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Knowledge and expertise in care practices: The role of the peer worker in mental health teams

ABSTRACT

Our research examines how different forms of knowledge and expertise are increasingly important in caring for people experiencing mental illness. We build on theoretical developments regarding multiple ontologies of knowing about illness. We examine how experiential knowledge of mental health problems, learned by being subject to illness rather than through objective study, is enacted in mental health care teams. We focus on Peer Workers (PW), individuals who have lived experience of mental health problems, and who contribute knowledge and expertise to mental health care within multidisciplinary healthcare teams. Our longitudinal study was undertaken over two years by a multidisciplinary team who conducted 91 interviews with PW and other stakeholders to peer support within a comparative case study design. We show how workers with tacit, experiential knowledge of mental ill health engaged in care practice. First we show how subjective knowing is underpinned by unique socialisation that enables the development of shared interactional spaces. Second we point to how the situated nature of subjective knowing is uniquely embedded in time and space and allows for the alignment of embodied knowledge with trajectories of care. Third we provide insight into how subjective forms of expertise might be incorporated into multidisciplinary care.

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Knowledge and expertise in care practices: The role of the peer worker in mental health teams

Knowledge is central to modern healthcare delivery (Freidson 1972; Timmermans and Berg 2003; Oborn and Dawson 2010). The standard for medical knowledge and expertise has been defined in relation to professionally based knowledge, and the medical profession holds strong jurisdictional control over the content of knowledge as well as the definition of what counts as fact and expertise (Freidson 1972, 2001; McDonald 1995; Mol 2002). As highlighted by Mol and Law (2004) this form of medical knowledge is an objective, public and scientific way of knowing the body from the outside, as an object; the knower and the known are separate entities. This understanding of medical expertise underpins modern healthcare delivery, and is epitomised through the gold standard of evidence based medicine and controlled clinical trials (Timmermans and Berg 2003), being rarely questioned by professionals, wider state health regulators or the public at large.

However, knowledge can also be developed as a subject. Thus, one can learn about dyspnoea, depression or diabetes by living through, or with, the condition. Mol and Law (2004) argue that this ontology of knowing as a subject leads to a private and personal way of knowing about the body or illness from the inside. They point out that the critical task is not to arbitrate which way of knowing is better, but to point out the multiple realities by which knowledge about the body (and mind) might be posed. This form of knowledge connects more readily with a person's social context, or 'lifeworld' (Barry et al 2001) as it integrates knowledge into wider social and biographical experience (Lo & Bahar 2013).

We build on these insights from Mol (2002) and colleagues (Mol and Law 2004) regarding the multiple ontologies of knowing about illness; knowing about illness as an object and a subject. We examine how different forms of knowledge and expertise are important in teams caring for people with mental health problems. To do so, we build on Collins and Evan's (2007) understanding of specialist tacit knowledge to show how subjective forms of knowledge gained through lived experience differ from objective formal forms of knowledge. We contribute by showing how tacit knowledge based on lived experience of an illness differs from knowledge held by professional staff and, in particular, how workers with tacit, lived experience engage in caring for persons with mental health problems.

In this paper, we examine how Peer Workers (PW) – consumer-providers; individuals who have lived experience of mental illness – contribute their knowledge and expertise to mental health care by formally working within multidisciplinary healthcare teams, and in wider care practices. The employment of PW by mental health service organisations is increasingly common internationally (Gillard et al 2013). Recent reviews have indicated the impact of peer support in mental health services on outcomes such as hope, empowerment and self-rated recovery (Lloyd-Evans et al 2015; King and Bender Simmons 2018), with improved self-efficacy indicated in newer trials (Mahlke et al 2017). Qualitatively, hope and strength of social networks have been explored as important outcomes for people in receipt of support from PW (Walker and Bryant 2013).

We build on this research to understand PWs' forms of knowledge and expertise and how they use them in supporting care practices. The research question for our study specifically focused on 'what forms of knowledge and expertise do PW's develop and how they do use them in enacting mental health care practices?' Our findings show how, in the treatment of people with mental health problems, self-awareness need not be silenced, but can be used as a resource in enacting care practices. Additionally, we found that PWs were able to draw on their knowledge and expertise to establish therapeutic trust within a shared communicative space, and thereby gain unique insight into people's distress in contributing to care.

Literature Review

Expertise and knowledge claims have traditionally been defined through professional institutions (Abbott 1988; Freidson 1972). As such, knowledge has conventionally been developed through extensive periods of study and learning within professionally controlled environments (Friedson 1972; Abbott 1981). Early work (Foucault 1972) has traced the modern organisation of medical knowledge through the 'medical gaze' in late 18th century medical clinics. He argues that through the careful study of patients' (live or dead) bodies, including their tissues, symptoms and behaviours, medical knowledge regarding patients' illnesses has developed and expanded. This simultaneously led to the partial medical separation of the patient's body and the patient as a person (Foucault 1973; Sullivan 1986). These developments led to an emphasis on objective forms of knowledge and expertise in professional healthcare teams (Gittell and Douglass 2012; Mol 2002) formalised as 'gold standards' which span contexts of care (Timmermans and Berg 2003) and national and international guidelines (e.g. NICE in UK).

