

Bridging the Gap: Towards a theory of peer-support worker integration within early intervention psychosis services

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ABSTRACT

Background: Peer Support Workers are increasingly recognised as integral components of person-centred care provision within mental health services globally, and their presence within early intervention services is expanding. The benefits that peer support workers provide are well established, but less is known about how to quickly and effectively integrate them within early intervention services to maximise their role.

Aim: This study explored barriers and enablers to effective implementation of peer support worker roles in early intervention services, through multi-stakeholder perceptions and insights involving service users, peer support workers, and clinicians.

Methods: A qualitative, multi-site study within an NHS Foundation Trust in the North-West of England was employed. Semi-structured interviews with 18 participants across the three stakeholder groups were conducted, with Normalisation Process Theory guiding the collection and interpretation of participant data to identify barriers and enablers. Data were analysed thematically using a six-phase, deductive approach.

Results: Four core themes and nine sub-themes emerged from collated participant data, providing context across Normalisation Process Theory constructs. The four core themes related to: *Navigating Uncertainty and Discovering Value, Building Engagement through Trust and Reliability, Structural and Relational Conditions Shaping the Functions of PSWs, and Recognising Impact in the Absence of Formal Structures.*

Conclusion: Effective integration in this context is underpinned by dynamic, relational factors. A theory of integration and logic model were developed to support policy and implementation efforts. These emphasise the need for comprehensive onboarding and evaluation mechanisms, and consideration of sustainability for these roles.

1. Introduction

Over the last two decades, peer support workers (PSWs) are increasingly working within mental health services, providing a unique, yet complementary aspect of care and support for individuals with mental health conditions (Mutschler et al., 2022). Traditional models of mental health care have focused on clinical remission, yet functional recovery remains a challenge for mental health services in improving individuals' overall wellbeing (McCartan et al., 2022). As experts with 'lived experience' of mental health challenges, PSWs are now shaping how mental health care is planned and delivered (Cooper et al., 2024,

2025), not only in recovery phases, but also early intervention services (EISs) for psychosis (NHS England, 2023). Despite this, the integration of PSWs into EISs remains underexplored in relation to factors which support or hinder the success of integration. Research which addresses this gap by investigating how PSWs can be effectively embedded within these services, via multistakeholder perspectives, is therefore warranted.

A typology of peer support work has recently been offered by Kotera and colleagues (2025), identifying 242 candidate components of PSW roles. These were thematically synthesised into 16 components and eight sub-components, and categorised under four themes: recruitment,

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preparation, practice, and PSW wellbeing. However, the authors' cautioned that the specific mechanisms which drive the success of these roles remain poorly understood and lack uniformity within and across settings. Elsewhere, qualitative findings involving mental health workers across five countries examined their attitudes toward peer support and the implications these have on successful implementation of PSW roles (Krumm et al., 2022). The authors found that while mental health workers were supportive of PSWs within their services, some hesitated over the idea of non-professionals offering support in clinical settings. In particular, there were some doubts about whether PSWs could give appropriate advice to service users and potential for negative role-modelling. As a result, PSW integration strategies are likely to be influenced by these perspectives.

Haun et al. (2024) examined mental health workers views a year and a half after implementation of PSWs across the same sites previously explored by Krumm et al. (2022). By this point, many described stronger relationships with PSWs and growing trust, though not all early concerns had disappeared. PSWs were valued for how their lived experience helped to build rapport with service users, but the extent to which PSWs were seen as team members was dependent on local context and the experiences mental health workers had with them. The authors recommended that implementation efforts for PSW roles should prioritise interaction between mental health workers and PSWs, and that a better understanding of contextual factors is needed to determine successful implementation of these roles. Previous systematic review findings specific to implementation factors identified role clarity, supervision, organisational culture, and management support as critical influences (Ibrahim et al., 2020), although it is unclear if any of the included studies focussed on EISs.

There is less literature specific to EISs, though the limited research is encouraging as to the benefits. White et al. (2017) examined the introduction of PSWs in a UK EIS team, noting improvements in service user engagement, team communication, and a possible reduction in untreated psychosis duration. Despite this, concerns about role clarity and professional boundaries were present which may affect successful PSW integration. Further research of peer support within EISs found that key enablers of successful integration were appropriate training, supportive supervision processes, and role clarity (Nguyen et al., 2022). The same study found that when role clarity was absent, and emotional burnout and inflexible working structures were present, these hindered the effectiveness and sustainability of PSW roles.

