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What does a PeerTalk support group offer that other mental health services do not?

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1.0 Introduction

This report summarises a dissertation produced by one of Sheffield Hallam University's MSc student mental health nurses. Their project was a service evaluation to determine the benefits of a national charity's support for individuals experiencing depression. In particular, they sought to understand what the charity offered that differed from mainstream mental health services.

2.0 Background

2.1 Depression

Depression is a common and potentially serious psychiatric disorder that can have a detrimental impact on how individuals feel, think and act. Depression causes the highest disease burden of any single disease and is the second most common reason for admission to psychiatric hospitals (American Psychiatric Association, 2022, Beck & Alford, 2009).

The clinical symptoms of depression consist of hopelessness, unhappiness, losing interest in activities, anxiety, sleeping issues, loss of appetite, aches and pains, feeling mild to low in spirit, and suicidality (NHS, 2019). To be diagnosed with depression at least five variable symptoms proposed in the DSM-5 or ICD-10 must be evident with at least one occurring daily (Cullum, 2006, Fulghum Bruce, 2022).

2.2 Treatment

Treatment for depression can be viewed through a multi-modal, biopsychosocial lens. Medication is the mainstay of biological treatments. These medications are known as antidepressants and are thought to work by increasing the levels of neurotransmitters within the brain's synapses. However, antidepressants have not fundamentally changed since their accidental discovery over 50 years ago and many patients only experience partial and/or temporary remission with some going on to develop chronic depression (McLannahan, 2010, Sibillie & French, 2013).

Kirsch, 2019 completed a meta-analysis of the use of antidepressants for depression, comparing them to placebo, exercise, omega-3, homoeopathy, yoga and psychotherapy. The results found antidepressants to have the highest relapse rate, at 50%, compared to 33% for cognitive behavioural therapy, the placebo drug or psychotherapy. Given their higher relapse rates, together with side-effects such as suicidality, deep vein thrombosis, intracranial bleeding, pulmonary embolism, diabetes, epilepsy, and stroke; anti-depressants are clearly not without drawbacks.

Prescribers must therefore routinely weigh up their pros and cons, compared to non-pharmacological treatments, an exercise that has led to significant debate around the use of antidepressant medication. On the one hand, Light (2010) argues that it is fundamentally wrong to medicate people's spiritual, moral or behavioural troubles by simply defining them as a disease, assuming their biology to be defective, and seeking to alter it. Conversely, Cuijpers et al, (2014), claim that a mix of pharmacotherapy and psychotherapy is the best option to alleviate the signs and symptoms of depression and is more effective than antidepressants alone. The origins of these psychosocial (psychotherapeutic) approaches are often attributed to the work of Beck in the1950s. He argued that depression is a disorder where individuals' negative affect and self-defeating behaviours require logical analysis to examine cognition through talking therapy. This approach is reported to be equally efficacious to, and more enduring than, antidepressants (Hollon, 2022).

2.3 Peer support:

Social support has important links to health as Schurz et al (2021) state that human interactions are unusual in their intricacy, and that the amount and quality of our everyday interactions are crucial for our physical and mental well-being. The tight integration in individual groups and sense of community has been shown to improve resilience in times of adversity, boost the immune system, increase quality of sleep, and speed up tissue healing after injury. In contrast, individuals who find themselves to be socially isolated are more prone to cognitive performance decline, Alzheimer-related dementias, and premature mortality. The relationship between peer support and health was also discussed in the work of Boothroyd and Fisher (2010) who argued that social interactions have long been associated with health and wellbeing, with

considerable evidence of social support as a protective factor for depression, cancer to myocardial infarction and strokes.

A relatively recent psychosocial intervention modality is that of peer support, described as providing and receiving support based on key ideas of mutual respect, shared accountability, and mutual agreement about what is helpful. This non-professional, non-clinical assistance from people in similar situations can prove helpful in achieving long-term recovery from mental illnesses. There are three distinct types of peer support: informal, peer-led support, and peers employed within a service to provide support. Informal peer support is typically the ad hoc, informal support offered by family, friends, and neighbours. Peer-led support involves peers participating in consumer-run programmes alongside mental health services as opposed to the final type where peers with lived experience are employed and work within statutory services. These various types of peer support differ in a variety of ways including the number of people involved, the degree of choice, the norms regulating the connections and the extent to which peers are at the same point in their recovery journey (Repper et al, 2013). Regardless of the specific model, peers are credible sources of knowledge and role models for healthy behaviour. The strength of the peer support connection stems from the supporter's capacity to relate to the individuals they are assisting through shared life experiences, comparable ethnic, social, cultural, or socioeconomic backgrounds. Individual volunteers with experiential expertise and similar traits work to provide the peer with a sense of validation, normalisation of their experience, reduced social and emotional isolation, and to create a sense of belonging (Colella & King, 2004).