As outlined by Collins and Evans (2007), expertise is also underpinned by specialist tacit knowledge. Tacit knowledge is socially derived, and ‘interactional expertise’ is learned in a way that cannot be explicated (Collins and Evans 2007; Polanyi 1967). Expertise is acknowledged to be associated with practical activity, such as practicing to be a midwife or operating on patients as a surgeon (Lave and Wenger 1991; Hutchins 1995; Kontos and Naglie 2009). These forms of knowing arise from engaging with an object of study whilst being temporally and physically immersed in the specialist culture of the practice in question (Lave and Wenger 1991, Emirbayer and Mische 1998). Thus healthcare professionals working in Emergency Departments in the UK have been shown to use both their experiential, tacit knowledge (about ‘types’ of cases) and technical knowledge (biometrics) when making rapid decisions during resuscitation procedures (Brummell et al 2016), while clinicians making care decisions in a neuro-rehabilitation team in the UK were shown to complement the codified knowledge offered by routine use of standardised clinical measurement tools with their intuitive, experience-based (tacit) knowledge of patients (Greenhalgh et al 2008). It is also argued that tacit knowledge (about health and healthcare) can be derived from aspects of selfhood that are beyond the experience of clinical practice (Kontos & Naglie 2009). Scholars have shown that healthcare professionals can draw on their social and experiential knowledge when caring for patients, and in so doing reach into their lifeworld (Barry et al 2001).

Thus, an increasingly important, yet competing, discourse in healthcare delivery is knowledge and perspective of the person as a consumer of care (Mockford et al 2012; Staley 2009; Komporozos-Athanasidou et al 2011; Gauvin et al 2010). This form of knowing emanates from experiences of illness or of using healthcare services (Mazandurani et al 2013). As suggested by Mol and Law (2004 pp3) ‘in being a living body we experience pain, hunger or agony ... And while the object-body is exposed and publicly displayed, the subject-body is private and beyond, or before, language.’ For example, Mol and Law (2004) suggest, in the daily lives of people with diabetes, ‘hypoglycaemia is something they know about, [though] the point of their dealings with it is not to gather knowledge but to intervene’ in their own illness management.

This more recent shift in thinking about relevant knowledge in medical services gives more credence and acknowledgement that non-traditional forms of knowledge can be productively used. The current emphasis (e.g. in the UK) on patient feedback and patient centred care (Staley 2009) seeks to incorporate the perspectives of such subjective knowledge more

formally into health service delivery and into the treatment processes. This has led to considerable effort to encourage self-care and management of one's own chronic disease (mGillard et al 2013), though these forms of knowledge often work in tension with more formal objective knowledge of one's illness as held by trained professionals (Barry et al 2001; Mol 2002; Martin 2008; Davies et al 2014). For example, online patient forums have been shown to be sites of exchange of tacit knowledge about how to navigate the healthcare system, rather than a sharing of 'facts' about health and illness (Foster 2016), while the challenges faced by patients and practitioners in identifying goals as part of chronic illness self-management programmes has been attributed, in part, to tensions between tacit (lay) and professional knowledge (Williams et al 2011).

Subjective knowledge about illness might also be used in treating or supporting the care of others. Quinlan (2009) describes a process whereby, through articulation in the public sphere, tacit knowledge becomes mobilised as 'new' knowledge in the context of clinical decision-making in multi-disciplinary healthcare teams. Quinlan (2009) points to the importance of social and communicative spaces as central for sharing these tacit forms of knowing. Indeed, Collins and Evans (2007) highlight that having tacit knowledge in a particular area enables individuals to uniquely interact with others having similar knowledge and expertise. While the manner in which tacit experiential knowledge can be used to support one's own care and chronic illness has gained currency (Mol and Law 2004; Armstrong 2014), there remains a dearth in understanding of the uniqueness of this expertise and how this form of knowledge can become integrated into formal healthcare teams to support wider care practices.

We distinguish PW from psychiatrists, nurses and psychologists, who know about mental illness as an object, though we acknowledge that these professionals also gain considerable tacit knowledge related to illness through treating and caring for people with mental illness (Kontos and Naglie 2009; Williams et al 2011). PW know about illness primarily as a subject, in addition to having opportunity for acquiring more formal knowledge during their own treatment processes. By drawing on knowledge derived from experiencing mental health problems and the processes of receiving psychiatric care, PW develop knowledge that is integrated with self-awareness, rather than being formal and objectified; that is, experiential knowledge that connects to their lifeworld and a particular context of living. For example, their knowledge of depression (or hearing voices etc.) is gained from living with mental illness at a particular time and place; from knowing how mental health problems impact on key relationships, how others perceive you, and the opportunities you have. 'Doing'

depression, including emotions of fear, anxiety, hopelessness experienced in a particular time and space of their mental health trajectory, we argue leads to a different knowledge, and in our case, brings a new expertise that can be made available to the healthcare team and the people they care for.

