Peer Distinctiveness, Is It Enough? A Qualitative Study on a Peer-Run Recovery Course

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This thesis has taken many roads with many sudden turns, which is only natural when one studies humans. It started off on one topic and landed on a completely different one. The process of finishing it involved a lot of head-turning and many *killed darling* (whom are still secretly saved in a separate document). During this process my internal motto has been *"The only constant is change"*, which is a pure reflection of this process, myself, and of the sample studied for this thesis.

Foreword

The thesis is split into two sections. The first section is an outline for the thesis expanding on themes for the second section, the article.

The main focus for the outline is to give the reader the opportunity to evaluate the quality of the study by offering more insight into methodological decisions and theory.

An effort has been given to avoid repetition, yet some parts from the article will be repeated in the outline. This is mainly to generate a wholeness for the readers experience.

The outline has been written according to the study guidance from my master's program, therefore the APA6th reference style has been used. The article has been written according to guidelines from the journal Psychiatric Services, with a Vancouver reference style.

The article has to this date not been published.

Section 1 -Outlining the thesis

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Abstract

A qualitative study from the peer-run recovery course *Recovery is up to you* was conducted to uncover what is distinctive in a peer-run recovery course for participants with mental health challenges and addiction, and if peer-run differentiates from traditional care services. The following research question was asked to uncover this, *how do peers impact each other?* Interviews were conducted with completed participants from *Recovery is up to you* before a content analyses on the data was undertaken. The findings indicate peers are distinctive in that they generate a sense of belonging, resemble hope and offer practical advice. The support from peers was found to differentiate from traditional care, in that participants sought one (service) over the other depending on which area of challenge they faced. Traditional care was sought out when challenges with their mental health were the prominent challenge, whilst peer support was sought in regard to challenges they met due to their addiction. Albeit both services were valued, a mix of them was not preferred. Rather the services should be offered on separate arenas, to avoid confrontations regarding respect and hierarchical tendencies. The results emphasize one should not exclude a service over the other, but rather attempt to offer services from both sides

Key words

Peer support, recovery, addiction, mental health challenges

1. Introduction

This master thesis raises curiosity on the topic of peers in peer-run recovery services for people with mental health challenges and addiction. To obtain knowledge on this, data was derived from the peer-run recovery course **"Recovery is up to you"** (RIUtY). The course RIUtY is a recovery-oriented course, developed by peers and for peers. RIUtY was established in 1996 in the Netherlands before introduced to Norway in 2016. This thesis bases its focus on the experiences from participating in RIUtY, raising the overall research question *"how do peers impact each other?"* followed by the specific aims: what is distinctive in a peer-run recovery course and how does this type of service differentiate from traditional care? In addition to exploring this topic as part of a master thesis, it is also part of a more extensive study looking in to the feasibility of RIUtY in Norwegian settings. It is therefore valuable to gain knowledge on experiences the participants had to understand how the course is adapting to Norwegian settings, but also to identify what seems to be unique with this course as a measure on personal recovery and as a service run by peers.

This thesis is sequenced under different headings, firstly introducing the reader to the course RIUtY before stating the terminology and the societal relevance. A summary of what previous research has concluded is presented, in order to answer why the topic is essential and where the rationale is drawn from, following are the aims. Next, the reader is introduced to the theory and approaches, which work as ground pillars supporting this thesis. An extensive section of the method is presented before a summary of the results appear. The discussion will draw on previous research and suggest a model as an interpretation of the results combined with the theory. Lastly, the thesis provides limitations, before coming to a conclusion. As the data for this thesis is derived from the specific course, RIUtY, outlining it in the following paragraph becomes essential for understanding this thesis.

1.1 Recovery Is Up to You

Recovery Is Up to You has mainly focused on recruiting participants with mental health challenges, but in recent years added additional courses for participants challenged with addiction. In Norway, the course combines participants with either -or both -challenges in the same courses. A course period stretches over 12 weeks, consisting of a two-hour weekly session. The course being peer-run is designed to regenerate itself by recruiting past participants as future course-holders. The peers running the course this study retained its data from consisted of three people; two who had experience from running last round's course and the third being recruited as a participant from last round's course. Addition to following the structure, content and leading the course, the peer-instructors are also in charge of recruitment. Being in charge of recruitment involves reaching out to potential participants and conducting individual interviews to map out motivation. Mapping out motivations is intended to minimize drop-outs. In return for running RIUtY, the peer-instructors receive a salary from the municipality. Receiving a salary from the municipality is explicit to the courses held in Norway.

Throughout the course, the peer-instructors use a detailed and standardized manual, translated from Dutch to Norwegian. Additionally, the participants also use an individually standardized workbook, again translated from Dutch to Norwegian. The course is based on a psycho-educational perspective enabling participants to learn problem-solving, communication skills while providing education and resources in an empathetic and supportive environment. It runs on a set structure working around particular recovery-oriented topics every week. These are typical topics consisting of attitudes towards recovery, personal wishes for the future, social participation, roles in their daily life, how to get social support, qualities and personal resources, empowerment, and self-assurance. These topics are then discussed in groups allowing the participants to share experiences and develop personal, social and practical skills. Additionally, to participating in the sessions, homework is also given.

The course RIUtY has been studied in various ways on the Dutch population (H. van Gestel-Timmermans, Brouwers, Bongers, van Assen, & van Nieuwenhuizen, 2012; H. van Gestel-Timmermans, Brouwers, van Assen, & van Nieuwenhuizen, 2012; J. van Gestel-Timmermans & Brouwers, 2014; J. van Gestel-Timmermans, Brouwers, & Van Nieuwenhuizen, 2010) One of the studies involves a randomized controlled trial assessing recovery related outcomes through self-report instruments (on confidence, empowerment and loneliness) on a sample with a mental health challenges. This study comprised a sample of 333 people, 168 subjects assigned to the experimental group and 165 to the control group. Conducting assessments at baseline, three months, and six months after course finish the results revealed RIUtY had a positive and significant effect on empowerment, self-efficacy and hope. These results were seen persistent up to three months after course completion (H. van Gestel-Timmermans, Brouwers, van Assen, et al., 2012). Another noteworthy study conducted on RIUtY is a feasibility study, looking in to the usefulness of RIUtY for people with challenges related to addiction (J. van Gestel-Timmermans & Brouwers, 2014). Through qualitative measures the study found RIUtY to be useful and feasible for people with challenges related to addiction. Positive experiences were mentioned, both from participants and peer-instructors. Participants for this study mentioned the course was important for their personal recovery as they learn more about themselves and their specific needs. Having peers as course instructors was valued as a non-judgmental and a non-hierarchical environment was created. In addition, the peer-instructors were mentioned to act as role models and an inspiration for the participants (J. van Gestel-Timmermans & Brouwers, 2014).

1.2 Terminology

Acknowledging different terms used in the literature, this study uses the term *peer-run* to cover the synonyms peer-delivered, consumer-run, peer-operated, peer partnership and peer-delivered services (Solomon, 2004). These services are unique in that the participants share a common

challenge, rely on experiential knowledge, value reciprocal help and include a personal change/recovery as their goal (Humphreys, 2003). Participants in peer-run service are peers, which in this setting is defined as a person one identifies with through mutual experiences (Davidson, Chinman, Sells, & Rowe, 2006), in this case, involving challenges with one's mental health and/or addiction. On the opposite side, the study uses the term traditional care, which comprises services offered by professionals representing the healthcare system.

Peer-run services naturally draw on the concept of peer support. Peer support is defined as a system where reciprocal help is given and received on the premises of respect, shared responsibilities, and a joint agreement on what is helpful. It deviates from diagnostic criteria and biomedical models but instead focuses on understanding one another's situation through shared experiences, creating a mutual and nonhierarchical setting (Adame & Leitner, 2008; Mead, Hilton, & Curtis, 2001)

In this thesis, mental health challenges will encompass the terms mental illness, mental disorder, mental disabilities, psychiatric disorders. The intention of using the term *mental health challenges* keeps the study intact with the recovery approach, it is more recognizable for lay people, as well as it creates an openness and a distance from stigma, or a set criterion for diagnostics. Additionally, this term is recognized in the propositions and legislation by the Norwegian Ministry of Health and Care Services (Ministry of Health and Care Services, 2017)

Regarding addiction, the World Health Organization describes it as a harmful or unhealthy use of psychoactive substances, comprising of both illicit drugs and alcohol. It becomes a problem because using substances over time typically leads to a strong desire to take the substance, trouble controlling it's usage, persisting to use it albeit damaging consequences, giving it a higher priority than other obligations or activities, increase in tolerance levels, and it could lead to a state of physical withdrawal (World Health Organization). This study does not focus on the specifics regarding which substance is used, nor the state the person is in or diagnoses related to this; therefore, the terms drug-

dependency, substance-user or other synonyms will encompass in the word addiction.

2. Societal relevance

Addiction and mental health challenges are arguably the most significant threat affecting on a global, societal and individual level (Dalsbø et al., 2010; Humphreys, 2003). The complexity and seriousness vary from person to person, which also reflects on the variety of care needed from health services. Mental health challenges and addiction are associated with detrimental impacts on the individual involving a reduction in quality of life, increased mortality, increased sickness absence and disability pension (Norwegian Directorate of Health, 2014). Increased sickness absence and disability pension may also explain why many of the given people who are considered to be at working age are out of work (Norwegian Directorate of Health, 2014). Being out of work can again have negative consequences, such as stigmatization and isolation (Ministry of Health and Care Services, 2006-2007).

To understand the scope of addiction and mental health challenges one can look at the prevalence over the last years. A recent report from 2017 revealed 28,000 patients in Norway received interdisciplinary specialized treatment for substance abuse (Indergård, Solbakken, & Urfjell, 2017), revealing an increase of 1.7 percent from the former year. Additionally, to the increase of patients receiving interdisciplinary specialized treatment over the years, this is also seen for outpatient treatment services and outpatient consultations. The topic has gained further interest as a public debate rose after the Norwegian newspaper Aftenbladet's Magazine contributed with a report on the steady increase of overdoses in the past years in Norway (Gran, 2017). The report revealed that the year 2015 claimed the most lives, seen the past 11 years, in which 289 people passed away due to overdosing on heroin (Gran, 2017). Seen in a global perspective, the World Health Organization reports addiction to account for 5.4 percent of the global health burden.

Regarding mental health challenges, the diagnostic system reflects its magnitude on classifications (American Psychiatric Association, 2013). Suicidality, which, according to the DMS V Manual is recognized as a separate diagnose (Oquendo & Baca-Garcia, 2014), and is estimated to affect around 800,000 lives worldwide yearly (World Health Organization, 2017). In Norway, reports show this affecting around 150 women and 400 men yearly (Norwegian Institute of Public Health, 2015b). Addition to suicide, the Public Health Institute for Norway reports depression affecting 6 to 12 percent of the population at any time, and anxiety disorders affecting more than one in every tenth person (Norwegian Institute of Public Health, 2015a).

Addiction and mental health challenges are often mentioned as separate entities, yet comorbidity of them if frequently seen (Landheim, Bakken, & Vaglum, 2006). Hence addiction among people a with mental health challenges is often reported, and the opposite combination; people with an addiction who also are challenged with their mental health is also seen. Distinguishing the two can, therefore, be challenging. A report from SINTEF, based on three national surveys of patients in both mental health care facilities and in intervention centers (in 2003 and 2004), revealed approximately ten percent of patients receiving mental health care treatment (either inpatient or outpatient clinics) and 47 percent of patients diagnosed with an addiction, had both an addiction and a mental health challenge (Gråwe & Ruud, 2006). Many of the patients challenged with an addiction reported on a lack of treatment for their mental health challenges, alongside many whom were struggling with their mental health challenge lacked treatment for their addiction. From a political perspective, it is therefore essential to implement health care services to minimize the negative health impacts that were mentioned at the start of this chapter, and where dual diagnoses are permissible.