A need exists to understand the context and nuances that support the implementation of PSW roles within mental health services. This is particularly relevant within EISs due to the somewhat nascent nature of the role within this specialty. This study builds on a growing body of literature, focusing on the integration of PSWs in the specific context of EISs, offering multi-stakeholder insights into barriers to, and enablers of, successful implementation. This context lends itself to Normalisation Process Theory (NPT) (May and Finch, 2009) as a conceptual framework for understanding implementation factors related to PSW roles in mental health settings.

2. Aim

To explore multistakeholder perspectives of the barriers and enablers of PSW integration in EISs within an NHS Foundation Trust in the UK, and set out working theory, supported by a logic model, to inform implementation efforts.

3. Methods

3.1. Design

This study employed a qualitative research design, using a multi-stakeholder approach to gather comprehensive perspectives on PSW integration within EISs.

3.2. Context and setting

This study was conducted across six NHS sites within a single NHS Foundation Trust in England's North-West region. Site selection was guided by the following: 1) wide geographic coverage to reflect the range of services across the Trust; 2) existing EIS teams already working with PSWs; and 3) access to service users, PSWs, and clinicians to support involvement in the study. The work was undertaken by the second author (Senior Peer Facilitator) enrolled in a 12-month research internship programme. The third author, also a senior peer facilitator, supported the work. The first author provided supervision of the internship.

3.3. Theoretical framework

Normalisation Process Theory informed the study's theoretical approach. It was used as a framework for understanding how PSW roles were embedded into routine EIS organisational structures. Its four constructs: coherence, cognitive participation, collective action, and reflexive monitoring, guided data collection and analysis of how stakeholders understood the role, engaged with it, enacted it, and assessed its effects in practice.

3.4. Participants and recruitment

Participants were recruited using purposive sampling to include those with direct experience of PSWs in EISs. The study recruited six service users (18+) diagnosed with first-episode psychosis or identified as having an 'at risk mental state' (Hunt et al., 2024). Additionally, six PSWs and six clinicians were recruited to provide operational and organisation insights into PSW integration. The sample size was predetermined to ensure balanced stakeholder representation while remaining feasible within the 12-month internship timeframe. Recruitment was facilitated through NHS email networks (PSWs and clinicians) and information leaflets displayed within NHS facilities (service users). Service users received a £20 voucher as an incentive for participation.

3.5. Data collection

Data was collected through semi-structured in-depth interviews with participants from the three stakeholder groups. The interview guide was informed by the four constructs of NPT to ensure comprehensive coverage of the factors influencing PSW integration (see Tables 1–3). Interviews were audio-recorded and later transcribed for analysis. Interviews were conducted by the second (x5) and third (x13) authors either in person at the chosen NHS sites or virtually through Microsoft Teams, depending on participant preference. Data collection took place between October 2024 and January 2025. No demographic data were collected beyond participants' cohort role. The study focused on implementation processes across stakeholder groups rather than individual characteristics, and aimed to limit the collection of potentially identifiable information.

3.6. Data analysis

Braun and Clarke's (2006, 2022) six-phase approach of thematic analysis was followed: familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Coding was guided by NPT using deductive codes aligned with NPT constructs. The second and third authors carried out initial coding, with the first author independently reviewing and coding transcripts following this for consistency. Themes and subthemes were identified collaboratively and reflexive notes were kept throughout for transparency. Qualitative standards of credibility, dependability, confirmability, and transferability were followed (Lincoln and Guba, 1985). Data were de-identified to protect participant

Table 1
Service user interview guide mapped to NPT constructs.

NPT Construct	Interview Questions
Coherence	What do you understand about the role of PSWs in your care? What do you understand to be the main purpose of having PSWs in the EIS?
Cognitive participation	What benefits do you think PSWs bring to the EISs? How did you first become involved with a PSW? How did you feel about engaging with a PSW initially? What influenced your decision to participate in peer support services? In what ways do you engage with peer support services? Were your expectations of working with a PSWs met? How so?
Collective action	How do PSWs interact with you and the rest of the healthcare team? How does working with a PSW differ from your interactions with other healthcare professionals? What kind of activities or support do/did you receive from PSWs?
Reflexive monitoring	How were these integrated into your overall care plan? Have you provided feedback about the Peer Support Services? Were there any changes or improvements made based on your feedback? In your opinion, what makes peer support work well in this service? Are there any ways it could be improved? How has working with a PSWs impacted your recovery journey? Can you share any specific examples? What aspects of peer support have you found most helpful or challenging?