Case Context

The study took place in ten contrasting cases in England, UK comprising Mental Health National Health Service (NHS) Trusts (governmental mental health service providers), voluntary sector (not-for-profit) service providers, and partnerships between the NHS and voluntary sector providers. PW were employed in a variety of roles, paid and unpaid, in psychiatric inpatient settings, community mental health services, and Black and Minority Ethnic (BME) specific services. In all cases PW based their knowledge, skill and practice on the lived experiences that they had acquired to therapeutically support or care for others. We use the expression ‘supported person(s)’ below to designate individuals receiving support from PW, both in our study and more generally, reflecting current debate about the appropriateness of the term ‘patient’ in the context of mental health services (Christmas & Sweeney 2016).

Methods

The research was undertaken by a multidisciplinary research team which included health services researchers and management researchers, medically trained professionals, PW and managers of peer-led services, and service user researchers (i.e. researchers using their lived experience of mental distress alongside their research expertise). The study used semi-structured interviews within a comparative case study design (Yin 2004). Comparative aspects of the study exploring organisational context are reported elsewhere (Gillard et al 2015a).

Recruitment and sample

We asked project or team leads in each case to help us identify potential participants involved in services employing PW. Participants were recruited purposively, by role, to ensure variation (rather than representation) in the data. We recruited 91 people comprising 18 supported persons, 22 PW, 17 other members of healthcare staff working alongside PW, 14 line managers (of PW) and 20 senior managers and commissioners (responsible for paying for peer support services) in approximately equal proportion at each site.

Data collection

The interview schedule was informed by the literature on peer support in mental health services and by relevant expertise across the team. Interviews were undertaken by the service user researchers in the places where peer support was usually provided, and lasted between 40 and 90 minutes. Interviews were digitally recorded and transcribed verbatim. Ethical approval for the study, including the recruitment and informed consent process, was given by the London Bridge National Research Ethics Service Committee, reference 11/LO/0703.

Data analysis

Data were initially analysed by service user researchers using a complementary thematic and framework approach (Averil 2002) to produce a set of analytical categories. This was an iterative process in which the wider research team was involved in shaping the framework as new data were collected and analysed. NVivo qualitative software was used to compare data between organisational contexts, service delivery settings and stakeholder groups (Gillard et al 2015a). Theoretical memos were then developed around the conceptual themes of knowledge and expertise, sensitised and informed by the literature (Golden-Biddle and Locke 2008). Memos were developed as narratives and themes around the specific ways that subjective knowledge could contribute to the care of people experiencing mental health problems and how this form of knowledge differed from the knowledge brought by healthcare professionals.

Results

We explore three ways that knowledge learned from lived experience is a unique expertise and enacts unique care practices in mental health services, articulating the role that peer workers play in: establishing trust and rapport with the supported person; understanding and interpreting the supported person's mental distress; bringing insight into the processes of treatment and care. In the data presented below, participants are identified by role (PW; Supported peer; Staff; Manager; Senior manager), a two digit site code (01-10) and a third digit (1-3) which specifies whether they are the first, second, or third participant recruited in that role at that site.

Establishing trust and rapport with the supported person

PW bring knowledge of mental health grounded in their own experiences (of mental ill health) which was acknowledged as important by people receiving peer support.

The most important thing is the awareness about yourself and the insight you have ... I know probably [PW] have some mental health knowledge before, their own mental health issues I guess, and things. (Supported person 071)

This tacit knowledge was identified as both a point of connection and a source of trust in the PW for people receiving peer support. The unique connection established between PW and supported persons enabled a comfort level established through a sense of being understood, as they shared knowledge related to experiences, such as crises at a specific point in time.

I feel comfortable because I know they know about mental health. You know, they're not scared of anything or be upset by anything I say... (Supported person 071)

I also think people know that we understand their experience ... because we've had our own experiences of crisis. So people trust our empathy and trust that we get what they're talking about. (Manager 081)

That sense of connection – shared experiential knowledge of mental health – seemed to apply even where there were other differences between people, suggesting that it might be shared tacit knowledge of living with mental ill health, rather than wider social knowledge, that is the primary source of connection in peer support.

I just think people's, like, relief. Like they seem relieved that someone can understand what they're going through, in a sense. I think it's just a lot of comfort. It brings a lot of comfort to them even though I'm so much younger than some of the older people on the ward. (PW 042)

As such PWs were able to establish trust with the people they supported more easily than most formally trained staff involved in their care. Data suggest that PWs' experiential knowledge gave them access to a shared space, or 'domain' with the people they are supporting, while the understandings of mental health that healthcare staff might voice, grounded in their professionally acquired knowledge, might prevent them from entering that space. This enabled a unique form of knowledge exchange with PW.

[People] say, 'I couldn't speak to my nurse because they just didn't really get it, they didn't really understand me.' ... And it was really useful because the [peer worker] was sat in the lounge and we just started chatting about, 'Did you see [TV show] last night?' And we ended up talking about, whatever, hearing voices or... but in a different way. (Senior manager 042)

As indicated in the above quote, the knowledge held by the nurse was perceived to be insufficient to 'really understand' the supported person, creating instead a sense of difference

and distance and preventing them from talking about 'whatever'. While the inclusive space between PW and supported person led to open conversation ('talking about whatever'), the nurse 'sitting and chatting' was apprehended as probing and threatening. As such, the nurses were generally prevented from entering the same shared space of interaction.

