>Randomised control trial</td>
<td>Intervention group = 70; control group = 66</td>
<td>12 months</td>
<td>Peer support combined with intensive case management for patients with severe mental illness living in the community</td>
<td>Increase of 132 days over 12 months</td>
</tr>
</tbody>
</table>