Table 2
Peer support worker interview guide mapped to NPT constructs.

NPT Construct	Interview Questions
Coherence	How do you understand your role as a PSW within the EIS? How do you think your role is perceived by service users and other staff members? Did you receive any training in preparing you for your role? If so, what? What aspects were most helpful?
Cognitive participation	How were you introduced and integrated into the EIS team? What factors do you think contribute to successful peer support integration? How do you collaborate with other healthcare professionals? What helps or hinders this collaboration?
Collective action	Can you walk me through a typical day or week in your role as a PSW? How does this fit within the broader EIS? What challenges have you faced in your role? How have you overcome these?
Reflexive monitoring	How do you evaluate the effectiveness of your work with service users? What impact do you think you're having? How is your performance as a PSW evaluated? What metrics or feedback mechanisms are in place? Have you noticed any changes in your role or responsibilities over time? What prompted these changes? What changes or improvements would you suggest to enhance the peer support program?

anonymity.

3.7. Researcher characteristics and reflexivity

Reflexivity was embedded throughout in line with Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014). The research team comprised two senior peer facilitators with lived-experience perspectives, and a capacity-building academic with a clinical background in mental health nursing supervising this particular internship. Weekly supervisory meetings initially during design, then

Table 3
NHS clinician interview guide mapped to NPT constructs.

NPT Construct	Interview Questions
Coherence	What is your understanding of the PSW role within the EIS? How does the peer support role align with the overall goals of the EIS?
Cognitive participation	How do you perceive the value added by PSWs to the EIS? How were PSWs initially introduced to your team? In what ways do you interact or collaborate with PSWs? How did you initially feel about integrating PSWs into your team? Did you have any concerns or expectations? How has your involvement with PSWs evolved over time? What kind of training or support did you receive to help integrate PSWs into your team?
Collective action	How has the integration of PSWs affected your daily work routines and the overall service delivery? How do PSWs fit into the team dynamics? Can you provide examples of effective collaboration? What organisational changes, if any, were made to accommodate PSWs?
Reflexive monitoring	What operational challenges have you encountered with the integration of PSWs, and how have these been addressed? In your view, what are the key factors for successful integration of PSWs? How do you monitor and assess the outcomes of the PSW service? What indicators do you use to assess the impact of PSWs on service user outcomes? What benefits or challenges have you observed since the introduction of PSWs? Based on your experience, what improvements would you suggest for the better integration of PSWs into EISs?

fortnightly thereafter, provided opportunity to reflect on researcher roles, assumptions, biases, and interpretations. Discussions helped identify how respective experiences and positions might influence the research, and also enabled transparency across all stages of the study.

Ethical approval

Ethical approval was obtained from a relevant NHS Research Ethics Committee, as part of the Health Research Authority (HRA) approval process (IRAS 346382). All participants provided informed consent, and data handling adhered to statutory and organisational guidelines for confidentiality and security.

4. Results

Four key themes and nine sub-themes emerged from an integrated synthesis of service user, PSW, and health professional data, highlighting a complex and nuanced perspective on PSW integration within EISs. These are presented below and aligned with NPT constructs.

5. Coherence

This construct reflects how stakeholders made sense of PSW integration. Service users, PSWs, and clinicians reported initial caution, highlighting issues relating to role clarity, professional overlap, and boundaries. However, initial concerns were balanced by the perceived complementary value PSWs brought to clinical teams with expertise in lived-experience and the distinct role they had in bridging clinical and non-clinical care. Increasing value and legitimacy ensued when everyone was aware of the unique part PSWs play in multidisciplinary care planning and support, where they can be seen as role models in recovery-oriented practice.

5.1. Theme: Navigating Uncertainty and Discovering Value

Initial uncertainty and transition to meaningful integration of PSWs in EISs highlighted two sub-themes regarding onboarding and

communication process, and how role and function clarity transpires.