2.4 PeerTalk

PeerTalk is a nationwide independent charity organisation that hosts weekly volunteer-led peer support groups for individuals suffering from depression, anxiety, and other forms of psychological distress. By providing a forum for sharing and listening, as well as encouragement and, more significantly hope to those who attend, the charity seeks to increase attendees' awareness of depression and resilience. More broadly, they seek to combat the stigma surrounding depression by presenting information to other community groups about depression, encouraging good communication and supporting practises with people who have mental health

conditions (PeerTalk, 2022). Peer Talk is featured in Gijbel, Sapouna & Sidley's (2019) book: "Inside Out, Outside In" which highlights the importance of providing attendees with time and space, with open-ended support, and the idea that 'people start to heal the moment they feel heard'.

3.0 Aims

This study aimed to evaluate the PeerTalk charity's provision. Its objectives were:

- To gain an understanding of PeerTalk attendees' experiences and perspectives.
- To identify what PeerTalk offers its service users that other services do not.

4.0 Methodology

This study employed a qualitative approach, which was appropriate as qualitative research is a humanistic approach that enables the researcher to obtain data focused on participants' experiences and what peer support groups offer them. This could not have been obtained through quantitative measurement of variables alone (Pathak, Jena & Kalra, 2013).

Qualitative research is a broad umbrella term that encompasses a variety of designs, allowing for in-depth explorations of peoples' experiences through the use of a set of research methods such as life histories, biographies, in-depth interviews, focus groups, content analysis and observations. This philosophical approach enables the identification of issues from the participants' perspectives as well as an understanding of the meaning and interpretations that they give to behaviour or events in order to comprehend their experiences with illness or disability or their use of health or support services (Hennick, Hutter & Bailey, 2020). Furthermore, the qualitative paradigm provides meaning to individual experience showing how social phenomena work in real-time, meaning that it is a credible and rigorous approach (Silverman, 2016).

4.1 Research design

This study's overall design was that of a service evaluation, ideal when monitoring participants' perceptions of service quality. Because service quality comprises attendees' perceived values, contentment, and loyalty; providing high-quality services is a prerequisite for their success. Increased demand for healthcare, rising costs, limited resources, and a wide range of clinical interventions have prompted many health systems throughout the world to focus on assessing and improving service quality through service evaluation (Abbasi-Moghaddam et al, 2019).

4.2 Methods

4.2.1 Recruitment of participants

Following ethical approval by Sheffield Hallam University, an advertisement was circulated through numerous PeerTalk support groups asking, for volunteers. This convenience sampling sought to recruit participants with depression who had attended a PeerTalk group, due to their direct knowledge of the topic and ability to share and reflect on the experience of interest (Gill, 2020).

The sample was sent an invitation and information sheet written in plain English via the PeerTalk organisation. This included instructions that participants with any further questions about the research should contact either PeerTalk direct or the researcher via their email. Allowing for further questions made sure that the volunteers have all the information they required to give true consent. Participation was voluntary, and travel expenses were to be reimbursed by the charity if necessary. However, the study method was changed from face-to-face to conducting the research online and via telephone interviews due to a lack of initial volunteers.

4.2.2 Inclusion criteria

Volunteers were able to participate if they were: aged over 18 years of age, had attended a Peer Talk support group at least four times, identified themselves as having depression, regardless of any other demographics.

4.2.3 Exclusion criteria

Participants who had not attended more than four support group sessions were excluded as their experiences may have been limited. Under 18s were excluded due to the ethical issues arising when obtaining informed consent.

4.2.4 Consent

Whilst obtaining consent, it was made clear to the participants that if they chose to withdraw from the study, it would have no effect on the care or support they would receive from the PeerTalk. It was also explained that they could withdraw their consent (and data) up to two weeks post focus group, after which the analysis would have commenced. Consent was re-confirmed verbally at the beginning of the focus group session and the telephone interviews.