The benefits for the patients are that it's somebody that I think they have felt – this is from feedback – they've felt less threatened by because a nurse, you know, wearing a nurse badge and asking questions, sitting chatting, you know, they perhaps find it a bit probing. And sometimes, dependent on their illness, their diagnosis, they can feel a bit suspicious of us. But [PW] introduce themselves as just being that, a peer support worker. They're here just to support, give advice, they introduce themselves by using, um, oh, their skills like music or arts and crafts and they kind of enter the patient's domain... Enter the patient's domain, kind of – well, 'lightly' is not the word – but less threatening. (Manager 042)

Being able or trusted to enter that shared space seemed to engender an openness with the PW that could have potential therapeutic value to the individual, offering unique opportunities to develop rapport and dialogue in a 'domain' akin to their lifeworld which they could relate to in their interactional space.

A couple of them seemed really surprised when I said about it and she was like, 'Really, you've had mental health problems?' And I was like, 'Yeah, and I'm currently on medication and stuff.' And she was like, 'Really?' And she was like, almost like surprised but kind of like in her face you could see she was quite relieved as well, that she could talk to someone, I guess, that was feeling something similar to what she was feeling. (PW 042)

PWs noted how that privileged access resulted in the people they supported being more open with them than they might be with healthcare professionals:

Some of the patients who don't know me they'll say, 'Are you the doctor?' And I say, 'No, I'm not the doctor.... I'm a [peer worker]' and, and they're 'Oh, are you?' And they want to talk because if I was a doctor they'd probably just clam up. (PW 062)

I was sitting with a [supported person] in one of my rooms and we were having a discussion and then her care coordinator walked in and she just completely shut down ... and then when the care coordinator left she had become kind of another different person ... She was very open with me, very comfortable ... I've kind of seen that now with a lot of my clients ... (PW 011)

Professional staff concurred that PWs' ability to encourage openness in this way had therapeutic value, enabling recovery and pointing to the ability of PW to engage in the lifeworld of the supported person through the unique interactional space. Experiential knowledge enabled PWs to cross a clinician-patient boundary that is perhaps in itself a manifestation of a

professional expertise that does not readily support communication with the supported person, being based on different experiences of mental health. In this sense, supported persons held different expectations of mental health workers depending on their role in the team. Thus, in the quotes above, people would ‘clam up’ or ‘completely shut down’ when professional staff came into contact with them pointing to a perceived boundary. Subjectively derived expertise blurs the boundary between carers and those being cared for, in terms of the formal identities of being a patient or being a member of staff. The experiential knowledge offered by PW could therefore allow boundary crossing or can remove the boundary even temporarily through sharing of common (tacit) experiences, as acknowledged by a professional staff member:

I was talking to somebody who has bipolar that is a peer support worker who said they found that really, really beneficial to reach someone on an Acute Admissions Ward, [being able to say] "Actually, when I was really high I remember those similar feelings"... there is some boundary sharing which comes around recovery and not so much about, 'This is what happened to me.' (Staff 011)

We suggest this boundary sharing around their interactional space enables a liminal space where roles were less important but understanding of how to go on (e.g. recovery) was paramount.

Understanding and interpreting mental health needs of supported persons

One of the key challenges in mental health care lies in measuring and assessing symptoms in an objective and reliable way (for example, through a blood test). A large proportion of medical knowledge about mental illness is derived from observing and assessing behaviour. Yet, interpreting the meaning and implications associated with someone’s behaviour is far from straightforward. Our data showed that PW could understand and interpret the mental health needs of people in a way that differed from other staff as they could relate with the lifeworld of supported persons. As such they could contextualise the ‘why’ of behaviour.

Because sometimes you need the experience to understand why it is – other people don't know – people who haven't been in treatment, don't have personality disorder, they always seem to interpret this stuff differently. (Manager 071)

I think they understand more because they've been through it ... than, like the [psychiatric nurse who] are professionals ... they're more distant ... they're doing it on a very professional level. Whereas a [PW] can relate to what you're going through more because they've been through it ... I think it's important for people to understand what you're going through. And I think [PW] are brilliant at that. (Supported person 011)

There was evidence of how PWs might apply that differential knowledge directly in therapeutic practice which we would suggest occurs as PW tacitly connect to their lifeworld.

They [peer worker] will deliver a group or a one-to-one session in a very different way than we do. So they will, you know, in a sense I've seen, one individual in action and she doesn't skirt round the issues. She goes straight in there [on a topic] which we would really tread carefully about. (Staff 041)

Importantly, in terms of contributing to an individual's care, a PW's knowledge could at times indicate an area of pending challenge for the supported person, based on their experience of having 'been there' and reading the situation as an insider to the trajectory of an illness within the flow of time. They could contextualise various signs to 'spot danger'.

I think a lot of it is just understanding because sometimes it's spotting the danger signs. Sometimes it's just being aware of what might be difficult. I mean, everyone has such different triggers, but there are certain topics that you can go, well, you know, which someone who hasn't had that experience might not realise because it's not always the obvious ones. So sometimes it's a little bit pre-emptive. (PW 101)

This knowledge was not restricted to experience of stages or symptoms of illness but included experience of having lived with the feelings and emotions associated with stages or symptoms. These feelings are attached to events in time and space rendering them more real.