6.1.1. Sub-theme: Ambiguity linked to onboarding and role communication

The importance of structured orientation of PSWs to the service and orientating existing staff and service users to the PSW role was notable in the early stages of employment. One health professional noted:

"Were peer support workers initially introduced to our team? I don't think they were well introduced at all. I think it was really quite difficult ... It almost felt as if ... well, actually, here we are as peers and we're going to be taking your role." (C4)

Early uncertainty was echoed by a PSW:

"I was put into the role before starting the course [eight-week peer support training programme] and to be honest I didn't really know what I was doing ... no one really knew what I was supposed to do." (PSW4)

Similarly, a service user felt equally in the dark about these roles:

"I didn't even know about peer support workers at all ... so it was all brand new for me." (SU5)

6.1.2. Sub-theme: Clarity emerges through lived experience and ongoing presence

Awareness of the functions and value of PSWs was strengthened when visibility and proximity were routine, enabling everyday collaboration and shared understanding:

Yeah, So usually I'll go into the office and we all have a morning meeting ... So that's good because we kind of all know what's going on ... I'll go back to the office, write up my notes, have a bit of a chat to the people in the office ... speak to my senior peer, just to kind of keep each other updated." (PSW6)

While a service user noted the value of lived-experience brought by the PSWs:

"... it's having that person who you know really understands. Because. You know unless you've been through it, you don't understand. So it's no, it's brilliant just having that support." (SU4)

6. Cognitive participation

This construct reflects how people engaged with PSW integration. Early experiences of PSWs were shaped by apprehension regarding professional status, specific roles within teams, and concern regarding relationship boundaries. Consequently, PSW agency was challenged by referral and collaboration hesitancy, impacting early integration efforts. Through time, presence, proximity, and informal interactions enabled trust and familiarity, and therefore role and fit clarity. Integration was also supported by clinician acknowledgement of lived-experience value and service user feedback on relatability of PSWs, increasing engagement and legitimacy over time.

6.1. Theme: Building Engagement through Trust and Relatability

How PSWs engaged with clinicians and service users determined the transition from hesitancy to connection, involving a delicate balance between role legitimacy, boundary navigation, and authentic connection to gain trust and value in their unique role.

6.1.1. Sub-theme: Initial apprehension and the need for role legitimisation

Clinicians' uncertainty about PSW purpose was identified, with onboarding and awareness processes highlighted by one health professional:

"And I think it was kept quite quiet. And then suddenly you were told you're getting peer support ... and what are they and how do they differ from our STRs (Support, Time and Recovery Workers) and how do they do this? It would have been nice, I think, to have had a build-up of talking about peers in group meetings ... but that didn't seem to happen". (C4)

A PSW similarly noted:

"Yeah, it's really hard if you're coming into a team. I did it when I was on board. You walk into a team and nobody knows what you are, or what you're supposed to do." (PSW4)

PSWs initially needed to prove their value, with clinicians hesitant to make referrals if early interactions raised concerns about readiness or professionalism:

"(a peer) that we had at the time, some of the things she said in the office ... I was a bit like, I hope they wouldn't then go on to say those kind of things. So I was maybe a little bit more reserved about referring certain people on my caseload that maybe might be quite vulnerable to the things the peer was saying ... I wondered had she maybe had the training." (C2)

6.1.2. Sub-theme: Navigating relational boundaries in peer support

PSWs oversharing and focusing more on their lived experience than that of the service user created boundary concerns, and a potential risk that PSWs drift away from service user needs. One service user noted:

"It's usually more about him than me. It's usually what goes on ... him talking about himself, not what I want to do" (SU6)

A health professional noted related risks around boundaries and preparedness:

"... there's a danger I think that the agenda can become more about the person doing it than the person receiving it. I think also when there's lack of clinical knowledge of the person delivering it, I think they're sometimes doing things potentially worse or actually making things more entrenched" (C3)

Reflections from PSWs highlighted how relational trust was often grounded in shared experience, rather than formal role definitions:

"Yeah, I think it's perceived quite well, especially with other service users. I think they like it. So you sort of build up the trust because obviously you've been through similar things to what they have as well." (PSW5)

Meantime, role clarity was enhanced when communication channels were in place to mitigate concerns:

So I didn't know whether we could, like, refer people for, let's say, support with PIP (Personal Independent Payments) or Universal Credit and things like that. But when I sort of raised that concern, it was very quickly really like explained as to what they can and can't do" (C1)

6.1.3. Sub-theme: Trust-building through informality and shared experience

Visibility, proximity, and informal office interactions, facilitated collaboration over time and enhanced integration:

"I make the effort to come into the office to talk to people, so therefore I'm a constant reminder that peer support is here ... I could work from home but to me it doesn't work." (PSW2)