The society has responded by creating complex networks of professionally operated health care services, ranging from inpatient treatment programs to social work agencies. Despite the range of services offered for individuals having a mental health challenge and addiction, a

significant amount of them seek support from each other for guidance, understanding, belonging and practical advice (Humphreys, 2003).

Consequently, peers have been added to the services, and implementing their role as, or to, services has been seen trending in a positive direction the last years (Norwegian Directorate of Health, 2014). The demand for adding peers to health services has been increasing on the bases of positive experiences from the user's perspective alongside the high prevalence of addiction and mental health challenges. Supplementing with peers in services is also mentioned as a high priority area from the Ministry of Health and Care Services in Norway (Ministry of Health and Care Services, 2016), as they emphasize this could support for an individual and customized offer from the Health and Care services (Norwegian Directorate of Health, 2014).

Nonetheless, peer-workers are often isolated to one field, not in combination. Looking into details of separation, 19 percent of peer-workers report working isolated to the field of addiction and 29 percent to the field of mental health challenges (Indergård et al., 2017). Support is growing for tailoring integrated treatments for the comorbidity of addiction and mental health challenges (Davidson & White, 2007; Drake, Mueser, Brunette, & McHugo, 2004), yet challenges on implementation of the combination are still seen. Davidson and White (2007) suggest recovery-oriented care as organizing principles for integrating addiction and mental health services.

2.1 Previous research

Reviewing the literature was necessary to identify and assess research on the topic of peer-run services for people with mental health challenges and addiction. An independent database search was conducted to understand where the literature is at (see Appendix A for more details), a few from the database search are critically discussed below.

Implementing peers as support for people with mental health challenges is viewed as a relatively new phenomena. According to the literature the first publication on the subject was in 1991 by Sherman and

Porter as cited in Davidson and colleagues (2012). The use of peers, in general, (but non-published until later), was seen early around 1920, in the USA, where Harry Sach Sullivan employed past patients who had experience from a psychosis (Davidson et al., 2012). Implementing peers was valued as it was reported they were more friendly, gentle and human in their touch.

The first plea associated with peer involvement in the traditional healthcare service is with Deegan (1993), who argues their presence would resemble hope and dampen, the often associated, stigma. A section of the article below shows her argumentation;

"To me, mental illness meant Dr. Jekyll and Mr. Hyde, psychopathic serial killers, loony bins, morons, schizos, fruitcakes, nuts, straight jackets, and raving lunatics. They were all I knew about mental illness, and what terrified me was that professionals were saying I was one of them. It would have greatly helped to have had someone come and talk to me about surviving mental illness- as well as the possibility of recovering, of healing, and of building a new life for myself. It would have been good to have role models –people I could look up to who had experienced what I was going through –people who had found a good job, or who were in love, or who had an apartment or a house on their own, or who were making a valuable contribution to society" (Deegan, 1993, p 8).

Davidson and colleagues (Davidson et al., 2012) review of the literature on peer support and describes it going through three phases. Due to the history of discrimination and stigma towards individuals with mental health challenges, the first part of the research involves feasibility studies to demonstrate the fact that people with these challenges were apt to function as mental health staff (Davidson et al., 2012). These studies revealed peers were producing outcomes similar to non-peer staff. Results from these studies lead to the second phase of the research, where peers were contrasted with non-peer staff, but both functioning in conventional roles. Results revealed a difference in the two, where peers

were better able to reach out to clients who were usually hard to reach, and generally, demonstrated results in a more positive direction than non-peers in conventional roles. The positive influence peers were seen to have led to the third section of the literature, trying to identify the significant difference in peers and non-peers, and if peers were unique in their service. The review mentioned (1) hope through self-disclosure, (2) role modeling through self-care in one's illness, and (3) the relationship built on trust and empathy that arises to be unique to peer-support. Alongside reviewing the literature, Davidson and colleagues (2012), suggest strategies with implementing peer services. A critique to this review, from the readers perspective, is little attention is given to which types of studies are involved in this review.

Another study conducted by Davidson and colleagues (2006) reviewed four randomized control studies demonstrating that peer support had no significant effect when compared with non-peer staff. However, two of these studies are from the late 90's (1998 and 1999) and the other two are from the early 2000's (2000 and 2004). As the study from Davidson and colleagues (2006) themselves note, peer support started to gain recognition in the 1990's. Therefore, one could speculate that these RCT's were too early in the phase of implementing peers to study and see significant results.

A cohort study conducted by Resnick and Rosenheck (2008) compared effectiveness of a peer supported and peer educated group (involving war veterans having a serious mental health challenge), with a standard care (excluding peer education and peer support). Three cohorts between 2002 and 2006 were taken, involving a sample consisting of 298 people. Measures linked to recovery were obtained, through questionnaires and scales. The study suggests participating in a peer support group could enhance personal wellbeing measured in recovery outcomes (linked to confidence and empowerment) and clinical outcomes (linked to Global Assessment of Functioning scores). A note is that the study recruited participants over a three-year period, exposure to treatment could therefore have occurred, which in turn could have inflicted the results.

A systematic review, comprising 20 studies from the period 1995 to 2012 of peers added either to (1) traditional services, (2) peers existing in clinical roles or (3) peer-delivering curricula for people suffering from severe mental illnesses, found improvement in recovery-related outcomes when measured against professional (Chinman et al., 2014). In total the results revealed that these three different types of peer-combined services showed a reduction in inpatient service use, an improved relationship with the providers, more engagement with the care, an increase in empowerment, patient activation, and hopefulness regarding recovery. The studies involved in this systematic review were quantitative and the authors note they differ themselves from previous systematic reviews as quasi-experiments were also added to this review. The review conducted by Chinman and colleagues (2014) covers a lot of the literature and note many of the studies on peer-combined services do not reveal statistical significant results and report on methodological shortcomings. Nonetheless, results presented in this study show a positive attitude towards peer-combined services. Looking at where peer-combined services were mostly valued, the review reveals peers added to traditional services, (eight out of 13 studies showed positive outcomes), or peer delivered curricula, (four out of four studies showed a positive outcome), added the most benefit. Only one of three studies found a positive outcome for adding peers in existing roles. The results of where peers were the most valued are important for policy making to understand where peer-combined services should be offered. The review also noted that one study had a negative impact of peer involvement (van Vygt et al, 2012 as cited in Chinman et al 2014). In this case peers were associated with more hospitalizations. Yet the results show ambiguity, as peers were also associated with better psychiatric and social functioning. Chinman and colleagues (2014) review notes the methodological rigor varying within the studies yet emphasizes the value of peer-combined services.

A more recent study conducted by Crane, Lepicki, and Knudsen (2016) looked into the specifics as a peer support worker to uncover what is unique to their role in contrast with traditional service workers (case managers). Involving focus groups and a set of prompts the results

revealed peers support workers had a stronger emphasis on (1) wellness, (2) recovery, (3) empowerment and (4) personal development. They were viewed as unique in the sense that they empowered the consumer. The case manager tended to focus on clinical care conditions, coordinating the support and services for the client. Both peer -supporters and case managers admitted their roles would sometimes overlap, yet their approaches to the task was different. This addresses the role ambiguity that peer supporters might meet as legitimate services, and also addresses how peers-supporters and case managers could interact in a complex organizational setting.

An essential factor amongst participants in a peer-run service is openness and is seen as critical for the alliance with the service to arise (Chinman et al., 2015). Feeling allied with the treatment or service is further regarded as a decisive factor for treatment completion and increase in personal recovery (Brorson, Ajo Arnevik, Rand-Hendriksen, & Duckert, 2013; Sells, Black, Davidson, & Rowe, 2008). Sell and colleagues (2008) found peer instructors who showed openness from their own experiences, regarding mental health challenges, were perceived as more validating and credible than health professionals, who did not show openness. Additionally, peers also had an influenced on changing unwanted behavior through validation, which a professional care worker were unable to do. A note to this study is these results where only short term, seen after six months, but not after 12 months. Acknowledging the results being significant at six months, but not after 12 months, add value to placing peers to services at early stages (Sells et al., 2008).

Moreover, research reveals that if given a choice, people whom themselves have suffered from mental health challenges, are more likely to choose a peer over a psychiatrist, when again faced again with the challenge. These results were based on a peer being perceived as more friendly and active. The findings from this study were however not significant, and were based on actors playing out the role as a peer or a professional, yet they reveal a positive attitude towards peers (Flanagan, Farina, & Davidson, 2016).

The presence of a peer is considered necessary regarding power balance. A qualitative study involving people with problems related to addiction found peers created equalitarian settings (J. van Gestel-Timmermans & Brouwers, 2014). Peers eliminated the feeling of hierarchy, which participants mentioned as a factor in therapeutic environments. With a fair and equal ground, there was more openness regarding topics they viewed as challenging. The presence of peers also conveyed a visible and real hope for recovery, and the participants, as well as the course leaders, could recognize and share common problems they encountered, create solidarity and feel a stronger social support. Participants learned from the course instructors and each other that there are other ways to see and cope with problems. The results of the study showed peers created openness, inspiration, and an atmosphere where acceptance, respect, and understanding was generated (J. van Gestel-Timmermans & Brouwers, 2014) Hierarchical tendencies was also brought up in Solomon's (2004) article, mentioning the importance of peers being in charge of peer-run services for power relations. She argues that if non-peers were in charge, it would disempower the peers, which in turn would negatively affect the effectiveness of the service.

The last study to present is a recent randomized wait-list controlled trial over a two-year period, looking into the impact of a specific peer-run recovery program. The sample was drawn from a Dutch population, consisting of 80 people in the experiment group and 83 in the control group. This study found outcomes for individuals having severe mental health challenges and whom participated in the peer-run recovery course to be to be empowerment, mental health confidence and a reduction in loneliness. Secondary outcomes that were reported revealed an increase in quality of life, self-reported symptoms, care need, service use and community outcomes. The study reported small effect size, yet being consistent (Boevink, Kroon, van Vugt, Delespaul, & van Os, 2016).

Obtaining a clear image of what has been studied on the topic of peer-run services for people with addiction or a mental health challenges is difficult as there are no standardized definitions for the terms peer-run services, addiction or mental health challenges. Nonetheless, the studies

presented in this chapter does add some clarity to what is known on the topic of peer-run services as well as it sheds light on the many variations of peer-implemented services. A general note is that a majority of the studies mentioned in this chapter vary in methodological rigorousness. Lacking a clear and rigorous picture on the topic on peer-run services yields itself for further research. Alongside this the majority of the studies are quantitative, few qualitative studies were found on the topic of peer-run services for mental health challenges and addiction. This leads to the section of research question and aims for this thesis.

3. Research question and aims

In reviewing the literature, reflections were made on the numerous of studies on the topic of peers. Seen in a geographical context a majority of the samples are drawn from American, Dutch or British populations, few were uncovered from Scandinavian countries. A majority of these are also, as mentioned, are quantitative. Therefore, focusing on measurable outcomes in recovery rather understanding underlying aspects. Fewer studies have looked into the distinctiveness of peer impact to understand the underlying factors of *what* and *how* peer impact is occurring with qualitative methods. Gaining further and more profound knowledge is therefore still relevant.

This study aims to generate knowledge on *what* is distinctive in a peer-run recovery course, and *how* peer support distinguishes from traditional care. The overall research question asked is: *how do peers impact each other in a peer-run recovery course?*

This study distinguishes itself from the literature on the bases of its aims, its geographical context, and the sample involving the co-occurrence of a mental health challenge and addiction. This study is also part of a more extensive study looking into the feasibility of implementing RIUtY to Norway.