...it's anticipating— so if you say, 'Right, okay, if having this condition X, most people are going to feel anxious about, you know, items one, two and three' then it's important, that to understand and really know what those items are, to have lived through those items yourself... So the [PWs] come from a position of understanding what those things feel like ... it's not guess work, it's actually based on reality... (Manager 071)

In this sense, PWs' knowledge about mental health goes beyond knowledge of objective information about illness to using an embodied understanding of illness in time and space of life events – in the PW's lived reality – to interpret meaning and gain insight into the challenges faced by someone else with mental illness. This embodiment of tacit health knowledge, noted in the literature above, was also understood by a manager of a peer-led service:

I am my work. Obviously I am my work in a way ... I don't know if that makes sense, do you know what I mean? It's like I am using myself and my experience and that is my work, it's part of my work and I'm lucky enough to be paid for it. (Manager 081)

As such, enacting the self was as important an expression of experiential knowledge as verbally imparting it:

For me, it feels like it's about being human and I don't feel I need to be saying, 'I've had mental health problems, it was tough for a while.' (PW 083)

Having said that, one PW did not immediately recognise the validity of knowledge grounded in their own lived experience:

I'd had a bit of a journey myself in terms of not valuing my own journey, my own experiences ... I've had the difficulties over more than a ten-year period, but I didn't value that ... but, I suppose being selected for this [PW role], and then, you know, the training, helped me to acknowledge that. (PW 022)

Ultimately, the embodiment of experiential knowledge in the peer worker role had a therapeutic, role modelling effect for people receiving peer support. As a role model, PW could demonstrate a hopeful future trajectory of the supported person's illness. This could enable the person to realistically consider their future and that the present illness experience would not endure endlessly. Juxtaposing their present experience with the PW's embodied knowledge of a positive potential future provided therapeutic hope.

It's also about being a positive role model. So, 'I've been through the service. I'm here. I'm recovered. I'm a [PW]. You're not going to be ill ... for the rest of your life. It comes in peaks and troughs.' ... This is a small part of your life. It feels like, you know, you're at your lowest ebb at the moment but seeing somebody who's been through it can be positive. (Manager 031)

As such PWs offered a 'living proof' that hope in the future was grounded in a lived reality, rather than being words offered by someone who did not share those experiences in a lived trajectory of time and at 'the next step' of a journey.

I think it's to know that you can have life beyond this ... I think it's very inspiring and useful and perhaps critical ... thing to have contact with people who've sort of moved to the next step ... If you're depressed you don't see any other light. You don't see the other side. But if you meet somebody who tells you, 'Oh, I've been through depression, it gets easier. You just have to hang on through it.' And if you realise that person is telling you the truth and you can see that because they're saying things that you've felt then you can resonate with that and it does give you some hope. (Supported person 101)

Perhaps just as importantly, PWs had lived experience of the wider associated stigmas and social challenges of mental illness, such as living on a psychiatric ward for extended periods of time or being unemployed. Knowing how to cope with stigma, understanding the alienating feelings related to stigma was based on different socialisation processes between staff and PWs though both acknowledge the reality.

We've all got our own different experiences of mental health problems and how we cope with our problems. How we come off the ward, how we get back into the community. We've all got a different way to how we cope to getting back into the community. But from you being on the ward for a whole year, for a whole year out of your life – ... I think it allows for people to be much more honest. Your cards are on the table. (PW 102)

All the stigmatisation and discrimination, the pain that labels bring on to that one person, I could never understand that breadth of it. (Staff 073)

Thus the tacit knowledge of PW went beyond a unique understanding of living with mental illness, but also encompassed a tacit knowing of the treatment process, and the reactions of society being perceived by someone with mental illness. The PW above indicates how living on a ward for year is experienced as a 'year out of your life', a temporal sense of loss that is important to acknowledge in order to communicate and cope with their challenge. The subjective knowledge related to stigma and discrimination experienced in a specific time and place further supports PW ability to communicate in a unique interactional space that engages the lifeworld of supported persons. There was also an understanding that people receiving peer support had, in turn, their own experiential knowledge of their mental health validated through the way the PW embodied experiential knowledge.

[Supported persons] feel more understood, a great sense of validation, it's less directive, that there's a real value to feeling that the person you're talking to actually has a lived experience of what you're experiencing.....There's a greater sense of acceptance. (Senior manager 012)

From a care perspective, an important aspect of recovery is acknowledging the challenging feelings and mental states associated with mental illness. This goes beyond identifying and treating feelings as symptoms, but rather acknowledging their reality. This validation of experiential knowledge could be used by PWs to encourage the people they were supporting to actively engage with their own feelings and within their lifeworld, concretising the feelings into present reality.

You sit with feelings and somebody else, like, acknowledges them, like, to me that's the most powerful thing, like being with a feeling and not trying to hide it. To me, that's where the problems start, if you squash them down or try and ignore them or try and get on with it, put on a brave face ... (PW 082)

Thus a liminal space that did not require the role play of 'a brave face' but allowed for feelings to surface and be acknowledged was enabled by their unique interactions.