As PSWs became integrated, their role was increasingly recognised:

"But I think because I've had repeat referrals from some people, I think that they're valuing that role". (PSW3)

A health professional recalled a positive, proactive introduction of the PSW role, promoting collaboration:

"They were very much introduced in the meeting, really promoted sending over referrals and discussing it with our service users. So it was very much

promoting that 'let's get stuck in'. That's how I remember it anyway' (C1)

Therapeutic relationships with service users were also enhanced as peer engagement evolved:

"So it's good having someone that I can relate to that's been through a similar situation. And especially with it being psychosis. You know there's not many people that I know of that have that experience." (SU6)

7. Collective action

This construct describes the collective action needed for implementation efforts. Successful PSW integration was shaped by system-level and role-specific challenges, including PSW availability and limited workforce capacity. Clinician-PSW role differentiation, PSW gender representation, and variable training challenged successful early integration. PSWs collaboratively supported community re-engagement of service users, with lived-experience enabling his. Close working relationships with clinicians were reported, with co-location enhancing visibility and joint working.

7.1. Theme: Structural and Relational Conditions Shaping the Functions of PSWs

This theme describes how structural and relational conditions shaped what PSWs were able to do in practice. Wider system factors influenced how and when PSWs could be involved., whilst collaborative working supported recovery-focused care.

7.1.1. Sub-theme: System-level factors influence access to and use of PSWs

Employment conditions and service structures shaped how PSWs were brought into teams and made available to service users. Contract type, pay, and physical location influenced their availability, perceived value, and visibility, shaping how they were able to enact their roles and contribute sufficiently.

A clinician and service user noted in relation PSW access and provision:

"It's only a part-time post as well, so they wouldn't have too many service users ... Peers can be a bit too thin on the ground really ..." (C5)

And

"Probably, in one sense you'd say 'see them more often' because you only see them twice a month. So seeing them more often would help. More interaction." (SU2)

whilst PSWs commented on contractual issues influencing value and contribution:

"I think there was talk of the role becoming a Band 3 instead of a band 2. I think that would be good ... I write the notes on RIO [clinical records system] ... So yeah." (PSW4)

Structural factors such as physical presence was seen to influence the effective use of PSWs. Office-based peers were perceived as more integrated and accessible:

"I think them being in the office is really helpful as opposed to peers working from home ... we can learn from them, they can learn from us and we all just sort of work together more as a team, and maybe when they start off maybe shadowing some visits ..." (C1)

7.1.2. Sub-theme: Collaboration supports recovery-oriented practice

Collaboration between PSWs, clinicians, and service users supports recovery-oriented care, with PSWs bringing distinct value to relationships through their lived experience. Although access to peer support and service user preferences varied, PSWs strengthened recovery-

focused engagement within collaborative arrangements. One clinician noted a potential challenge in meeting gender preferences:

"Guess the only thing I would say is more peers and possibly a female. That's the only thing we're lacking really, which hasn't been an issue up to now, but potentially could be an issue in the future if there was a female that wanted to see the female ..." (C3)

PSWs enhanced collaboration with service users through connection rooted in shared experience:

"Again, it's that lived experience. It's having someone who understands really what you've been through ... Everyone's been through something different, but it's having that person who understands." (SU4)

And

"I think it's always important that I say to people that I don't know how they feel, but somebody with a lived experience could maybe understand more and make it more real for that person" (C5)

This understanding supported a collaborative approach, with PSWs tailoring support to recovery goals:

"We go for walks or sometimes go to a cafe ... I've got social anxiety, so I'm supposed to be doing like graded exposure therapy. So that's, you know, I mean, go to the cafe and have more people around me." (SU3)

PSWs helped maintain collaborative relationships between service users and teams during periods of tension:

"... our service users have seen me as a bridge when they've been feeling challenged by the team. They'll use me as a bridge between themselves and the team. And we've kept that relationship going, if you like, that otherwise might have broken down". (PSW1)

8. Reflexive monitoring

This construct describes how participants appraised the integration and ongoing value of PSWs within EISs. Feedback highlighted high levels of satisfaction with peer support from a service user perspective, particularly in relation to recovery milestones and social confidence following PSW involvement. Improvements in service user engagement and daily functioning were noted as a result of successful PSW involvement in care. However, evaluation is primarily informal and challenged assessment of PSW impact.