4.2.5 Data collection

The data collection was carried out through three participants attending an online (Zoom) focus group and two individual telephone interviews. The questions used in both were bespoke to PeerTalk, and comprised open-ended, semi-structured questions which were specifically designed for this project (see appendix). Semi-structured questions were suitable for this study since they are comparable to conversations, allowing for a more natural flow of the interviews with no pre-set responses. Semi-structured questions can also encourage rich descriptions through reports of experiences and perspectives on a phenomenon, in addition, they allow for the questions to be answered spontaneously and in-depth. (Baumbusch, 2010).

Advances in communication technology provide new avenues for conducting qualitative research. The online focus group was conducted via an electronic video conferencing service known as zoom which has various features that increase its appeal for qualitative researchers. On the day of the focus group, participants were all sent a zoom invitation via email. Introductions were given, and participants were offered a final opportunity to ask questions. Consent was verbally confirmed to ensure participants still wished to go ahead. The focus group was transcribed verbatim. As a number of the participants spoke with strong regional accents, transcribing technology may have had difficulty interpreting what was being said therefore, a manual transcription method was chosen.

Compared to face-to-face research, with participants spread across a large geographical area, the cost, efficiency, flexibility, and convenience of online interviewing means that online methods can replicate, complement, and possibly improve upon traditional methods. Whilst this type of data collection requires technological and logistical requirements to participate, it can yield high-quality data under appropriate conditions, making it a productive mode of data collection comparable to face-to-face. However, the use of modern technology may mean participants choose to opt out of studies unless other forms of participation can also be considered (Archibald, et al 2019, Kee & Schrock, 2019, Lobe, Morgan & Hoffman, 2020, Oliffe et al, 2021).

With this in mind, participants were offered the choice of an online focus group or a 1:1 telephone interview. Three participants requested telephone interviews however, one subsequently withdrew. An initial call was made to the volunteers to establish a convenient time and day for the interview to be conducted. The telephone interviews lasted around 30-40 minutes. The conversation began by reminding participants that they did not have to answer any questions that made them feel uncomfortable and could just state the word pass. The open ended, non-directive questions were not asked in any specific order, as the researcher felt this did not fit with the narrative of the flowing interview conversation. Calls were not audio recorded, instead the researcher took handwritten notes verbatim to the responses that were given by the participants, these notes were then written up following the interviews.

According to Novick (2008), telephone interviews are infrequently used in qualitative interviews because they are frequently portrayed as a less appealing option to face-to-face questioning. The absence of visual clues over the phone is thought to result in a loss of contextual and non-verbal data, compromising rapport, probing, and answer interpretation. However, telephone interviews may make respondents feel more relaxed and comfortable disclosing sensitive information, and there is no empirical evidence that they yield lower-quality data.

4.2.6 Data analysis

Thematic analysis was the chosen method of analysis with themes generated inductively rather than pre-determined ones being tested deductively. Thematic

analysis provides insight beyond statistics. Its flexibility of interpretation creates its transparency, promoting trust in the findings of the research (Castleberry & Nolen, 2018).

Analysis of the data was undertaken in six stages (Fereday & Muir-Cochrane, 2006). The first stage was the development of a code guidebook so that codes could be identified by name, definition, or description. Secondly; the reliability of the codes was tested against the raw data to ensure applicability. Thirdly, the data was summarised, the key points outlined. The fourth stage identified meaning entities, with the fifth identifying patterns and themes from the data. Lastly, the sixth stage was to legitimise and corroborate the coded themes by looking at the overarching themes that were thought to capture the phenomenon.

Braun & Clarke, 2017 argue that thematic analysis is helpful due to its flexibility and that it will work well with anywhere from one to around 60 participants. They suggest it can identify patterns within and across data, from lived experiences, views, behaviours, and patterns perspectives from interviews to focus groups to qualitative surveys and story completion (Clarke & Braun, 2017, Clarke & Braun, 2013).

5.0 Ethical issues

This project adhered to Beauchamp and Childress' (2009) four principles of biomedical ethics theoretical framework of autonomy, beneficence, non-maleficence, and justice. This was confirmed by completion and approval of a UREC 2 application form which outlined safeguards such as the availability of PeerTalk facilitators to support anyone who became distressed during the focus group.

6.0 Results

Four themes were generated from the data. These were: connectedness, self-awareness, positive environment, and facilitation.