Bringing insight to treatment processes having previously received care

We noted in the literature review that healthcare professionals complement their formal, training-based knowledge with tacit knowledge of healthcare practice, acquired through lived experience of enacting care. Our data indicate how PWs also bring a tacit, or experiential knowledge of receiving mental healthcare to the teams they work in or alongside. However this tacit knowledge is not acquired through experience of delivering care and thus distinct from the tacit knowledge brought by healthcare professionals.

I think it's just the lived experience aspect, like, especially when, like, you've had experience of mental health services, whether in hospital or in the community, just knowing what it feels like to take medication ... (PW 041)

It was just great, suddenly there was this person that really understood me. I wanted to have a discussion about my medication in preparation for my discharge with someone that's honest, that might have experienced it from my point of view. (Supported person 101)

In this respect the experiential knowledge PW brought to the role was shaped in part by socialisation in the care environment and knowledge gained from experiences of professionalised treatment. We suggest this enables PW to relate to, and dialogue with, staff and share elements from this aspect of tacit knowing with staff. PWs who lacked experiential knowledge of using mental health services could thus be at a disadvantage in the role, in part due to their lack of linguistic ability.

So I guess the knowledge [of receiving care] is quite important ... most of the cohort had all been part of the services but one lady particularly struggled because her admissions had been a lot of years ago, sort of the old-school services, so to speak, and since then her contact's only ever been with her psychiatrist. So when we started talking about a lot of the language around the services she was totally out of the loop. So we had to do a lot of education through the training. (Manager 021)

Again, data suggest that there is an emotional content contextualising experiential knowledge in relation to care in the mental healthcare system. Taking on the label of having a diagnosis in itself comes with a challenging set of feelings, regardless of how the mental illness itself might affect the individual. A repeatedly important aspect of enabling someone to acknowledge where they are in their illness journey is to understand where they are at emotionally in relation to receiving their diagnosis.

You know, the minute you're labelled as [personality disorder] you're seen as on a professional basis as untreatable, on a personal level people think that you're crazy or that you make things up or that you're not to be trusted. I mean, there's so much just having that [personality disorder] label. (Staff 073)

Thus the knowledge that a PW brings to the supported person's care process also comprises knowledge about the stigma, misunderstanding and disempowerment associated with being treated for mental illness and being cared for in a formal organisational context. Becoming part of the formal care system often implies strict control over the person's behaviour. In the following quote, for example, being 'sectioned' - which means that the person is deemed to not be able to make their own choices and thus care is placed in the hands of the state or formal care system - implies the added challenge of dealing with the loss of personal autonomy and corollary emotions. PW who have experienced being sectioned or administered mood altering medication against their will have situated insight into the emotions that the supported persons experience.

To be Sectioned, to, you know, sit in a meeting with a panel who are all deciding how you're going to be treated, effectively... just understanding some of the emotional levels that you go through as you journey through the mental health system. (PW 041)

Thus the professional healthcare worker would have knowledge regarding when a 'Section' might be most appropriate in managing risk; yet they have much less subjective knowledge of the actual challenge to one's personal autonomy when forced into care. As such healthcare staff, and particularly managers, spoke about the role PW play, using that distinctive knowledge base, in bridging between the person receiving care and the healthcare professionals on the team:

The PW sits right between professional and the service user ... because of their lived experience and because where they sit within the team they see things from a different perspective... And sometimes you get conflict from, say ... how [the PW] sees the professional's dialogue with the service user ... and [the PW will] pick up on things that you wouldn't generally, as a professional, pick up on. (Manager 031)

This bridging role was valued by clinical teams, and attributed to the insight PWs have gained through experiencing care:

I think it's because they have a different perspective of working in that environment, they are able to inform staff about any particular issues they may have found and also relay any information that service users have, or any experiences that they have, negative ones or positive, that are impacting because of the environment or because of how, you know, staff were interacting. And it's only when you've gone through that, in this environment, that you kind of understand what the issues are. (Manager 031)

Arguably it is the fact that the experiential knowledge brought by PWs is in part shaped by their experiences of treatment and care, and the personal challenges associated with moving

in and out of care settings that offers the liminal potential of PW knowledge. For example, part of the care process and recovery journey might entail the supported person taking on more responsibility for their medication, decisions and care boundaries. This part of care requires close engagement of the supported person with care staff and critical judgment points about safety. Having experienced this tension enables PW to offer unique insight in discussing these tensions in relation to where a person is navigating at that unique point in time in their lifeworld and thus how to go on in life.

Staff can sometimes struggle particularly around engaging [people] in their own risk assessment and management. There's almost this kind of mystique that exists... something that only very experienced, qualified clinicians can do because it's some magic art... and then we wonder why we have the incidents that we have... So there's almost something about peers kind of being able to challenge that and be able to have, perhaps, more open and transparent conversations with [people] around them owning their own risks... Because actually, probably if you've got to the point of being a [PW], probably somewhere down there you've had to navigate your way through some risks? (Senior manager 021)

Thus for some participants – from peer-led services – peer support self-consciously offered something different to the predominant approach to formal care, one which is diagnosis focused and based on more objective forms of mental illness knowledge.