8.1. Theme: Recognising Impact in the absence of formal structures

Tension existed between value recognition of PSWs and the methods by which this emerges. While subjective appraisal points to the perceived benefits and unique complementary nature of PSW involvement with service users, there is a sense that objective PSW performance, and service user outcome measures would better support PSW integration.

8.1.1. Sub-theme: Informal signs of progress and the value of peer support

Increased hope and motivation in an individual's recovery journey emerged through PSW engagement:

"Yeah, it's helped me immeasurably working with my peer support worker. Completely. And made my life better ... I went from a place of having zero confidence ... to a place of support ... it showed me that she'd been in a similar place to where I'd been and got through it ... and not only got through it but gone through it." (SU5)

And:

"Because I'm totally out of my shell now, because I wouldn't even leave the house, but now I go on a walk with my peer and I'm doing stuff like that and seeing people." (SU1)

A clinician reflected:

“So the peer support role for me is something that’s really important because it allows the people who we are working with to understand hope and understand recovery and have someone that they can speak to who isn’t just someone who has learnt something, but someone who has been through it and understood it.” (C6)

8.1.2. Sub-theme: Gaps in evaluation and ongoing role recognition

PSW input lacked structured tracking mechanisms and metrics to fully assess the impact of the role itself or its influence on service user outcomes:

“We don’t monitor ... and we don’t know what they’re doing well ... apart from talking things out and things being said like that.” (C2)

PSWs also reflected on performance appraisal challenges in the absence of quantifiable indicators or measures:

“The measures that you take in a role like ours, they’re very difficult ... you don’t know the effect that the conversation you had whilst walking alongside somebody ... it could happen a little bit later on for that person when I’m not involved anymore.” (PSW3)

These challenges contributed to concerns from PSWs regarding long-term sustainability of such roles. Sustainability is also hindered by PSW temporary contracts and position grading, which affect perceived continuity of service provision, role agency, and job security:

“I would personally like permanent posts. I would like us to be at least the band 3 ... because we carry quite a lot of responsibility with the job we do ... I feel, I don’t know, like we might be valued even more than we are now if we were band 3.” (PSW1)

9. Discussion

This study explored service user, PSW, and clinician insights on the integration of PSWs within EISs within an NHS Foundation Trust in the North West of England. It sought to identify barriers and enablers to successful integration and set out a working theory, supported by a logic model, to assist healthcare managers, clinicians, and policymakers with PSW implementation efforts in mental health settings. Findings highlight a dynamic interplay of organisational, relational, and structural factors which influence successful PSW integration, and provide a theory-informed framework for future implementation and service design. Consequently, we propose the following theory of PSW integration in EISs.

9.1. Towards a theory of peer-support worker integration within early intervention psychosis services

Peer Support Worker integration in Early Intervention Services is a dynamic and relational process shaped by organisational processes, visibility, and collaborative culture. Integration begins with uncertainty, where insufficient onboarding and communication delay role clarity. Role legitimacy develops over time through presence, staff interactions, and engagement with service users. For peer support to remain focused, PSWs must attend carefully to boundaries, especially when drawing on lived experience expertise. PSW roles are enhanced when co-located within multidisciplinary teams and integrated into everyday service routines to enable collaborative care planning. Sustainability is dependent on job security and structured supervision, as well as formal evaluation mechanisms which assess impact and reinforce value and contributions. A logic model (Fig. 1) outlines relevant inputs, mechanisms, and outcomes.

Our theory of integration, along with its mechanisms and conditions, can be situated within the wider literature. Findings from a study of