6.1 Connectedness

Connectedness describes a relationship with peers and PeerTalk. Peer support is designed to establish a sense of physical and emotional security, allowing peers to feel at ease connecting and sharing with others with the same knowledge and experiences. The positive interactions discussed by participants demonstrate how comparable experiences make attendees more credible role models and the perfect individuals to establish a connection and a feeling of normality. In terms of connectedness with the PeerTalk service, the participants stated that they had previously tried other services for support but found that PeerTalk offered the different kinds of help they required:

> *I did use other services, I was actually at EA as well, but that was quite different in some ways I actually stuck with PeerTalk I didn't stick with EA and that's my personal preference (Participant 2)*

> *I was there like five minutes early, say, and I could tell that, that like the rest of the group, knew each other but they're friendly, not clicky. And I was like, oh, I think I like this (Participant 1)*

> *There's a lot of things that I had implemented, but I do find PeerTalk, its different and helpful (Participants 1 and 4).*

The discussion went further when a participant gave their personal experience of the connection to PeerTalk and their peers and how it worked for them when they said:

> *It was strange how on the second week, I talked about something totally different, and I didn't even realise it was something that I needed to talk about, but I was clearly so relaxed in that room that it came out (Participant 2).*

> *One person speaks at a time, it's really more of like you sit around in a circle and have a cuppa (Participant 2)*

There was a strong emphasis on the connections that the participants had built with one another. Relationships were founded on empathy and mutual respect; bonds were formed (through the facilitation of PeerTalk support groups) that showed a special connection in that participants showed concern for the welfare of their peers:

And we do sort of ask, obviously, ask how each other are doing (Participant 1)

You can tell when people are having good and bad days (Participant 4)

There's one or two people I would class as friends there it's not that I see them outside that setting; it's just that I care about them, and there's this person, and there, like maybe, trying to do the maths but there's a good age gap between us, and on paper we don't have a lot in common, but if a don't see that person for a few weeks, I will get concerned, I do wanna know that there all right (Participant 2)

PeerTalk clearly leaves participants feeling at ease, in a safe, relaxing environment with like-minded people that share their experiences. In doing so it creates a sense of connection to the service that other services may not achieve.

6.2 Self-awareness

Participants explained how they felt PeerTalk assisted individuals through a process of self-healing, towards recovery, that was undertaken by acquiring self-awareness of their current situation:

I need to process my thoughts, people when they discuss, they also organise their thoughts, their memory Yeah So, it's really important to have. (Participant 2)

PeerTalk provides attendees with the chance to build their confidence by talking openly about their issues in a non-judgemental environment and eradicating their initial fears as they move through the support sessions. This self-awareness allows for personal growth and sets attendees on the road to recovery:

First time I went, I wasn't sure why exactly I was going. And I didn't even know what I what I wanted even to talk about. So, I went there, and they couldn't shut me up (Participant 1)

Finally, several participants noted the impact of Peer support on their lives became most apparent if they missed a session:

I certainly notice the difference when I don't attend, I sort of get caught up in everything else (participant 2)

I definitely notice when I don't have an outlet (participant 3)

6.3 Positive environment

The PeerTalk environment was described as providing the right environment to support healing by facilitating people to work through their issues with like-minded people who also have shared experiences. The therapeutic environment was highly valued for the way it fostered recovery:

> *It helps me to examine some situations desensitised from them see it from a completely different cultural point of view, which is extremely enriching. Like having a different perspective and endpoint (participant 3).*
>
> *I liked PeerTalk because after I started talking about My mental health, or Depression, I should say I started to feel safe and I know that sounds crazy, but I felt I could talk more (participant 4).*
>
> *You share, and you are peers as you are really equal. And you can speak, and if you don't want to speak, you don't have to. And if you want to speak a lot, like I often do, then you're free to (participant 2)*
>
> *There's no pressure to talk (Participants 1,2 and 4)*
>
> *The power of the group can heal (participant 3)*

PeerTalk support groups offered attendees an opportunity to work with other peers in a safe environment as they go through some difficult periods. Participants discussed supporting others, using their knowledge and experience, while learning more about mental illness and other coping strategies themselves:

> *In being with others, you can really see people in situations you have been in yourself. It's an eye-opener but you offer support and guidance, and next week, you never know, it might be your turn to need the support. And I think by offering your coping strategies, they sometimes offer you some back what might work. (Participant 5)*