[Our peer-led service] came out of a deep dissatisfaction with [existing] services. That's why we exist. Because what is on offer is a medical approach to mental distress, a diagnostic approach, a medication-based approach, which people have found really unsatisfactory. And so our service was explicitly set up to provide something that was an alternative. (Senior manager 081)

Discussion

Our paper develops an understanding of how new forms of knowledge and expertise of mental illness, learned as a subject through lived experience, shape the emerging role of PW in providing care to people with mental health problems. We make three contributions to the literature.

First, we argue that subjective knowing about mental illness through lived experience is a unique form of expertise, one that is qualitatively different from, and can work in concert with, the formally and tacitly acquired knowledge held by trained mental health professionals. Collins and Evans (2007:27) highlight that tacit knowledge is developed by acquiring a social understanding as one is ‘socialised into relevant group practices’. One key

difference in subjective and objective forms of mental illness expertise stems from the very different socialisation processes and locations of practice in acquiring the tacit knowledge. While medical experts learn considerable knowledge through the social conventions of medicine and the medical ‘gaze’ of observing and caring for people within the formal care system, subjective expertise is socialised through living with, and receiving care for, the illness, including relatives’ reactions to the illness, hospital treatment processes and ones’ own self-evaluation of the illness experience.

We note that healthcare professionals acquire tacit knowledge and expertise through practice as well as formal education (Lave and Wenger 1991) – learning what works well in healthcare practice – and that this informal, perhaps more intuitive knowledge complements their formally acquired expertise (Brummell et al 2016; Greenhalgh et al 2008). Yet we argue that the tacit, or experiential knowledge brought by peer workers is distinctive. Their knowledge is learned through living with the illness, receiving care and engaging in a social sphere where others in society (e.g. family, work colleagues, casual acquaintances) are reacting to the illness; hence the language of socialisation by which knowledge is gained is entirely different. Language is crucial for the development of expertise (Polanyi 1967; Tsoukas 2005). Collins and Evans (2007), in particular, suggest that what they term ‘interactional expertise’ enables individuals to discuss and converse on a topic in a way that enables mutually understood, shared tacit knowing. We suggest their tacit understanding enables PW to engage with the lifeworld of people receiving care so that they are able to ‘talk about whatever’ and thus build unique knowledge exchange with supported persons. The experiences of socialisation have commonality and sense of ‘sharedness’ with persons requiring mental health support, enabling trust through shared understandings and shared spaces of vulnerability.

Peer workers’ subjective expertise is also learned through being immersed in experiencing processes of care for their mental distress, and being socialised in the challenges of living with mental illness. In our context we saw peer workers enacting this interactional expertise as they communicated with the people they were supporting, through role-modelling, and by acknowledging and validating the experiences and knowledge of mental health brought by supported persons. We suggest this can work to normalise the experience of care in a way that renders it less alienating, knowing that their experience is affirmed and acknowledged. As highlighted in research about patients’ lifeworlds (Barry et al 2001; Lo and Bahar 2013), communication that supports one’s understanding, as opposed to technical rationality, brings

harmony and moral strength. In this way PW earned the trust of the people they were supporting around the process of care which offered potential therapeutic benefit, whilst contributing to the team's wider understanding of care.

These interactions were in large part dependent on linguistic skill (Collins and Evans 2007) that, conversely, mental health professionals lacked, not having been socialised in that wider sphere where mental health plays out in people's lives. As a result, and often by their own admission, health care professionals were unable to enter this shared interactional space as easily. As our findings highlight, PW have strong interactive ability with the people they support. The corollary is also true; formally trained mental health experts without their own lived experience will always lack the social understanding of being cared for and living with mental illness. Their knowledge will be limited in this dimension as will their ability to verbally engage people in establishing strong connections with their lifeworld, lack that has been noted in the literature (Barry et al 2001). These findings contribute a complementary perspective to other research on the way in which healthcare professionals use their own lived experience in their practice, which, to date, has largely focused on issues of self-disclosure (c.f. Henretty and Levitt 2010).

Second, and relatedly, our findings emphasise how the ontology of subjective (experiential) knowing is necessarily temporally embedded in experiencing practice. The literature suggests this differs from the objective goal of professional knowing which aims to be universalistic, decontextualised and atemporal, being focused on the object of illness rather than living with it (Abbott 1981, Timmermans and Berg 2003; Mol and Law 2004). Whilst we consider all knowing as being temporally bounded (Emirbayer and Mische 1998) the formal systems in which it is produced are often insufficiently reflexive on this (Barry et al 2001). Subjective knowing, based on lived experience of illness, is focused on being embedded in time and space. People experiencing mental illness (and the PW that support them) do not separate out their knowledge of mental illness from their living of life in different places, and how they felt and thought at different points in time. Subjective knowledge is embodied and comes with a history of experience of a specific lived onset, presenting feelings of stigma and future hope for personal recovery, thus connecting the lived trajectory of illness. This enables PW to privilege their situated expertise and not feel held to a specific professional canon. The contributory potential of this knowledge lies in it being embodied in time and space, highlighting the importance of its situated nature.