4. Approaches and theory

4.1 Philosophical foundation

The thesis' overall aim is to understand the participant's experiences from the course RIUtY to gain knowledge on the phenomena of peers. Social constructionism and hermeneutic contexts are therefore used as a scientific and philosophical foundation to shed light on this topic. The study is inspired by the hermeneutic approach as it seeks to understand the topic of interest through interpretation (Thornquist, 2003). To answer the aims of this study one had to understand the participant's situation, then interpret the interview material through a systematic interview and acknowledging preconceptions could affect interpretations of what is communicated.

Regarding social constructionism one can understand this theory as a reaction to the field of positivism, where knowledge was believed to be gained through objective observations through sensory experiences and interpreted from logic and reason (Macionis & Gerber, 2010). Disputing this idea the sociologists Berger and Luckmann (1966) who wrote the book «*The Social Construction of Reality*» giving rise to the topic of social constructionism. They shifted the focus to the individual's definition of a given situation and centered on the notion that humans rationalize their experiences by constructing models of their social world and actualize and share these models through their language. Adding to this Gergen (1973) argued that knowledge has to be historically and culturally situated, so to understand a person one had to see it related to the social, political and economic relations. He also introduced an additional concept, *constructivism*, which roots in psychology and focuses more on internal processes involved for the production of knowledge to occur. Acknowledging a difference in constructionism and constructivism, this thesis focuses on the individual experiences to understand the impact participating in a peer-run recovery course had with its focus on the social context, the viewpoint from social constructionism will, therefore, be used. Furthermore, addiction and mental health challenges are, according to the philosophical stand this

thesis takes, viewed as social constructs, adding additional leverage for using social constructionism as a perspective.

The theory on social constructionism claims knowledge and many aspects of the world around us are not real in and of themselves, yet their existence is reached by humans validating them through social agreement (Elder-Vass, 2012). Aspects like nations, institutions or diagnoses do, according to this theory, not exist in the absence of human society. Nations are for example groups of people who happen to share the same border or history; an institution resembles an establishment for care or confinement; and diagnosis is words resembling a standard, embedded behavior, and has no value unless it is assigned.

4.2 Recovery

A recovery approach becomes applicable as it is a central element in where the course data is drawn from, and arguably a basic attitude from. This approach has gained importance in recent years and has increased its visibility in the mental health services (Slade, Amering, & Oades, 2008). Alongside with this, the Norwegian Directorate of Health (2014) has stated its significance and mentioned it as a priority for healthcare services in the future. This perspective differs from the biomedical perspective, where detecting and curing illness has been dominating. Instead, a recovery-oriented practice involves contributing to an increase in hope, an identity, meaningful life and personal responsibility (Slade, 2017). The term *recovery* yields many definitions, yet they all encompass self-determination and self-management. This study will draw on Anthony's (1993) definition, explaining recovery as:

"A deep personal, unique process of changing your own attitudes, values, feelings, goals, and skills and/or roles. It's a way of living a life that's satisfying, participating and filled with hope, even with the limitations which cause the suffering. Improvement involves the development of new meaning and insight into one's own life " (Anthony, 1993)

The definition emphasizes the individual creating their recovery, thus promoting autonomy. Personal attributes associated with the term recovery are empowerment, belonging, hope, optimism, identity and goals (Anthony, 1993). It involves *being in recovery* rather than being *recovered*. Therefore, it is not a goal to achieve; instead, a process one learns to take through life. With this, the concept of recovery become a notion of continuity instead of a static meaning, and it eliminates descriptions of *chronic illness* or pressure to complete treatment. It creates room for the person to feel and take charge regarding life, personal arrangement, as well as an understanding of how people handle the presence of possible longevity of suffering. The problem with this definition is that it may be subjective and health professionals may have different views on what is considered recovery. On the webpage for Norwegian Competence Center for Mental Health (NAPHA) websites, Slade mentions the problem for this in the health sector, as it is difficult to measure the outcome due to its subjectivity and thus difficult to measure the costs associated with it (Karlsen., 2017). Therefore, the term recovery is seen split into two categories, clinical and personal recovery. This thesis will focus on recovery as an individual process yet acknowledges the term clinical recovery as well. Clinical recovery has emerged from professional care services emphasizing on sustained remission and restoring functionality (Slade et al., 2008). A personal recovery, on the other hand, emerged from the field of consumers where the focus is on living a satisfying and hopeful life, and being able to contribute, despite limitations caused by the illness (Slade et al., 2008). In a personal recovery, the *person* becomes the central actor and decision maker, where attention and respect to each and unique experience is given (Brekke, Lien, Davidson, & Biong, 2017).

4.3 Knowledge

Knowledge is a central benchmark underpinning this study. The thesis will use Berger and Luckmann's (1966) definition of knowledge, whom

describe knowledge as a certainty of a phenomena being real and possessing distinctive characteristics (Berger & Luckmann, 1966). This thesis recognizes that there is a variety of ways to understand and term knowledge. In attempt to reach clarity, this thesis splits knowledge into three different categories: lay knowledge, professional knowledge, and experiential knowledge. The difference in them is based on how the knowledge is gained and what it represents, this is further discussed below.

Lay knowledge resembles the commonsense ideas and pop culture beliefs which are easily accessible (Berger & Luckmann, 1966). This type of knowledge represents the average type of person in the given society and is gained through everyday experiences. For example, what the average person believes causes mental health challenges through what is learned through external projections. This form of knowledge has been familiar with sociologists and anthropologist a long time, who distinguish it from professional knowledge (Henderson, 2010; Prior, 2003).

Professional knowledge, on the contrary, is gained through academia, scientific principles, and analytical processes and usually viewed as coming from a person in an expertise role (Humphreys, 2003). This type of knowledge is not accessible for everyone and requires efforts for attainment and sustainment. Professional knowledge is specific and more extensive than lay knowledge. For example, a professional may know what causes mental health challenges through exhaustive readings and discussions on the topic, creating a deeper understanding of it. In the western world, it is believed professional knowledge has a higher status, associated with more power, than other types of knowledge (Boxall & Beresford, 2013).

The third type of knowledge is experiential and based on the experiences of the individual, and that this individual highly values it, as it has been gained through direct contact with the physical and social world (Borkman, 1976). Therefore, it has practical uses, as it can be translated into strategies for living with a particular problem. Additionally to its practical uses, when pooled with others sharing the

experiences, it also gains contextual, subjective, unconscious and emotional properties (Boardman, 2014; Borkman, 1976). While some argue experiential knowledge is synonymous with lay (Caron-Flinterman, Broerse, & Bunders, 2005), this thesis draws on its specific characteristics differentiating it from lay knowledge. Experiential knowledge differs from the former types as it and based on specific experiences. For example, one has knowledge on a mental health challenge as one has experienced a psychosis being able to relate actual and descriptive knowledge on the topic. Peer-run services benchmark on this knowledge, as *they have been there too* allowing them to share experiences. Addition to splitting knowledge into three parts, this thesis also acknowledges, without going further into it, that knowledge itself is *situated.*

An important note is that knowledge becomes useful when it is in the right contexts of relevance (Berger & Luckmann, 1966). For example, informing a school child on how to deal abstinence is not relevant, yet placing it in the right social context, for example, to the peers in RIUtY -it does become relevant. This basic structure of relevance is presented as common knowledge itself.

Knowledge is vital as this sets the grounds for what the different types of services offer. Traditional services have long been dominated by professional knowledge and are often *one-way*, one gives the help, and the other receives the help. In peer-run services, on the other hand, this is often reciprocal due to its nature. Although some peers are viewed more adept or proficient than other, it is believed all involved will benefit (Davidson et al., 2006).

The focus within traditional care is usually on the unique experience of the individual which may help to understand what their mental health challenge or addiction is. A professional will not be able to say, "*I know how you are feeling*", but can ask questions regarding this feeling and create meaning behind it. Traditional services also offer a neutral space where the focus is purely on the individual and their experiences. On the contrary, peers have the legitimacy of consoling on mutually shared experiences. The "*I know how you are feeling*" can be

said in an honest and fair way from a peer, which can generate comfort, safety, and support.

5. Method

The overall research question raised for this thesis is *"how do peers impact each other?"* followed by the specific aims: what is distinctive in a peer-run recovery course and how do they differentiate from traditional care?

5.1 Design

The study used an inductive approach; therefore theoretical perspectives were revealed alongside the data analyses (Jarvinen & Mik-Meyer, 2017). An exploratory design was chosen as the researcher wanted to explore the topic with open arms allowing the empirical data to guide for relevant theory. The aims for the study involved the words *how* and *what*, rich and informative data was therefore needed to answer these aims. The properties of a qualitative method open for this by providing diverse, nuanced and subjective experiences reflected in the data (Malterud, 2017). Additionally, as this thesis was curious in the human qualities such as experiences, thoughts, expectations, motives, and attitudes, which is also a something the qualitative methods opens up for (Malterud, 2017).

5.2 Pre-understanding

Revealing pre-understandings and a personal interest for the topic is relevant for the study's credibility and for the sake of the reader to understand interpretations drawn from the data. I am a 27-year-old woman, who, on a personal level, has an interest in human behavior. My interest has led me to take a bachelor's degree in psychology in Melbourne, Australia. After completing my bachelors, I traveled for six months with the intention to understand the function of socializing and force of motivation between people in different cultures. On returning to

Norway I started working at an acute bedpost within the psychiatric division at the Hospital of Stavanger. In two years of working at this division, I have come in contact with people struggling with addiction and mental health challenges. An experience I made through coming in contact with them is that many seek other patients they can identify themselves with. I have come to understand there is a gap between the healthcare professionals and patients, which in turn can impact the relational aspect and treatment outcome. My learning is this, a person who has experience from the field the patient comes from, a *peer*, from can thus be considered beneficial to convey real and visible hope.

5.3 Focus

The data is derived from a peer-run course, yet the focus is on the peer support attained from the viewpoint of the participants. This decision was made on the premises of the participants and course holders informing they were all participating on the same grounds, working through the same challenges. Even though the peers running the course were *in charge* and had a manual, they also used the same workbooks as the participants and engaged on the same level as the participants. There was therefore not much differentiating those running the course from those participating, other than the peers running the course had participated in RIUtY before, while the participants had not.

5.4 Sample

The focus of the study was on the participants' experiences from interacting with peers. The selection for the study was thus strategic (Polit & Beck, 2012), and primarily including all participants who completed the course within the 12 week timeframe that the course was held. Inclusion criteria were participating in RIUtY on the mentioned dates, having finished the course, and being able to meet-up and participate the interview in Norwegian. Exclusion criteria were peers running the course, drop-outs from RIUtY, and being heavily under the influence of substances -thus unable to participate in the interview. Six

out of seven gave consent to participate in the study. One declined later in the study, while another was recruited through a home visit when interviewing with their spouse.

The demographics of the sample showed age varying from 22 years old to 53 (M= 34), four of the participants were male, and two were female, four had completed secondary education, five received regular assistance from municipal follow-up services in the field of addiction and mental health work, one was an outpatient from treatment at the regional hospital, one recently completed treatment of municipal follow-up services in the field of addiction and mental illness, four of the subjects had one hospital admission within the last year, five subjects reported a comorbidity within addiction and mental illnesses, all subjects reported challenges regarding addiction. See Appendix C for further details.

5.5 Collecting the data

The researcher was allowed access the course location and had been present many times on course days to help with general course preparations, however, was never present when the course started, nonetheless the participants created a sense of familiarity to the researcher. Addition to this, the peers running the course informed about the study and notified them of the recruitment. Recruitment for the study took place before participants started their last course day, inquires for participating in the study was handed out. Oral information regarding the study had been given a week in advance, allowing the participants to consider their participation before recruitment took place. Feedback on words the researcher used was given, for example a participant said they referred to their group as *the RIUtY community* rather than the RIUtY environment. Small changes in the interview guide was done accordingly. The researcher was in charge of recruitment, as acquaintances had been established.