This discussion flowed into the giving and receiving of help and advice from someone without a title, an agenda, or a set of rules to follow. Participants valued the use of peers as support over some other services that had 'professionalised' their support:

> *Sometimes putting that professional stance on it, people would they open up as much, they feel relaxed because they're not on a time limit. And they have services you get, like, is it around six sessions? (Participant 3)*

Think to me experience, lived experience is as valuable as credentials. So, you know, I'm not really too fussed about the fact that there's not whatever title psychologists like, whatever the title, I'm not really that fussed about that. Like, it's not really, I mean, I'm not against the psychiatric model. But that's not really what I go for, you know, I'm going to be with people who have lived this (Participant 2)

I don't want it to turn into just another like, clinical setting (Participant 1)

Yeah, if you conventionalised it too much. Yeah, that will be a big problem (Participant 4)

Think people are making room and starting to realise the value of peer support and lived experience erm, so we just need to keep chipping away. I think that's all we can do, ya know. Me I do think lived experience is a lot more beneficial than any textbook read (Participant 2)

And like, not to be honest, a lot of what we want to say is about people who work in other services, we don't say by name, but like, a lot of what we're surviving or whatever is abuse by services, and by people. So, I don't know how much it would work on that level to have somebody there. Who, who sort of represents all that (Participant 2)

6.4 Group facilitation at PeerTalk versus other services

Participants discussed how and why they thought PeerTalk had worked for them where other services hadn't. PeerTalk appears to be getting things right, as participants felt that they offered the correct support at the right time with the right plans, procedures, and arrangements in place. This had not always been their experience in other services:

I approached PeerTalk for help it all happened really quick and if people are struggling, they should reach out and it beats the waiting times (Participant 4)

PeerTalk is a lot less formal and structured, there's no pressure to participate if you don't feel like it (Participant 5)

The staff that do the facilitating all seem keen and I think it's great that they give their time. I think there's something to it, I think it works. I think it has value (Participant 1).

They don't do any kind of therapy, just coordinate the whole thing (Participant 3)

Everyone can do what they're good at and everyone can have their role in contrast to professional way of working (Participant 5)

I think there's something to it, I think it works. I think it has value (Participant 1)

7.0 Discussion

The notion of **connectedness** (Theme 1) speaks to the literature which suggests that a sense of belonging leads to better psychological and physical health. Hendrick, Rosen & Aune's, (2011) study on international students found that students receiving support from other students felt more social connectedness, more satisfied, and more content with life. Keefe (2013) strengthens this argument, finding a sense of belonging to be a significant component that affects not only involvement but also retention in groups. Furthermore, creating a safe, caring group environment fosters a sense of belonging and is accomplished through the formation of positive relationships. Schurz et al (2021) and Boothroyd and Fisher (2010) made a direct link between receiving social support and good health. They found the amount and quality of everyday interactions are crucial for physical and mental well-being, as social support improves resilience in times of adversity, boosts the immune system, increases good quality sleep, and speeds up bodily tissue healing after injury. Furthermore, those with little or no social support are more prone to cognitive performance decline, Alzheimer-related dementias, and premature mortality. These findings are not new concepts, as social interactions have been associated with health as far back as the 1970s. However, with the rising rates of mental illness, and the limited services available, research into the use of peer support is increasingly necessary to mitigate the global disease burden of depression.

Research on the benefits of **self-awareness** (Theme 2) such as Miyamoto & Sono's (2012) literature review found that attendees of peer support groups gained increased confidence and became more outspoken as they developed a sense of identity and empowerment. Schwartz & Sendor (1999) argued that helping others also helps oneself. They found that peers felt a sense of reward in developing what was

described as an unexpected intimacy with peers, despite the burden of concurrently offering support. People's social status was also found to benefit after just six months, with the positive changes in the quality of life significant enough to be regarded as an adjunctive treatment for depression. Similarly, Dillon & Hornstein (2013) found that increased self-awareness had benefitted support group attendees by improving their confidence to speak out, to own their illness, to develop further understanding of their situation, and to be able to offer advice and support to others. This was evident in PeerTalk attendees who were often initially unwilling to disclose their experiences until their confidence grew.