We acknowledge that mental healthcare professionals exercise knowledge that is derived from their experiences of delivering care in practice; i.e. practice that worked with similar types of patient in the past (Brummell et al 2016; Greenhalgh et al 2008). However, the objective knowledge that governs healthcare practice also aims to remove the disorder of context and life from what is considered the actual illness (Abbott 1981, Timmermans and Berg 2003), leaving the relevant psychiatric problems professionally defined (Quinlan 2009). We suggest, in contrast, that PWs' subjective expressions of expertise are able to temporally align alongside the supported person's illness trajectory and the problems being experienced; for example normalising feelings about struggling with symptoms or living with the side effects of medication and so on, connecting with their lifeworld as discussed above. The peer worker embodies (Kontos and Naglie 2009) therapeutic change as they enact the PW role – the recovered, productive self (Gillard et al 2015b) – while a sense of alignment between peer worker and supported person imbues their relationship with therapeutic potential in three important ways. First, there is the sense of connection (that lies at the heart of all therapeutic relationships) between PW and supported person, made real in the shared experiential knowledge of having 'been there' (or somewhere similar) at some point in time. Second, there is the act of 'being alongside', perhaps physically, in person, but certainly in some knowing, discursive space, as the peer worker re-enacts or re-imagines (in the present) their own lived journey of mental illness and recovery trajectory as they support the individual (Gillard et al 2015b). Third, the experience of the supported person, and the way in which they know and make sense of their own mental health – their own experiential knowledge – is acknowledged and validated through the embodied knowledge (of living well with mental ill health) of the PW. The nature of living with mental illness is not erased, but instead is woven into the very fabric of knowing and therefore into the dynamics of relationships, activities of daily living, interacting with an often stigmatising wider world, and of their anticipation of the future for both PW and supported person. The focus of this knowing is not about the illness per se, but about how to go on living with it and how to work through the new relational challenges presenting at different points in time of illness trajectory.

Finally, our findings contribute insight into how the PW's expertise might be incorporated into the multi-disciplinary practice of mental healthcare teams. It has been widely acknowledged that it is difficult to incorporate PW, whose expertise is based on subjective knowledge, into the wider healthcare teams (cf. Berry, Hayward, Chandler 2011; Gates, Akabas 2007; Gillard et al 2013). Workers' knowledge shapes the roles they take on in

organisations, for example setting boundaries around their tasks (Lamont and Molynar 2002). The uniqueness of PWs' subjective knowledge in an organisational context where formal, objective knowledge is dominant, has implications for how their roles evolve and become enacted in practice. Subjective forms of knowledge challenge the social relations between 'carer' and 'those cared for', relations which have become formalised in health organisations. We show how a unique liminal space is occupied by the overlapping knowledge boundaries of PWs' expertise. In our study, a peer-led service informed by experiential knowledge served as an alternative for people who struggled with the medicalised milieu of formalised services. It has been suggested that peer-led services complement formal mental health care by offering opportunities for experiential learning from peers that can validate individuals' own approaches to problem solving and give them confidence in working with other healthcare providers (Solomon 2004).

Furthermore, our findings suggest the importance of an integrative approach which recognizes that PW, as past recipients of care, had gained experiential knowledge through socialisation in the practices and culture of mental health before subsequently becoming service providers. PW have a tacit knowledge of how mental health care practice is enacted which complements their tacit knowledge of living with mental ill health in the wider world, equipping them to work alongside healthcare professionals, as well as supporting people in need, thus articulating a liminal, interactive space. Almost as the exception that 'proves' the rule, we note how one of our PW participants lacked this secondary socialisation within mental health services and had to be given additional training, specifically to acquire the language required to effectively bridge boundaries of supported person and healthcare team. Thus we see that experiential knowledge held by people who have used mental health services, and the formal, learnt knowledge of healthcare professionals are not autonomous discourses that inevitably raise tensions and boundaries to shared clinician-patient understanding (Barry et al 2001; Williams et al 2011). Instead, these can be relational knowledge bases that may be bridged by a tacit knowledge of mental health treatment and care uniquely held by PW who have lived experience and are both recipients and providers of care. PW can be equipped with the linguistic skills to enter both worlds and as such occupy a liminal space, and can thereby effectively bridge gaps in understanding between mental health professionals and the people they care for (Simpson et al 2017; Watson 2017).

Conclusions

Our study synthesises how peer workers contribute to care through their unique interactional expertise and subjective knowledge in ways that are quite distinctive yet complementary to formally trained staff. Shared experiential knowledge of living with mental ill health could act as a point of connection between peer worker and supported person, earning the PW trust, and building rapport on which to base a therapeutic relationship. PWs' differential understandings of mental health challenges that people were facing – from a perspective grounded in their own experiential knowledge – complemented the formal expertise brought by the clinical team. PWs' embodied experiential knowing about living well with mental health offers further therapeutic potential as role models and by validating the way in which the people they supported experienced and came to know their own mental health. Finally, peer workers' tacit knowledge was in part acquired through their experiences of receiving care and as such the multiple ways of knowing they brought could act as a bridge between the healthcare team and the people they supported. Future work could usefully examine challenges of integrating the PW role into healthcare teams by examining how the distinctiveness of experiential knowledge and peer expertise can be retained while enabling the sharing of expertise across the team. New understanding is needed of how the subjective, interactional knowledge brought by peer workers can best contribute to the shared knowledge base, and therefore therapeutic potential of the team as a whole.

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