Interviews were conducted within two weeks after RIUtY was finished. Time and location were agreed upon after the course ended from a telephone conversation. Half the interviews were carried out at the

participant's homes, a desire from their part and the other half were conducted at a private room booked at The University of Stavanger (UiS). The interviews took place at mid-day, between 11 am to 4 pm. Tee and snacks were served at the interviews held at UIS to create a relaxed atmosphere. The interviews varied in length, depending on how many follow-up questions were asked by the interviewer and how much the respondent talked. During the interviews an audio recorder was used, allowing the interviewer to fully commit to the conversation without being distracted by taking notes.

Addition to in-depth interviews, informants were also asked to fill out a background information sheet to create an overview of the demographics of the group (See Appendix B for more information).

5.6 Interviews

Semi-structured, individual, in-depth interviews were undertaken to reveal the participant's thoughts on the topic. With this, the study did not go in a direction where predefined response categories or cumulative responses were sought out but, relied on open questions. Using the exploratory design and open questions allowed the study to collected answers to questions it did not know it could ask. Furthermore, questions during the interview, regarding meaning and importance on topics, were often embedded in *what* and *how* questions -creating deeper and richer details around it (Jarvinen & Mik-Meyer, 2017). Conducting in-depth interviews allowed the study to reveal patterns and processes that show suggestions for causality (Polit & Beck, 2012). The interpretation of the data also opens for the possibility of further systematic testing under controlled conditions (Polit & Beck, 2012). Further research is viewed beneficial as this study is part of the Norwegian feasibility study on RIUtY.

Additional strength in using semi-structured interviews lies in its nature of it being semi-structured, allowing the interviewer to create a natural flow in the conversation, add spontaneous follow-up questions, further dig around a topic the subject had much information about, while

producing uniqueness around each interview (Fylan, 2005). For the natural flow to arise, an emphasis was placed on giving the subjects the time and space they needed, to secure they felt safe while opening up about their experiences during the interview. The interview consisted of four questions regarding experience and six key questions focusing on the topic of interest (see Appendix E for full interview guide).

5.7 Data Analysis

In total, the interviews gathered 237 minutes (almost four hours) of data, with an average interview length of 40 minutes, resulting in 81 transcribed pages (with 1,5 in line spacing and size 12 on words). The interviews were transcribed verbatim directly after the interviews, before analyzed through a content analysis inspired by Graneheim and Lundman's (2004). The analytical process involved reading the transcripts several times to attain a sense of wholeness. The text was then fractured into small meaning units, then abstracted into condensed meaning units before labeled as a code. The codes were then generated into subcategories before given an overarching category, and lastly identified as a theme. The categories mutually exclude each other but were found to fit under more than one theme. The analytical steps were conducted through the qualitative software program Nvivo, allowing the researcher to conduct further analysis' through the queries tool. The queries tool was especially helpful when examining who said what, with which effect, potential trends, frequencies, and patterns of the words used by the interviewee.

5.8 Ethical implications

Since the data was retrieved from human beings, it was important that the study was performed with care to protect human integrity and rights, guidelines in the Helsinki declaration was followed (World Medical Association, 2018). A written consent to participate in the study was obtained in advance where it explained participants could withdraw from the study at any time without any consequences (see Appendix D for

further details). The project was submitted to REK, with a response that the study did not need approval from them. As the study is an extension of another project, a report on changes was sent to NSD (Project No. 49779, Appendix F).

When sensitive topics arose, consideration was taken by ensuring and reminding the subjects knew they could withdraw at any time, retreat from answering, or turn off the audio-tape. Further attention to the sensitivity was given beforehand when deciding to have individual interviews rather than focus group interviews.

5.9 Validity and reliability and credibility

Recovery Is Up to You inclusion criteria is having a mental health challenge and/or addiction and being motivated for change. With this in mind, it is assumed that the groups have a form of homogeneity, which can have a validating effect on prominent themes.

Regarding the study's reliability, it becomes crucial to show transparency by explaining step by step how the was a study conducted and how RIUtY operates, as mentioned in start of this thesis. This creates room for interpretation and criticism for the reader.

Credibility was obtained during the interview where the validation was sought on correct interpretation from the interviewee to ensure that the material was understood. Validation was sought out through paraphrases and a summary at the end where the interviewee could verify what the interviewer understood. In the result section quotes from the subjects are included to provide context and allow the reader to interpret themselves from the participants' perspectives.

5.1.1 Methodological considerations

The interviews used an audio recorder, and even though informants said this did not bother them, it could have influenced the conversation. Consideration was therefore taken by starting the interviews off with general talk, allowing the atmosphere to become relaxed and shift the focus from the recorder.

External factors such as nervousness, time of day, how the atmosphere was in the room during the interview were factors taken into account.

Using the content analyses inspired by Graneheim and Lundman (2004) in Nvivo brought challenges in presenting the different steps taken in the analytical process. Going from meaning unit, through a condensed meaning unit, to code was a process involving various steps abstracting the given node. Some of the codes were longer, with respect to keeping the codes as close to the original data as possible, while still generating meaning. Nvivo only uses nodes as a representation of the coded material. To distinguish them Nvivo allows a hierarchical order involving mother and child nodes. Child nodes, therefore, represented a code having undergone an abstraction from meaning unit and condensed meaning unit. The subcategories were created as mother nodes, before further abstracted to a category. Themes drawn from the categories were not done through Nvivo, but instead on a separate worksheet due to presentation preferences from the researcher.

The quotes used in the results represent a translation from Norwegian to English, and then from English to Norwegian again (from an independent person) to ensure meanings through the translations were upheld. Most of the quotes are a direct translation from Norwegian to English, yet the quotes which missed a meaning through a direct translation were translated with an approximation. An example of this is "er i *samme bås»* which would directly translate to *«being in the same booth»*. To keep the meaning an approximate translation would be*: «wearing the same shoe»*.

No form of compensation of remunerating on was given for participating in the study. Participants mentioned their motivation for participation was based on their wish to contribute and provide feedback viewed beneficiary (for RIUtY to continue). A wish from their side to participate could be noted as a participation bias.

6. Results

Three emerging themes arose from the data analyses revealed peers are distinctive in that they generate a sense of belonging, resemble hope and offer practical advice.

Belonging to the group reflected on the informants calling it safe, supportive and inclusive because all involved were "*wearing the same shoes*". Hope was associated with role models and a desire for attributes. Practical advice was offered in the sense that the participants said tips were exchanged and the course was solution focused.

A difference in peer-run services and traditional services was found, in that participants sought one (service) over the other depending on which area of challenge they faced. Traditional care was sought out when challenges with their mental health were the prominent challenge, as the participants described they were seeking understanding and acceptance for their challenge. Peer support, through peer-services, was sought when challenges they faced due to their addiction was prominent as peers could offer the mentioned features of distinctiveness. Review the article for further elaboration.

7. Discussion

In this study of peer impact in a peer-run recovery service for people with mental health challenges and addiction, results show peers impact in ways making them distinctive to their roles by offering hope, a sense of belonging and practical advice. These findings are consistent with the literature (J. van Gestel-Timmermans & Brouwers, 2014; J. van Gestel-Timmermans et al., 2010). An additional theme that emerged from the results, which answers the second aim, was peer -and -traditional services differentiate in what support they offer and associated outcomes. These aims are further discussed below under separate headings.

7.1 Peers offer hope, belonging and practical advice

Hope is defined as an optimistic state in the mind due to expectations on beneficial outcomes (OxfordDictionaries.com), and associated as a

recovery outcome (Anthony, 1993), was one of the aspects the participants found to be distinctive to peers. To understand how hope was generated it can be put into the context of hopeful thinking, which is described as a cognitive process that can generate potential health outcomes through the three thought processes consisting of goals, pathways, and agency (Lopez, Snyder, Rand, & Cheavens, 2012; Snyder, Rand, & Sigmon, 2002). Goals represent mental targets guiding human behavior; pathway thoughts involve one's perception to be able to generate multiple routes to the given goal; and agency thoughts is the perception of one's initiative and sustainability along the pathway (Lopez et al., 2012). Accordingly, if an individual perceives themselves capable to derive certain pathways and an agency to attain and sustain a chosen goal, it can generate health outcomes. Using these thought processes to understand how hope was generated in the context of RIUtY and for the participants, one can use the goal of abstinence (abstaining from drugs), which was a goal mentioned by the participants. Through participating in RIUtY, multiple pathways were learnt and generated on how to achieve the goal of abstinence through course material, through the established social networks, or through practical advice that arose during the discussions in the groups. Agency thoughts could have occurred through vicarious learning, observing the peers who had a long time of abstinence. An inner dialogue or a belief system of *you can, as other like you have,* may have enhanced this agency. One's initiative is therefore boosted, and one strives to sustain the goal of abstinence. Immediate health outcomes regarding abstinence are not necessarily seen, but consequences of continuing with one's addiction (to drugs) is well known.

Furthermore, the belief system of *you can, as other like you have* can generate a sense of affiliation with those one views *like* them. This affiliation is important for strengthening relationships as this is believed to generate a deep and holistic connection between the parties involved (Mead et al., 2001). The relationship established between the participants is present through the result *belonging.* Feeling a sense of belonging is important for health related outcomes, and included in one of Maslow's

basic human needs (Maslow, 1989), along with being associated as a recovery outcome (Anthony, 1993).

Belonging involved commitment and the participants felt safe, inclusive and supported. The word *community* was used when referring to the group and using this word for referral shows further emphasis on their affiliation to each other. They felt they were part of something, and that their presence was of meaning. Participating on meaningful purposes can explain why the participants were so engaged and valued the course and its outcomes. Contributing on meaningful purposes can also be seen as a decisive factor for course participation, or dropping out, through two of the participants, who mentioned they had little to no motivation for attending the course at the beginning. When asked why they continued in the course they responded with two reasons: first, since they had said yes to participating in RIUtY, they wanted to stay true to their word, arguably showing signs of personal agency. Second, for the course to get its benefits it was dependent on them coming and contributing. The *community* that had been established worked in a sense that either you were in, or you were out. Accordingly, if you were in you had to play your part for the community to receive benefits and outcomes. This could further be regarded as a positive reinforcement, as the individuals engaged in a behavior (for example abstinence) that would give them a sense of belonging to this *community*.

Feeling a sense of belonging also implied the participants grew a larger social network and made friends. Having friends who they affiliated with was important, as many of them mentioned they had broken off ties with former friends whom were still using drugs, or in general had few friends at this stage in their life. Avoiding the feeling loneliness is essential, as this is linked with negative health impacts (Cacioppo & Patrick, 2008)

Practical advice was offered in ways the participants could overcome difficult challenges and arose in discussions where participants did not even know they were seeking advice. This generates a sense that the was course was orientated towards challenging topics and participants were open on sharing their experiences.