Courtney et al (2022) work confirms the importance of a **positive environment** (Theme 3), finding that support groups offer enhanced safety / augmented coping in naturalistic environments. Burls (2008) particularly highlights importance of a positive environment for individuals previously marginalised and disempowered by their mental illness. This therapeutic milieu was certainly recognised by PeerTalk's attendees who discussed feeling a sense of safety and social embracement when sitting around having a 'cuppa'.

As far back as 1987, research emphasised role of the **facilitator** (Theme 4) in drawing out the expertise of group attendees (Dickel, 1987). Unlike many services, PeerTalk does not adopt a formal, time-limited approach with its facilitators simply being present, attentive, and supportive. This provides structure without creating a sense of pressure to talk or follow a rigorous therapy model (NHS, 2022). However, the precise mechanism through which peers support groups deliver their benefits remains uncertain. Boothroyd and Fisher (2010), and Schurz, 2012 posit that peer support provides a protective factor against serious health conditions and mitigates against cognitive decline. Other findings show that peer support groups enhance coping strategies, reduce social and emotional isolation, and provide a sense of belonging and security (Colella & King, 2004, Courtney et al, 2012). This service evaluation chimes with the literature, with participants describing a sense of belonging, a reduction of social isolation, a sense of connection, a feeling of safety, and the confidence to be open with one another. Clearly though, more research into this is warranted.

Whilst this study makes an important contribution, it is not without limitations. Firstly, as this research is a service evaluation and lacks a control group, its findings are not generalisable to other services. Moreover, even for a qualitative study, the number of participants is small, making bias a potential issue (Macpherson et al, 2017). Finally, some of the male participants may have struggled to open up about their experiences for fear of being perceived (by a female researcher) as vulnerable, weak, or unmasculine (McKenzie, 2018).

8.0 Conclusion

Depression is a leading global cause of disability. In the UK, this well-documented and growing burden is being compounded by cuts to statutory mental health services. Against this backdrop of growing demand and diminishing availability of mental health services, alternative, evidence-based interventions are urgently needed (Freidrich, 2017). This study found clear benefits for participants attending a PeerTalk support group. Its relaxed environment allowed for candid and free communication to take place between equals. Meaningful friendships were formed as a result of similar shared experiences giving the participants the confidence to speak out, recognise their own recovery styles and assist others on their journey in a non-judgemental manner. Participants favoured PeerTalk over many other services they had tried due to its relaxed nature, the absence of pressure to participate, and the provision of support from peers rather than healthcare professionals. Consequently, this study tentatively concludes that peer support groups such as PeerTalk should be considered as worthwhile interventions in their own right, rather than merely a way to reduce pressure on mainstream services.

9.0 References

Abbasi-Moghaddam, M.A., Zarei, E., Bagherzadeh, H., & Farrokhi, P. (2019). Evaluation of service quality from the patient's viewpoint. *BMC Health Services Research,* 19(1), 1-7.

American Psychiatric Association. (2022). What is Depression? Retrieved from https://www.psychiatry.org/patients-families/depression/what-is-depression

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using zoom videoconferencing for qualitative data collection: perceptions and experiences of researchers and participants. *International journal of qualitative methods*, *18*, 1609406919874596.

Baumbusch, J. (2010). Semi-structured interviewing in practice-close research. *Journal for specialists in pediatric nursing*, *15*(3), 255.

Beauchamp, T.L., Childress, JF. (2009). Biomedical ethics 6th ed. New York Oxford: Oxford University Press.

Beck, A.T., & Alford, B.A. (2009). *Depression: causes and treatment*. University of Pennsylvania Press.

Burls, A. P. (2008). Seeking nature: A contemporary therapeutic environment. *therapeutic communities*, *29*(3), 228-244.

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data: is it as easy as it sounds? *Currents in pharmacy teaching and learning,* 10(6), 807-815.

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. The psychologist, 26(2).

Clarke, & Braun, V. (2017). Thematic analysis. The Journal of Positive Psychology, 12(3), 297–298. https://doi.org/10.1080/17439760.2016.1262613

Colella, T. J., & King, K. M. (2004). Peer support. An under-recognized resource in cardiac recovery. *European Journal of Cardiovascular Nursing*, *3*(3), 211-217.

Courtney, J.A., Langley, J.L., Wonders, L.L., Heiko, R., & LaPiere, R. (Eds.). (2022). Nature-Based Play and Expressive Therapies: Interventions for Working with Children, Teens, and

Cuijpers, P., Sijbrandij, M., Koole, S. L., Andersson, G., Beekman, A. T., & Reynolds III, C. F. (2014). Adding psychotherapy to antidepressant medication in depression and anxiety disorders: a meta-analysis. *Focus*, *12*(3), 347-358.