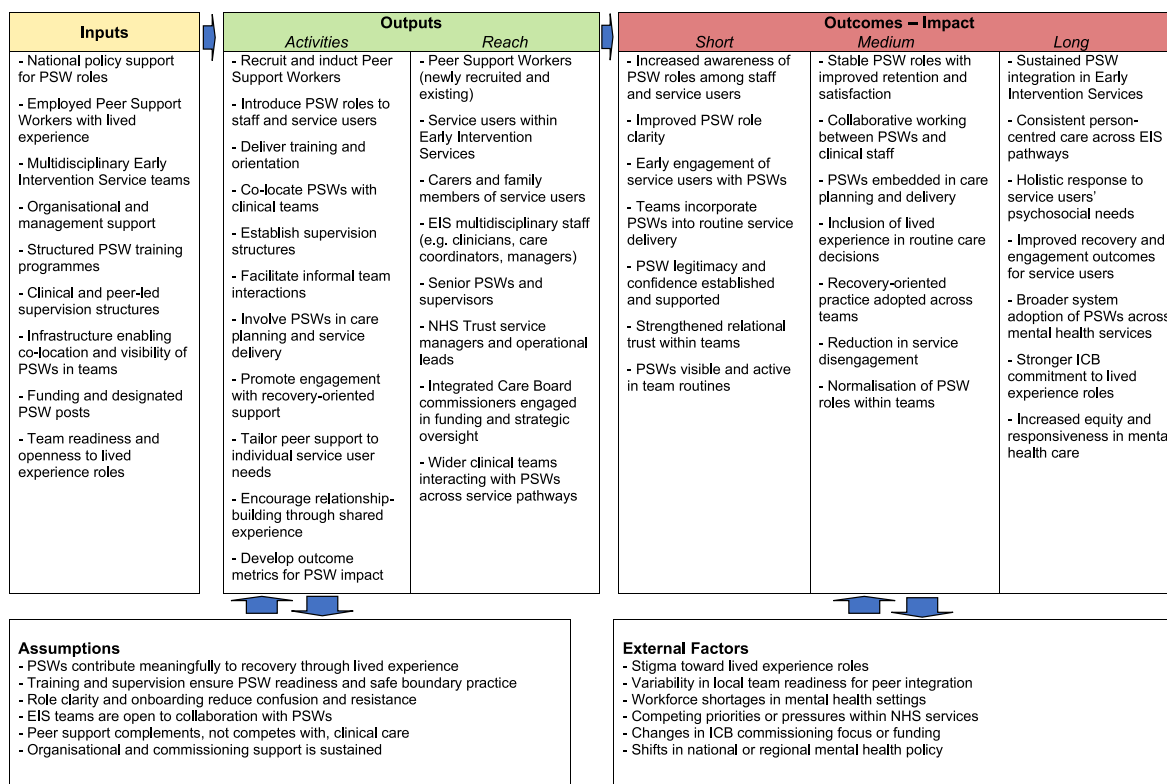


Fig. 1. Logic Model: Integrating Peer Support Workers in Early Intervention Services. Situation: Peer Support Workers are being introduced into Early Intervention Services as part of wider efforts to enhance recovery-oriented mental health care. This development reflects national priorities around lived experience roles and the transformation of service delivery models in mental health settings.

PSWs working across a range of mental health settings and geographical locations suggested a need to consider team and service readiness for implementing PSW roles (Reeves et al., 2024). The study identified the need for comprehensive induction and orientation processes, as well as training for onboarding teams to enable greater clarity of the PSW role and functions. Elsewhere, a study of PSWs working within substance use settings echoed these and our findings, highlighting that the role of PSWs was not fully understood by the wider workforce and organisations in which they worked (Elswick et al., 2024). The authors noted a lack of existing staff training and preparedness for working with PSWs, also highlighting tension between peer versus professional capabilities and identity, consistent with our findings of initial integration uncertainty and hesitancy.

Further insights can be seen in a study exploring role clarity from the perspectives of PSWs and non-peer workers working in mental health settings. Adams et al. (2023) supported our findings that knowledge of, and respect for, PSW roles altered over time, and were positively enabled when PSWs were socialised and became more established within teams and organisations. Continuing exposure to, and education about, PSW roles were highlighted as significant factors in the legitimisation of PSWs, whilst limited interactions between PSWs and colleagues delayed or prevented integration. These findings were echoed in a literature appraisal of PSW decision-making in mental health, where the authors found that the high-prevalent presence of stigma marginalised PSW integration into teams and resulted in exclusion from meetings and non-reciprocal communication efforts with colleagues (Mirbahaeddin and Chreim, 2022). The authors concluded similarly here, that PSW integration and colleague trust evolves gradually over time with ongoing exposure and collaboration.

Our findings point to the value of PSW lived experience providing a different dimension of care and support to that of clinicians, and in promoting service user recovery, echoed elsewhere (Tripathi, 2024). However, we also found health professional and service user concerns regarding lived experience disclosure and peer relationship boundaries influencing integration efforts, issues identified similarly in the wider literature (Janoušková et al., 2022; Joo et al., 2022). Janoušková et al. (2022) go on to articulate the challenges of the PSW role with service users transitioning from friend to professional. Some of the conditions which arguably enable a quicker journey to professionalism include onboarding, training, and supervision support. The literature identifies the need for embedding supervision processes to support PSW roles, with better outcomes relating to PSW retention and satisfaction arguably being achieved when this is provided by senior or more experienced peers (Castles et al., 2023; Foglesong et al., 2022).