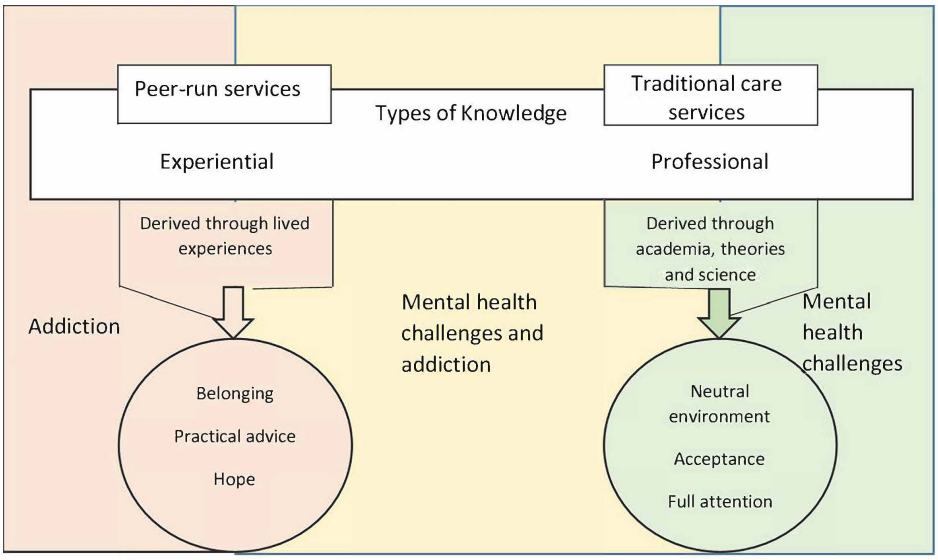
The three themes of belonging, hope and practical advices that arose, can be seen as dependent on the context. As the participants mentioned themselves, the course mainly relied on participant involvement and contributions made by them, not as much on the course material. What was generated in the course is therefore imbedded in how it is contextualized. The course outcomes for this specific round of RIUtY can be seen as specific to this individual course. Specifics on what types of practical advice was offered, how the hope was generated, or in which sense the participants felt a sense of belonging, depend on the those involved; and those involved were dependent on where they were at in their life, if and how they were motivated for a change, and if and how they were ready to work on a recovery process with their challenges. Therefore, one can say the specific knowledge on recovery was learned depending on their time of participation, the people they shared it with and history leading up to it. It is contextually embedded in their particular physical location. When shared by those involved in the location it endures, making it relevant over time (Sole & Edmondson, 2002).

7.2 Peer -and -traditional services differentiate

The results indicate a difference between peer-run services and traditional care services in the support they offer and on what background the participant seeks one service over the other. The results suggest that when mental health challenges were the prominent area of challenge the informants would seek help from a professional, whilst peers were sought out when addiction was the prominent challenge.

Addressing a need for traditional services was an interesting finding, as almost all the informants mentioned negative associations with the health care system involving, among other things, untrustworthiness and disagreement with diagnoses. Additionally, these result pose a difference from previous literature, where Flanagan et al. (2016) found, if given a choice, peers were favored over professionals. An assumption was therefore that the participants for this study would say they avoided this service. Further leverage for this assumption also

due to the participants almost glorifying peer support, as peer-support was mentioned unique and necessary. Nonetheless, the need for traditional services was also implied. To understand this, the perspective on knowledge is used. A model below presents the idea that the service one seeks is dependent on which challenge is prominent. Traditional care services and peer-run services are furthermore dependent on where their knowledge is derived from. Peer-run services offer experiential knowledge, whilst traditional services offer professional knowledge. With their different knowledge as benchmarks, this also affects their focus and outcomes.



Model 1. Different types knowledge benchmark the services, which in turn effect associated outcomes.

As mentioned, when addiction was their background for seeking help, they are most likely to engage in peer-run services to receive peer support. Seeing that peer-run service benchmarking on experiential knowledge they will feel a sense of belonging, see a resemblance of hope and be able to receive and give practical advice. The peers they interact with share a unique background as *they have been there too*, giving them legitimacy in their roles which could offer a sense of consoling. Therefore, it becomes helpful to meet people with similar experiences, to

understand and share commonalities which may be guide their recovery process.

If challenges with their mental health was their background for seeking help from a service, the traditional service was valued. Traditional services involve professional knowledge which offer the outcomes as full attention, help to accept and understand their challenge, and a neutral environment where the one sharing, is the main and only character. Although the professionals in the traditional service would have gained little credibility by saying *they have been there too,* they can offer another consoling factor by saying *"let's try to understand what you are feeling"*. With their professional knowledge they can offer clearance and explain reasons for why certain states occur or how this state may affect people.

Seeing that the participants clearly distinguish one service over the other, it could be explained through affiliative reasons. As all participants shared the challenge of addiction, this created a sense of affiliation. One could further speculate that when participants faced a mental health challenge, it was difficult to affiliate with others having the same, or similar, type of mental health challenge. Mental health challenges involve a larger spectrum both in seriousness and in types, than, arguably addiction. Seeking help from a neutral part (a professional) could be that an affiliation on mental health challenges was hard to establish, thus avoided. Alongside this, it could be argued that when participants faced with a mental health challenge they wanted to avoid the experiential knowledge, the *having been there too.* Given that mental health challenges do vary in different diagnoses and in seriousness, it does not necessarily mean it helps hearing someone say *having been there too,* as one could disagree.

The peer-run services and traditional care services were viewed as different, and a mix of the two was not preferred as this could challenge the respect and hierarchical roles, receiving both services was viewed as most helpful, yet on separate arenas.

Limitations

There are various limitations to this study worth mentioning. In regard to a difference in peer support and professional help, this was only hypothesized by the informants. However, all participants, except one, had recently or was still receiving care from the traditional Healthcare service (see appendix C for further details). Nonetheless, these results can by no means be generalized and should only be interpreted in their context.

As the methodological considerations acknowledges, the participants involved in this study were on a voluntary basis. A majority expressed they were eager for the course RIUtY to continue, therefore excited to share their experiences around it, a motivation from their side should, therefore, be noted, which could have influenced data with positive outcomes.

Additionally, within the two weeks the interviews were conducted, two of the participants had been asked to be course-instructors for next round of RIUtY. During the interview this was clear to be on two of the participants minds. One of the participants, who had been offered the role as a course-instructor, had reflected a lot on the experiences from their previous course and how a sense of belonging had impacted them as a group. This participant was in the middle of the thought process on who to recruit for next round's course, and had therefore reflected more on course outcomes, than, arguably, the others. Another participant showed sign of being upset by not being chosen to be next round course-instructor, as some of the reflections made in the interview showed signs of insecurity. This was taken into considerations when interpreting the data and should be acknowledged by the reader.

Another note is this round of RIUtY had a surprisingly success high rate, meaning few drop-outs. The last time this course was held in this municipality the drop-out rate was nine people, yet this round the drop-out was four people. These results themselves could yield to further research.

Regarding the interviews, most of the stories that surfaced disclosed on the subject of addiction. This may have been influenced by the fact that all participants shared addiction as a challenge. Sharing this specific goal could have also set grounds for affiliation and belonging and to arise. Recognizing that addiction was a salient subject during the interviews, it is also possible as this was a main focus during RIUtY. It could also be speculated that it was harder for the participants to identify, or affiliate with, peers struggling with the same mental health challenges, as the range associated with these challenges is broader.

Conclusion

This thesis looked into what is distinctive in a peer-run recovery course and how this type of service differentiates from traditional care services. The results derived from this study show peers are distinctive in that they offer a sense of belonging, hope and give practical advice. Peer-run services are found to differentiate from traditional care services, on the bases that participants seek one over the other depending on which area of challenge they face. The results imply peer-run services are favored when participants face challenges with their addiction. Set into context of knowledge, participants and peer-instructors in a peer-run service share their experiential knowledge. It is believed that this experiential knowledge will give rise to the feeling of belonging, hope and the practical advice. Regarding traditional care services, this type of service is valued when participants face a mental health challenge. Traditional care services offer professional knowledge, which the participants are believed to seek to generate a sense of understanding, acceptance and to share in a neutral environment.

With the results from this study, the trend of implementing peer service is viewed valuable, but the results also imply a field of service should not be excluded over the other, but rather attempt to offer services from both sides. Future research should further look into how these two types of services complement each other.

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Section 2 – The Article

Peer distinctiveness, is it enough? A qualitative study on a peer-run recovery course

Disclosure: No funding was received for developing or writing this article. This study is an extension of another project, looking into the feasibility of on implementing the course, Recovery Is Up to You, from Dutch to Norwegian settings.

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The article has to this date not been published.

Word count: 2996

Abstract

Objective: This article presents findings from a study looking into a) what is distinctive to a peer-run recovery course for people working on their mental health challenges in combination with an addiction,and b) to understand how this differentiates from traditional care.

Method: A qualitative method was used to generate rich data to understand the objective of the study. Interviews were conducted with participants that had completed the recovery-oriented course "**Recovery Is Up to You"** before a content analysis was used on the data.

Results: Peers are distinctive in that they generate a sense of belonging, resemble hope and offer practical advice. The support from peers was found to differentiate from traditional care, in that participants sought one (service) over the other depending on which area of challenge they faced. Traditional care was sought out when challenges with their mental health were the prominent challenge, whilst peer support was sought in regard to challenges they met due to their addiction.

Conclusion: Receiving services from both fields was viewed beneficial, one service should not exclude the other. Future research should look how traditional care services and peer-run services complement each other.

Introduction

Peer-run services developed for, and offered to, people with mental health challenges and addiction are seen trending both nationally here in Norway, and globally (1-3). It is believed people who have overcome these challenges can offer useful support, hope, and encouragement to others found in similar circumstances (1)

There is strong support for the beneficiaries of the provision of peer support/peer-run services (4). Studies show peer-run services for people with mental health challenges and addiction are associated to increase hopefulness, reducing psychiatric symptoms, enhancing quality of life, report less care needs, and are less likely for institutional residency (5, 6). When contrasted with traditional care workers, peers are found to reduce inpatient service use, improve the relationship with their provider and enhance engagement with their care (7)

Peer-run recovery programs are also seen effective in recovery outcomes involving: empowerment, patient activation, increased sense of support and an increase in their social network (7, 8). The uniqueness in peer-run services is their common grounds that may give rise to openness. Openness is viewed important for participants in regard to creating an alliance with their service (9). The alliance is further regarded as a decisive factor in treatment completion and to enhance a personal recovery (9, 10)

Although numerous of studies have been conducted on peers and peer support, the majority of them focus on measurable, quantitative outcomes. Less research looks at the *what* and *how* on this topic. Gaining more knowledge is therefore still relevant.

This study aims to understand *what* is distinctive in a peer-run recovery course, and *how* peer-run services differentiate from traditional care services (involving non-peers). The sample for this study is drawn from participating the peer-run recovery course **Recovery Is Up to You** (RIUtY). This course has been running since 1996 in the Netherlands and was further introduced to Norway in 2016. Previous research on this course, drawn from Dutch population, involving samples having a mental health challenges *or* an addiction, reveal course outcomes to involve an increased sense of support, social network, acceptance, understanding, empathy, belonging, hope and optimism for the future (8, 11)

This study distinguishes itself from previous studies on the bases of its aims, the geographical context, and the sample involving the co-occurrence of an addiction and a mental health challenge. This study is also part of a larger study looking into the feasibility of implementing RIUtY to Norway.

Method

Contents of Recovery Is Up to You

RIUtY uses a psycho-educational perspective, enabling participants to learn problem-solving and communication skills, whilst

providing information and resources in an empathetic and supportive environment. RIUtY consists of a two-hour weekly session, stretching over 12 weeks. Topics on recovery vary weekly and are discussed in groups where participants share experiences and develop personal, social and practical skills.

Participants

The focuses on the experience from the participants. The selection for the study was thus strategic (12), primarily all participants who completed the course within 30/02/2018. Inclusion criteria involved course completion by 30/02/2018, and capable of meeting and participating in the interview in Norwegian. Exclusion criteria were peer-instructors, drop-outs, or heavily influenced by substances -thus unable to participate in the interview. Eight participants completed RIUtY, six gave consent to partake in this study.

Procedure

The study used an exploratory design with an inductive approach. Individual, semi-structured, in-depth interviews were completed, generating rich data to answer the aims (13). The data was collected within two weeks after course-finish, for participants experiences from RIUtY to be fresh in memory. The interview consisted of four questions regarding experience plus six key questions focusing on the topic of peer-support. The interview varied in length depending on how much the interviewee wanted to share. The totality of interview data was 237 minutes, averaging on

40 minutes per interview. Addition to the interviews, the subjects were asked to fill out a form regarding background information, to generate an overview of demographics.

Sample

The sample included four men and two women (N=6), age ranging from 22 to 53, with a mean age of 34. Out of the sample, five received regular assistance from municipal follow-up services in the field of addiction and mental health, one recently completed this treatment and one recently completed treatment within the regional hospital. Four of the informants had one hospital admission during the last year, all informants reported having an addiction, five of them also reported of this co-occurring with a mental health challenge.