Cullum, S., Tucker, S., Todd, C., & Brayne, C. (2006). Screening for depression in older medical inpatients. *International Journal of Geriatric Psychiatry: A journal of the psychiatry of late life and allied sciences*, *21*(5), 469-476.

Dickel, C. T. (1987). Professional Facilitation of Support Groups: Necessary Attitudes and Knowledge.

Dillon, J., & Hornstein, G. A. (2013). Hearing voices peer support groups: a powerful alternative for people in distress. *Psychosis*, *5*(3), 286-295.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods*, *5*(1), 80-92.

Gill, S.L. (2020). Qualitative sampling methods. *Journal of human lactation,* 36(4), 579-581. https://doi.org/10.1177/0890334420949218

Hollon, S.D. (2022). Depression. *Cognitive and behavioural practice,* 29(3), 507-. https://doi.org/1016/j.cbpra.2022.02.016

Kee, K. F., & Schrock, A. R. (2020). Telephone interviewing as a qualitative methodology for researching cyberinfrastructure and virtual organisations. Second international handbook of internet research, 351-365.

Kirsch, I. (2019). Placebo effect in the treatment of depression and anxiety. *Frontiers in Psychiatry*, *10*, 407.

Light, D. (2010). The risk of prescription drugs. New York: Columbia university press. https://doi.org/10.7312/ligh14692

Lobe, B., Morgan, D., & Hoffman, K. A. (2020). Qualitative data collection in an era of social distancing. International journal of qualitative methods, 19, 1609406920937875.

Macpherson, R., Calciu, C., Foy, C., Humby, K., Lozynskyj, D., Garton, C., Steer, H., & Elliott, H. (2017). A service evaluation of outcomes in two in-patient recovery units. *BJPsych bulletin*, *41*(6), 330–336. https://doi.org/10.1192/pb.bp.116.055137

Miyamoto, Y., & Sono, T. (2012). Lessons from peer support among individuals with mental health difficulties: a review of the literature. *Clinical practice and epidemiology in mental health: CP & EMH*, *8*, 22.

NHS. (2022) Cognitive behavioural therapy. Retrieved from https://iapt.rdash.nhs.uk/about-rotherham-iapt/individual-therapy/cognitive-behavioural-therapy/

NHS. (2019). Overview- clinical Depression. Retrieved from https://www.nhs.uk/mental-health-conditions/clinical-depression/overview/

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research in nursing & health*, *31*(4), 391-398.

Oliffe, J. L., Kelly, M. T., Gonzalez Montaner, G., & Yu Ko, W. F. (2021). Zoom interviews: benefits and concessions. *International Journal of Qualitative Methods*, *20*, 16094069211053522.

PeerTalk, (2021). Find out more about Peer Talk. Retrieved from https://www.peertalk.org.uk/about-peertalk

Pathak, V., Jena, B., & Kalra, S. (2013). Qualitative research. *Perspectives in clinical research,* 4 (3).

Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R., & Rennison, J. (2013). *Peer support workers: Theory and practice*. London: Centre for Mental Health.

Schurz, M., Uddin, L. Q., Kanske, P., Lamm, C., Sallet, J., Bernhardt, B. C., & Bzdok, D. (2021). Variability in brain structure and function reflects lack of peer support. *Cerebral Cortex*, *31*(10), 4612-4627.

Schwartz, C.E., & Sendor, R.M. (1999). Helping others helps oneself: response shift effects in peer support. *Social science & Medicine,* 48 (11), 1563-1575.

Silverman, D. (2016). *Qualitative research* (5th ed). London: Sage Publications.

10.0 Appendix

Semi-structured interview questions:

- Why did you choose to attend the Peer Talk support group
- What aspects of Peer Talk did you find appealing
- What are the benefits of Peer Talk for you
- What are the benefits of Peer Talk in comparison to other mental health services (NHS)
- What if any, are the drawbacks of Peer Talk support groups
- What changes do you think are required by Peer Talk, if an? Would you like to see
- What advice would you give to future attendees of Peer Talk
- Has Peer Talk given you an insight into mental health conditions, services and support available
- Would you recommend Peer Talk to others