Structural conditions also play a role in PSW integration. Findings suggest that PSWs may be better integrated when employment offers security and recognition, and when they have consistent physical presence within teams. Lombardi et al. (2024) also found that PSW employment which did not meet financial needs was a significant predictor relating to intention to leave the workforce. Similar to our findings, the literature highlights the need to employ adequate numbers of PSWs in ensuring meaningful peer support service provision (Byrne et al., 2022). Once employed, PSWs still face challenges if teams are not structured in a way that promotes collaboration with PSW roles (Thomas et al., 2023). While the literature on shared office spaces is limited, suggested in our findings as enabling integration and collaboration, the wider literature supports efforts to co-locate mental health services and promote physical proximity in ensuring effective and integrated service provision (Gillard et al., 2024).

We identified trust strengthening and enhanced quality of care when PSWs are in close proximity alongside other members of the multidisciplinary team, consistent with literature elsewhere (Repper et al., 2019; Viking and Nilsson, 2022). Supporting research and guidance further highlight the concept of shared decision making in building strong relationships in teams and with service users (Chmielowska et al., 2022; NHS England, 2023). PSWs as experts by experience, supported the

development of purpose and meaning in service users within a recovery-oriented context, which further enhances MDT collaboration, care, and planning (Viking et al., 2022). Finally, standardised impact measures were found to be absent, which influenced the perceived value add of PSWs in our study. This is consistent with recent recommendations elsewhere to consider greater focus on recovery-oriented quantitative measures, and qualitative insights from service users on the impact of these roles.

9.2. Strengths and limitations

This study included multi-stakeholder perspectives from service users, PSWs, and NHS clinicians, providing a rich triangulated understanding of PSW integration in EISs. Using a theory-informed framework (NPT) provided a nuanced robustness to the collection and interpretation of participant data, in understanding PSW integration barriers and enablers. The development of a PSW integration in EISs theory and logic model supports mental health services implementation efforts and provides services, commissioners, and policymakers with a framework for replication. Finally, this was a lived-experience led research study, with two of the authors being employed as PSWs in mental health EISs. This lived-experience provides authenticity and insider insights, otherwise unavailable to traditional research teams. Despite these strengths, several limitations should be noted. The single NHS Trust context may limit transferability of findings to different geographical settings. While the purposive sample provided balanced stakeholder representation and rich data, it may not reflect the full breadth of perspectives in relation to PSW integration at the study site. Finally, researcher positionality in this PSW led research may have introduced design and interpretative bias, which we attempted to mitigate with regular reflexive meetings and note keeping throughout the research.

10. Conclusions

This study explored how PSWs are integrated into EISs using multi-stakeholder perspectives, with a resulting theory and logic model developed to explain its dynamic inter-relational components in supporting effective implementation of these roles. Findings highlight an employment trajectory from initial uncertainty to eventual role clarity, trust, and legitimacy over time, via mechanisms of proximity, informal interactions, and co-location, as well as increased awareness of lived experience, boundary management, and support. Onboarding and sustainability of PSW roles will likely benefit from structured orientation, job security, and peer-led supervision, as well as effective internal communications. Findings support efforts nationally to embed lived experience roles in mental health services, and the logic model developed can support implementation efforts in this regard. Future studies should examine this model's relevance and impact across settings, and consider comparing and contrasting this to similar frameworks for PSW integration/readiness of services adjacent to this model.

CRedit authorship contribution statement

Scott Lamont: Writing – review & editing, Writing – original draft, Supervision, Methodology, Formal analysis, Conceptualization. **Chris McAteer:** Writing – review & editing, Writing – original draft, Investigation, Formal analysis, Data curation, Conceptualization. **Leshia Patterson:** Writing – review & editing, Formal analysis, Data curation.

Data availability statement

The data supporting the findings of this study are available in UCLanData (University of Lancashire) at <https://doi.org/10.17030/uclan.n.data.00000599>. The dataset has been de-identified to protect participant confidentiality and is accessible for research purposes. Further inquiries regarding data access can be directed to the corresponding

author.

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Declaration of competing interest

The author(s) declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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