Ethics

Written consent to participate in the study was obtained before interviews took place. Oral consent for using the audiotape recorder was given before starting the interviews. Principles outlined in the Helsinki Declaration (14) were followed. The project was submitted to the Regional Committee for Medical and Health Research Ethics, responding the study was not in need of their approval. Due to this study being an extension of another project, a report on changes was sent to Norwegian Centre for Research Data (Project No. 49779).

Analysis

All interviews were audiotaped and transcribed verbatim directly afterwards. A content analyses inspired by Graneheim and Lundmann (15) was used to uncover emerging themes through the qualitative software program Nvivo. The analytical steps involved reading the transcripts several times to attain a sense of wholeness, before fracturing the text into small meaning units, then abstracting it into condensed meaning units before labelling it as a code. The codes were then generated into subcategories before given an overarching category, and lastly identified as a theme. The categories mutually exclude each other but were found to fit under more than one theme.

Given that the interviews were done in the Norwegian language, a translation from Norwegian to English was done by the researcher. To check that meanings in the translations were withheld, an independent party translated it from English to Norwegian again.

Credibility

During the interviews, the interviewee followed up with paraphrases and verifiable questions to clarify interpretations made during the interview. At the end of the interview, a short summary was presented by the interviewer to further verify interpretations.

Results

Based on the data analysis major themes emerged supporting the aims, a) peers are distinctive in that they generate a sense of

belonging, resemble hope and offer practical advice; b) peers were mentioned unique, yet traditional care was also viewed as necessary -this depended on the area of challenge they faced. The topics are presented in further details below.

Belonging

Collective remarks were made about the positive environment created in the course, and praise was given to participants for joining and sharing. Many of the participants mentioned they looked forward to course days, as they had a place to go to. Belonging to the group reflected on the informants calling it safe, supportive and inclusive because all involved were *"wearing the same shoes*". By feeling safe and supportive, the participants were able to open up on past events and support each other on stressful matters. This was important, as many of the participants mentioned incidents from the traditional care they defined as negative, untrustworthy, or stigmatizing.

The participants used the word "*community"* when talking about the group in RIUtY, where group rules like respect, inclusion, and sobriety were mentioned as important and established. Furthermore, it was mentioned *"you commit yourself*" when participating, as everyone's presence impacted course outcomes -giving rise to a shared responsibility for group dynamics and progress.

Feeling a sense of belonging meant the participants grew a larger social network. Many of them mentioned they made a friend, someone to grab coffee with. After completing the course, the participants arranged a social event for them to stay in touch.

"For me, that has been one of my biggest challenges. Because when I grew up, I had no friends. I was very often alone. I searched for friends. So, that's when I started experimenting with drugs, it was simply to make friends. So, to be part of a community like this as an adult, without drugs, it's a whole new experience. And that's a very good experience"

Hope

Another major topic was that peers resembled hope. Hope was associated with role models and a desire for attributes. To be a role model was something the participants identified as being something for someone else, someone they could look up to and was open and honest about their past. Both peer-instructors and participants who showed courage and openness were mentioned as role models. A desire of attributes, the "*I want what they have"*, varied in descriptions involving personality traits or abstract feelings. Peers using their background as means for their work was also viewed desirable, and respondents mentioned they did not know this was an option before introduced to the concept.

"(We) saw what the two having experiences with worked and said: "Gosh, it's possible to get free from the drugs and work with this". So that's when the journey started for me and my partner. And we were like, "hell, we will be able to do this". So, it turned good when we got off the drugs and started working (with our experience) like we're doing now. And now we meet a lot of people, and it generates itself. It's an incredible journey to be part of."

Stories surfaced on the topic of hope where informants mentioned: *"if he can do it, I can do it"*. Combining the attributes of a long period of abstinence from drugs with having faced death, or overcome other serious life events, was further regarded to emphasize hope.

"…I can meet someone who says "Yes, I have been addicted to syringes and amphetamines or heroin eight years ago, and now I am without it... and I am a lot better without today". If he can do it, I can do it. It gives this inner light. And say this person is good at telling how bad they had it, a bit about thoughts, feelings and preferably some extreme experiences where they almost died or something that backs them… because there are a lot of people think like "no one has it as bad as I do". And then suddenly you hear about a person who's had it ten times worse than you. And they still sit there sober. That hope, that is important.

Practical advice

A third theme that emerged was practical advice. The course was mentioned as solution-focused where they were taught coping and problem-solving skills. The informants mentioned tips and pointers, being exclusive due to mutual experiences, were exchanged throughout the course.

«It's really a bit solution-focused. To find solutions for a problem that seems insurmountable, which one cannot really think about. Then the solution comes, without one actually working for it. Because it's a bit like the same as saying you don't have to reinvent the wheel. It's a good idea to listen to other people's experiences»

The peers were numerous, which the participants remarked as helpful because if one peer could not help with a specific problem they mentioned there were plenty to ask. The practical advice was viewed as honest and credible as the peers offering the advice had experienced it too.

"They've simply worn the same shoe. It is honest. You know they've felt it on the body. It's not something they're just standing there and talking about. It's the real deal. It comes from something they've experienced, it's not something they've seen or have read."

Support from peers differentiating from traditional care

Even though peers were mentioned unique and desirable, traditional care was also mentioned as necessary. The results show the participants distinguished them depending on their area of challenge. Support from peers was sought out when addiction was their prominent challenge and traditional care was sought out when mental health challenges were the prominent challenge.

“There’s a lot a peer cannot help with. Such as trauma and things like that ... really heavy stuff that you no idea about. You have been there yourself, but you have not experienced it at all. Then I think it's important to talk to someone who is completely neutral then. Like a psychologist or something like that...”

A further difference was in on how they acted. A peer was mentioned to understand the things in a different way, not necessarily ask as many questions or say as much as a professional would. Additionally, the credibility on who could say what was also emphasized. This was based on their previous, personal knowledge on the topic, which professionals lack.

"If a nurse would have said, "now you have to shape up” ...no, you’d get so mad. It becomes something completely different when one has been there themselves. Then it will be like "yes, that kind of makes sense”."

Despite the difference, both backgrounds were mentioned as necessary as they were mentioned to "*overlap*" each other. Yet sharing the environment was not mutually favored, as the distinctiveness to peer support would be suppressed. It was rather suggested that they needed both services, yet on separate arenas.

Discussion

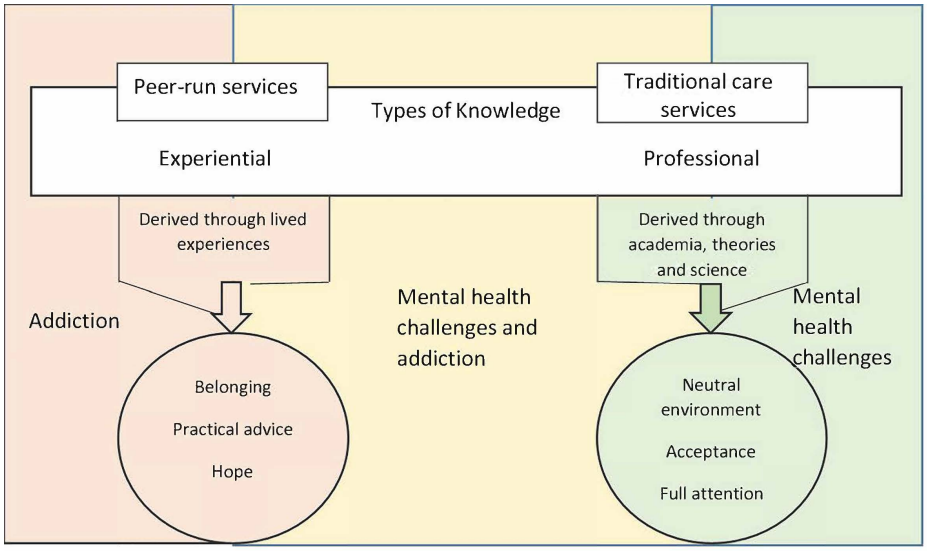
The findings from this study are consistent with the literature, peers give rise to a sense of belonging, hope and offer practical advice (17) and these elements are also linked to recovery outcomes (18). Seeing others who have learned to live a life free from drugs or found a recovery path with their mental health challenge can give rise to hope. Hope, set in the context of hopeful thinking, can be generated through three parts: goals, pathways, and agency (19, 20). Seen in the context of RIUtY, the participants mentioned abstaining from drugs as a goal. Throughout the course, multiple pathways were learnt, for example through the practical advice offered by the peers. The agency was enhanced by observing peers who had achieved this goal. You believe you can, as others *like you* have. The desired attributes, mentioned by the participants, could further enhance this agency.

Furthermore, when people affiliate with others they view *like* them, a deep, holistic connection is believed to arise, which strengthens relationships (21). The relationship established by the participants can be seen through their sense of belonging to the

group. The outcome of belonging was important as many of the participants mentioned lacking before they started RIUtY, and it is regarded as one of Maslow's basic human needs (22)

The generated practical advice could have been established and enhanced due peers having experiential knowledge. The result of practical advice also generates a sense that RIUtY had an openness since the participants were willing to share their experience. Openness is distinguished to peer-run services, and important for alliance with the group (7, 9).

Furthermore, the results imply that when mental health challenges were their prominent area of challenge the informants would seek out help from a professional, whilst peers were sought out when challenges associated with addiction was prominent. The need from traditional care was an interesting finding, as almost all the informants mentioned negative associations with the health care system. One could, therefore, assume they would avoid this service. Nonetheless, this service was valued as participants mentioned this service to offer something different from peer-services.



Model 1. Different types of knowledge benchmark the services, which in turn effect associated outcomes.

The model above indicates users will seek help from the different services depending on which are of a challenge is prominent. As the results revealed, if the addiction was their background for seeking help they were most likely to engage in peer-run services to receive peer support, which is linked to belonging, hope and practical advice. If challenges with their mental health was their background for seeking help, the traditional care service was valued, as this would offer a neutral environment, full attention for them to accept their challenge.

The model presents knowledge benchmarking the focus the services takes, which in turn affect the outcomes. Knowledge, differentiating on lay knowledge, experiential knowledge, and professional knowledge, is derived in different ways. Lay

knowledge is characterized by pop-culture beliefs and commonsense ideas; professional knowledge is gained from academia, theories and scientific perspectives; and experiential knowledge is derived from specific lived experiences (23-25) .The two latter differs from the former in that it is not accessible for everyone. Additionally, both experiential and professional knowledge have precursors, making them unique from lay knowledge. Peer-run services offer experiential knowledge, whilst traditional services offer professional knowledge. With the professional knowledge, traditional care can offer a unique and neutral environment for the individual, allowing them to understand what their mental health challenge or addiction is. A professional will not be able to say, "*I know how you are feeling*", but can ask questions regarding this feeling and to create meaning and understanding behind it. On the contrary, peers have the legitimacy of consoling on mutually shared experiences. The "*I know how you are feeling*" can be said in an honest and fair way from a peer, which can generate belonging, hope and practical advice.

The results therefore suggest that sometimes it is helpful to meet people with similar experiences, to understand commonalities that may be helpful in their recovery, yet other times is may be helpful to focus on the unique experience itself, in a neutral environment where one's personal experiences, thoughts, and feelings dominate.

Limitations

Participating in this study was on a voluntary basis, and a majority of the participants expressed eagerness for RIUtY to continue running, motivation from their side should, therefore, be noted and could have influenced the data for positive outcomes.

Concerning the difference in peer support and professional help, this was only a hypothesized by the informants. However, all participants, except one, had recently or was still receiving care from the traditional care service.

Conclusion

The results show peers are distinctive in that they offer a sense of belonging, hope and practical advice. Peer-run services are found to differentiate from traditional care services depending on what challenge one is faced with. Receiving services from both fields was viewed beneficial; one service should not exclude the other. Future research should look how traditional care services and peer-run services complement each other.

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Appendix A, Database search

SØKEORD	DATABASE	DATO	RESULTATER	BRUKT	AVGRENSNINGER
"RECOVERY" AND "SUBSTANCE ABUSE" AND "PEER COUNCELING" OR "PEER ASSISTING PROGRAMS"	Cinahl	1901	9	0	År: 2000-2018
"RECOVERY" AND "MENTAL DISORDER, CHRONIC" AND "PEER COUNCELING" OR "PEER ASSISTING"	Cinahl	1901	1	1	År: 2000-2018
"MENTAL HEALTH" AND "PEER" OR "PEER COUNCELING" OR "PEER RELATIONS" AND "RECOVERY" AND "SOCIAL SUPPORT" OR "SUPPORT" OR "SUPPORT GROUPS"	Ovid	19.01	117	20	År: 2000-2018
"MENTAL HEALTH" AND "PEER" OR "PEER COUNCELING" AND "RECOVERY"	Wiley	22.01	6	6	År: 2000-2018 keywords
"ADDICTION" AND "PEER" OR "PEER COUNCELING" AND "RECOVERY"	Wiley	22.01	3	1	År: 2000-2018 keywords
"PEER" AND "RECOVERY"	Idunn	22.01	16	4	År: 2000-2018
"PEER SUPPORT" AND "MENTAL ILLNESS" AND "RECOVERY"	Svemed	22.01	0	0	År: 2000-2018

Appendix B, Background information sheet

Alder	
Kjønn	☐ Menn ☐ Kvinne ☐ Annet
Utdanning	☐ Ikke fullført videregående ☐ Fullført videregående ☐ 3-årig høgskole ☐ Master
Arbeidssituasjon	☐ Jobb, fulltid ☐ Jobb, deltid ☐ Studier/skole ☐ Arbeidsløs ☐ Tiltak/uføretrygdet ☐ Annet: …….
Bosituasjon	☐ Bor alene ☐ Bor sammen med foreldre ☐ Bor sammen med partner uten barn ☐ Bor sammen med partner med barn ☐ Enslig forelder ☐ Institusjon ☐ Bostedsløs (UFB) ☐ Annet: …….
Ekteskapelig status	☐ Ugift ☐ Gift/samboer ☐ Skilt ☐ Enke/Enkemann
Økonomisk situasjon	☐ Under sosialhjelpssats (5 850,-) ☐ Over sosialhjelpssats (5 850,-)
Utfordringer i forhold til rus og psykisk helse (kan sette flere kryss)	☐ Avhengighet ☐ Problematisk bruk av rusmidler ☐ Lettere psykiske lidelser ☐ Mer alvorlige psykiske lidelser ☐ Annet: ……

Status nåværende situasjon	☐ Ingen kontakt med hjelpeapparatet ☐ Jevnlig bruk av kommunale oppfølgingstjenester innenfor rus og psykisk helsearbeid ☐ Innlagt ☐ Poliklinisk behandling i spesialisthelsetjeneste ☐ Venter på behandlingstilbud ☐ Nylig avsluttet behandling/bruk av kommunal oppfølgingstjenester innenfor rus og psykisk helse (innenfor siste 6 måneder)
Antall innleggelser siste år?	

Appendix C, Responses regarding background information

age	22	40	41	38	53	38
gender	male	male	female	female	male	male
education	completed secondary education	completed secondary education	completed secondary education	completed secondary education	not completed secondary education	not completed secondary education
work situation	unemployed	work, part time	work, part time	work, part time	work, full time	disability benefit
living situation	alone	with partner, without child/ren	with partner, without child/ren	with partner, without child/ren	alone	with partner, without child/ren
maritial status	not married	partner	married	partner	divorced	married
economic situation	Over social assistance (5850kr)	Over social assistance (5850kr)	Over social assistance (5850kr)	Over social assistance (5850kr)	Over social assistance (5850kr)	Over social assistance (5850kr)
area of challenge	problematic use of substances & lighter mental disorders	addiction, problematic use of substances & lighter mental disorders	addiction, lighter mental disorders & more serious mental disorders	addiction, problematic use of substances & serious mental disorders	addiction, problematic use of substances & lighter mental disorders	addiction & problematic use of substances
status	recently completed treatment / use of municipal follow-up services in the field of substance abuse and mental illness	regular use of municipal follow-up services in the field of substance abuse and mental health work	regular use of municipal follow-up services in the field of substance abuse and mental health work	regular use of municipal follow-up services in the field of substance abuse and mental health work	regular use of municipal follow-up services in the field of substance abuse and mental health work	outpatient treatment in the specialist health service
hospital admissions the last year	1	1	0	1	1	0

Appendix D, Consent sheet

Forespørsel om deltakelse i forskningsprosjektet

Hvordan får likepersoner i et recovery orientert kurs betydning for deltakere

Bakgrunn og formål

Jeg heter Emilie Bryne og tar en master i Helsevitenskap ved Universitet i Stavanger. Jeg skal i den anledning skrive en masteroppgave omhandlende likepersoner og recovery blant personer med psykiske helseutfordringer og rusproblematikk. Studien har som hovedmål å undersøke opplevelsene deltakere har i et recovery orientert kurs som er drevet av likepersoner.

Utvalget er deltakere fra kurset *Recovery is up to you* som har blitt avholdt i Stavanger kommune i perioden 31/20-30/01. Deltakerne har blitt informert på forkant at prosjektleder er interessert i å høre deres opplevelser fra kurset.

Hva innebærer deltakelse i studien?

Metoden for å samle kursdeltakernes erfaringer vil være gjennom semi-strukturerte dybdeintervjuer. Spørsmålene under intervjuet vil omhandle erfaringer og opplevelser deltakerne har ansett som nytteverdige gjennom kurset, samt refleksjoner om likepersonarbeid. I tillegg til intervjuet vil det hentes deskriptiv data berørende alder, kjønn, nasjonalitet, utdannelse, jobb status, bosituasjon, sivilstatus, psykiatrisk karakteristikk og eventuelle sykehus innleggelser. Intervjuet har en varighet på ca 45min og dataen blir lagret på lydopptak om samtykke foreligger. Opptak vil bli slettet etter prosjektet er avsluttet. Intervjuene vil foregå på

tomannshånd på avtalt sted eller via telefon. Alle personopplysninger og notater fra undersøkelsen vil være anonyme, og vil bli destruert etter innlevert oppgave. Deltakerne har til alle tider mulighet for å trekke seg fra intervjuer, eller velge å ikke svare på spørsmål.

Hva skjer med informasjonen om deg?

Alle personopplysninger vil bli behandlet konfidensielt. Det vil kun være prosjektleder som renskriver opptakene. Lydopptakene vil bli lagret på en mobiltelefon i lukket mappe med kodelås. Veileder vil eventuelt være med å veilede analyseringen av utskriftene. All data vil være anonymisert, og det vil ikke bli mulig å for allmennheten å gjenkjenne enkelte sitater som blir tatt med i oppgaven. For å ivareta konfidensialiteten vil navnelisten til deltakerne bli lagret på en annen enhet en selve oppgaven.

Prosjektet skal etter planen avsluttes 01.06.2018. Etter dette vil alt lydopptak bli slettet. Ingen person opplysninger vil bli lagret etter prosjektslutt..

Frivillig deltakelse

Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn og uten at det vil ha noen konsekvenser for deg. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med prosjektansvarlig Emilie Bryne (på 958 24 236). Veileder Hildegunn Sagvaag sine kontaktopplysninger er: 51 82 42 36 eller 997 93 634 (hildegunn.sagvaag@uis.no)

Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS.

Samtykke til deltakelse i studien; *” Hvordan får likepersoner i et recovery orientert kurs betydning for deltakere?”*

Jeg har mottatt informasjon om studien, og er villig til å delta

---

(Signert av prosjektdeltaker, dato)

Emilie Bryne

masterstudent

Appendix E, Interview guide

Erfaringer

Avklare og ta utgangspunkt i respondentens erfaring med eller kjennskap til temaet/problemstillingen

«Jeg henvender meg til deg for du har erfaring fra likepersonarbeid og recovery»

«Nå som du nettopp har fullført kurset, hva har du fått ut av dette kurset?» (motivasjon, forventinger?)

«Hva legger du i ordet likepersoner?" (hvem gjelder det, hva innebærer det for deg? -sikre en felles forståelse for begrepet)

«Er dette første gang du har vært med i et kurs drevet av likepersoner?»

«Hva tenker du når jeg sier order recovery?»

Nøkkelspørsmål

«Hadde det noe å si at alle i her var likepersoner?» (gå innpå fellesskap, felles erfaringer, likhet, følt støtte)

«følte du det var en åpenhet blant recovery gjengen?»

«hvordan påvirket dette fellesskapet?»

«Hva hadde det å si at dere hadde felleserfaringer?»

«På hvilke måter har/har ikke fellesskapet i recovery gjengen bidratt til å støtte og utvikle din recovery?»// «koss er det fellesskapet har hjulpet/ikke hjulpet i din recovery prosess?»

«Tror du dette ville vært annerledes hvis fagpersoner involvert?»

«Er det noen i kurset du anser som rolle modeller?»

«Hva er det som gjør at du anser de som rollemodeller?»

«hvordan opplevde du å ha likepersoner som kursledere?» (hadde det en verdi?)

evt «hva tilfører disse som er unikt» evt «skiller de seg fra en med faglig bakgrunn?»

Avslutnings spørsmål

Avklare misforståelser, spørre om man har forstått riktig dersom noe er uklart

«Er det noe mer du har lyst å legge til?»

«Er det noe jeg burde ha spurt om som jeg ikke har gjort?»

MELDESKJEMA

Meldeskjema (versjon 1.4) for forsknings- og studentprosjekt som medfører meldeplikt eller konsesjonsplikt (jf. personopplysningsloven og helseregisterloven med forskrifter).

1. Intro		
Samles det inn direkte personidentifiserende opplysninger?	Ja ● Nei ○	En person vil være direkte identifiserbar via navn, personnummer, eller andre personentydige kjennetegn. Les mer om hva personopplysninger. NB! Selv om opplysningene skal anonymiseres i oppgave/rapport, må det krysses av dersom det skal innhentes/registreres personidentifiserende opplysninger i forbindelse med prosjektet.
Hvis ja, hvilke?	■ Navn ■ 11-sifret fødselsnummer ■ Adresse ■ E-post ■ Telefonnummer □ Annet	
Annet, spesifiser hvilke		
Skal direkte personidentifiserende opplysninger kobles til datamaterialet (koblingsnøkkel)?	Ja ○ Nei ●	Merk at meldeplikten utløses selv om du ikke får tilgang til koblingsnøkkel, slik fremgangsmåten ofte er når man benytter en databehandler
Samles det inn bakgrunnsopplysninger som kan identifisere enkeltpersoner (indirekte personidentifiserende opplysninger)?	Ja ○ Nei ●	En person vil være indirekte identifiserbar dersom det er mulig å identifisere vedkommende gjennom bakgrunnsopplysninger som for eksempel bostedskommune eller arbeidsplass/skole kombinert med opplysninger som alder, kjønn, yrke, diagnose, etc. NB! For at stemme skal regnes som personidentifiserende, må denne bli registrert i kombinasjon med andre opplysninger, slik at personer kan gjenkjennes.
Hvis ja, hvilke		
Skal det registreres personopplysninger (direkte/indirekte/via IP-/epost adresse, etc) ved hjelp av nettbaserte spørreskjema?	Ja ● Nei ○	Les mer om nettbaserte spørreskjema.
Blir det registrert personopplysninger på digitale bilde- eller videoopptak?	Ja ○ Nei ●	Bilde/videoopptak av ansikter vil regnes som personidentifiserende.
Søkes det vurdering fra REK om hvorvidt prosjektet er omfattet av helseforskningsloven?	Ja ○ Nei ●	NB! Dersom REK (Regional Komité for medisinsk og helsefaglig forskningsetikk) har vurdert prosjektet som helseforskning, er det ikke nødvendig å sende inn meldeskjema til personvernombudet (NB! Gjelder ikke prosjekter som skal benytte data fra pseudonyme helseregistre). Dersom tilbakemelding fra REK ikke foreligger, anbefaler vi at du avventer videre utfylling til svar fra REK foreligger.
2. Prosjekttittel		
Prosjekttittel	Evaluering av "Recovery is up to you"	Oppgi prosjektets tittel. NB! Dette kan ikke være «Masteroppgave» eller liknende, navnet må beskrive prosjektets innhold.
3. Behandlingsansvarlig institusjon		
Institusjon Avdeling/Fakultet Institutt	Universitetet i Stavanger Det samfunnsvitenskapelige fakultet Institutt for helsefag	Velg den institusjonen du er tilknyttet. Alle nivå må oppgis. Ved studentprosjekt er det studentens tilknytning som er avgjørende. Dersom institusjonen ikke finnes på listen, har den ikke avtale med NSD som personvernombud. Vennligst ta kontakt med institusjonen.
4. Daglig ansvarlig (forsker, veileder, stipendiat)		

Appendix G, Guidance on publishing for Psychiatric services

Psychiatric Services is a peer-reviewed interdisciplinary journal published monthly by the American Psychiatric Association. The journal provides comprehensive coverage of all aspects of psychiatric care, treatment, and service delivery. It has a strong clinical focus but also offers in-depth coverage of administrative, legal, economic, and public policy issues.

The journal gives priority to material that is clearly applicable in everyday clinical and administrative practice or in public policy development. Wherever appropriate, practical implications should be emphasized in such a way that they lend themselves to a highlighted presentation (such as a list or table) when the article is published. Abstracts should be clear, concise, and readable and able to stand on their own as a description of the article.

To enhance readability, authors should use a minimum of jargon and abbreviations. They should use active voice, first person, and short sentences whenever possible. Language should be gender-neutral.

Submission of manuscripts

General requirements

Psychiatric Services reviews material for publication on condition that it has not been previously published, including electronic publication, and is not being reviewed for publication elsewhere.

Six paper copies of a manuscript, plus a PC-compatible disk with the manuscript file, are needed for peer review. Label the disk with the manuscript name and software program. Send all copies to the editor, John A. Talbott, M.D., *Psychiatric Services*, 1400 K Street, N.W., Washington, D.C. 20005. (Phone inquiries, 202-682-6070; fax, 202-682-6189; e-mail, psjournal@psych.org.) Include telephone and fax numbers and e-mail address for the corresponding author.

For peer review, all material, including case reports and references, must be double-spaced on standard-size paper, with all margins a minimum of 1 1/2 inches. All pages should be numbered.

Authors must protect patient anonymity and disguise identifying information.

Copyright, financial disclosure

Psychiatric Services requires transfer of copyright to APA so that the rights of authors and the association can be protected. The journal also requires disclosure of financial interests in products or services described in the paper. A form describing these requirements, which must be signed by all authors, will be sent to the corresponding author.

Types of articles

Please state in the covering letter the type of article submitted and the word count (excluding references and tables).

Regular articles, including research reports.

In general, articles should not exceed 3,000 words excluding references and tables, although some exceptions are made by the editor. For articles not reporting research studies, include an unstructured abstract of 100 to 150 words providing factual information.

Research reports must include a structured abstract (maximum 250 words) with the following headings and information: *Objective,* the study purpose or research question; *Methods,* including study design, setting, subjects, intervention(s) if any, and main outcome measure(s); *Results,* the main results of the study; and *Conclusions* directly supported by the data.

Research reports should follow these guidelines:

1) Use the standard format of introduction, methods, results, discussion, and conclusions. 2) In the last paragraph of the introduction, state the purpose of the research. (If the purpose is not stated as a research question, it should be

translatable into a research question.) Also indicate the type of study design, such as experiment, survey, or retrospective or prospective study. 3) Include data on the sex, age, and race of the study subjects. 4) Include the dates the original data were collected. 5) Preferably in the methods section, describe the data analysis procedure concisely and in a manner understandable by nonstatisticians. 6) In the results section, including tables, report only the findings related directly to the research purpose or research question. Omit other data. 7) Report numbers for all percents. 8) When reporting statistically significant results, always report the observed test statistic value, degrees of freedom, probability level, and, for t and F tests, whether repeated measures were used.

The journal considers publication of randomized research trials with negative findings if they are accompanied by adequate statistical power analysis and a discussion of what was learned from the research.

Literature reviews and special articles.

Generally they are solicited by the editor and are 4,000 to 7,000 words plus no more than 100 references. Anyone interested in submitting such material should consult the editor. Reviews should focus on recent literature.

Literature reviews must include a structured abstract (maximum 250 words) with the following headings and information: *Objective,* the primary purpose of the review; *Methods,* the data sources searched, how studies were selected or excluded, and (if applicable) how data were abstracted; and *Results and Conclusions,* the main findings or conclusions from the review and their applicability.

Brief reports.

Maximum length is 1,200 words, plus no more than ten references and one table or figure. Include an unstructured abstract of 100 words maximum. When reporting research in a brief report, follow the guidelines for research reports, above, but provide an unstructured abstract of 100 words maximum.

Reports of unusual cases.

Reports describing unusual or challenging patients and their management should not exceed 1,200 words plus ten references. They should consist of a brief literature review, an account of the case and its treatment, and a discussion. Include an unstructured abstract of 100 words maximum.

Commentaries.

Provocative commentaries of 425 words maximum are invited for Taking Issue. Authors may also submit commentaries of up to 1,200 words and ten references for the Open Forum section. The editor may invite one or more commentaries (for Open Forum or elsewhere) on any paper accepted for publication. Authors may be asked for source material to support factual statements in opinion pieces.

Letters.

Letters (published at the editor's discretion) can be no more than 500 words with a maximum of three authors and five references. Letters related to material published in *Psychiatric Services* will be sent to the author for possible reply.

Columns.

Material for columns is solicited by the column editors. Authors of possible submissions should contact the column editor directly.

Book reviews.

Books to be considered for review should be sent to the book review editor, Jeffrey L. Geller, M.D., M.P.H., Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, Massachusetts 01655. Book reviewers are selected by Dr. Geller; potential reviewers should contact him.

Arranging the manuscript

Title page

Psychiatric Services uses a blind review system; thus on all manuscripts except letters and book reviews, put authors' bylines and identifications on a title page that can be removed when the manuscript is sent for review. Please provide a second title page with only the manuscript title.

Authors.

Only principal researchers or writers should be listed as authors. Persons listed as authors must have made a substantial contribution to the paper (that is, to conception and design or data interpretation, and to drafting, and to final approval) and must be able to take public responsibility for it. Other contributors can be named in an acknowledgment.

For each author, list a maximum of two academic degrees or certifications and the author's primary current affiliation (including specific title and department or agency). List a second affiliation if desired. If an author's affiliation when doing the work described was different from the current affiliation, list it also.

Acknowledgments.

List all financial support, including drug company support, and any financial relationships that may pose a conflict of interest. (See the financial disclosure form sent to the corresponding author for details.) For grants, include the grant number and full name of the granting agency. Acknowledgment of individuals or groups is limited to those who contributed to the paper's intellectual or technical content.

Other title-page information.

Include the corresponding author's full address; also include phone and fax numbers and e-mail address. List the word count, excluding references and tables.

If the paper was presented at a meeting within the last three years, give the meeting name, city, and full meeting dates.

Tables and figures

Include tables only when they present relevant numerical data more clearly than could be done in text; data in short tables often can be incorporated more concisely in text. Authors will be asked to delete extraneous tables. Follow the table formats used in recent issues of the journal. Specify all units of measure clearly. Tables will be edited to conform to journal style.

Figures are published only when they contain essential information that cannot be adequately presented in text or tables. Most figures without data, especially flow charts, are judged nonessential.

Figures accepted for publication must be clear, uncluttered, and two-dimensional. Please provide a separate electronic file for each figure, on a PC-compatible disk, specifying the software used. Because the journal recreates some figures, please list, on a separate sheet, values for the data points shown on the figure.

Psychiatric Services discourages the use of previously published tables or figures. Authors who use such material must obtain written permission for reprinting from the copyright owner and include it when they submit the paper.

Checklists and forms generally are not published. A note that such material is available from the author may be included in the paper.

References

Limit references to relevant published material cited in text, including all but widely known tests and scales. Complete literature reviews are rarely necessary.

Only material that has been published, accepted for publication, or presented at a major national meeting is included in the reference list. Citations of material in press must include journal or publisher name. (If unpublished material is cited, note the source and year in parentheses in the text of the paper. Citation of unpublished material should be kept to a minimum.)

Double-space all references. Arrange and number them in order of appearance in text, not alphabetically.

In the reference list, name all authors and editors through the third; if there are more than three, list the first three, followed by et al. Spell out journal names; do not underline or use italic or boldface. Follow *Psychiatric Services* style for reference punctuation.

Journal articles.

Include authors, title, journal name (*not* abbreviated or underlined), volume number, first and last pages, and year. Example: Aleman A, Hijman R, de Haan EHF, et al: Memory impairment in schizophrenia: a meta-analysis. American Journal of Psychiatry 156:1358-1366, 1999

Books or monographs.

Include authors or editors, book title (*not* underlined), volume or edition (for federal government publications, any series designation), city, publisher, year, and, if pertinent, page numbers of the material cited. Example: Goldberg JF, Harrow M (eds): Bipolar Disorders: Clinical Course and Outcome. Washington, DC, American Psychiatric Press, 1999

Chapters in books.

Include chapter authors, chapter title, book title (*not* underlined), volume or edition, book editors, city, publisher, and year. Example: Clark HW, Kanas N, Smith DE, et al: Substance-related disorders: alcohol and drugs, in Review of General Psychiatry, 4th ed. Edited by Goldman HH. Norwalk, Conn, Appleton & Lange, 1995

Legal proceedings.

Follow *The Bluebook: A Uniform System of Citation*, published by the Harvard Law Review Association.

Review process

Manuscripts submitted for publication (including invited papers) are sent for blind review to at least three independent reviewers. Separate statistical review is often obtained. The final decision is the editor's. Authors are usually notified of a decision within three months, although some delays are unavoidable.

Revised manuscripts. Authors may be asked if they wish to make suggested revisions in a paper and resubmit it. If substantial revisions are requested, the paper will be sent again for outside review. Every effort will be made to expedite such review.

Revised manuscripts must conform to the general requirements listed above, including minimum 1 1/2-inch margins, full double-spacing, and a word count. Authors submitting a revised manuscript will be asked to provide four copies and a PC-compatible disk.

Processing of manuscripts

Manuscripts (including revised manuscripts) are accepted with the understanding that they will be edited for clarity, elimination of redundancy, and conformity with *Psychiatric Services* style. Generally, manuscripts are edited within three or four months from date of acceptance.

The corresponding author receives a printout of the edited paper (not galley proofs). He or she will be asked to check the printout carefully to make sure the editing did not introduce any inaccuracies and to make any necessary changes, answer editorial queries, and contact the editorial office by a specified date.

All authors receive complimentary copies of the issue as well as a price list for ordering reprints.

Indexes and databases

Psychiatric Services is covered in *Index Medicus, MEDLINE, Cumulative Index to Nursing and Allied Health Literature, Current Contents, Excerpta Medica, HealthSTAR, Psychological Abstracts, PsycINFO, Social Science Citation*

Index, and other indexes and databases. Recent years of the journal are available on line at psychservices.psychiatryonline.org. The journal publishes an annual index each December.