The experience of working as a peer support worker in Norway

Universitetet
i Stavanger

Det helsevitenskapelige fakultet

Master i helsevitenskap

Masteroppgave 50 studiepoeng

Elin Edda Karlsdottir

Marianne Storm

August 2021

Word count: 23234

Acknowledgement

I wish to extend my deepest gratitude to my thesis supervisor Marianne Storm for guiding me through the two deeply turbulent years that it took to get here.

Losing my mother from a long cancer battle during my work on this thesis took away a lot of concentration, focus, and energy. Marianne stood by me through the whole process, doubts and fears, grief, and the feeling that I should just give up. She has been endlessly patient, encouraging, and helpful in this eternal Covid-19 situation. Always ready to answer any questions or give good advice. This thesis would not exist without her. She has given input on everything right from the start and her motivation and inspiration have been invaluable.

I would also like to thank my fantastic informants, those dedicated souls that work for the good of others, system changes and to keep themselves on the road to recovery. This has been such an inspiring thesis to write, the experiences of these peer support workers fascinate me, the resilience and will to fight for your own mental health and others' is awe-inspiring to witness and gives me hope for the eventual development of better mental health services where the patient is always at the center of any service offered.

To my darling partner and dog for endless cuddles, loads of food and walks and support. And my friends for being my cheerleading gang.

Elin Edda Karlsdottir

Kleppe, 30.09 2021

Contents

Appendices

1. Information for interview participation
2. Declaration of consent
3. Interview guide
4. Information about survey
5. Questionnaire
6. Approval from NSD

Sammendrag

Feltet for erfaringskonsulenter er et relativt nytt felt i psykiske helsetjenester i Norge. Hensikten med denne oppgaven var å utforske hvordan det er å være erfaringskonsulent i de psykiske helsetjenestene i Norge. For å utforske dette valgte jeg å bruke mixed metode design. Dette ble valgt for å oppnå både bredden og dybden av tilgjengelig informasjon. Jeg gjennomførte semistrukturerte intervjuer med seks informanter og sendte ut en nettbasert undersøkelse som mottok svar fra 30 deltakere. Jeg brukte tematisk analyse for å analysere intervjudataene mine og brukte SPSS for enkel analyse av undersøkelsesdataene mine.

Mine hovedfunn var at erfaringskonsulenter i Norge jobber i mange forskjellige arbeidsplasser og utførte en rekke ulike oppgaver. Rollen er ganske uklar, stillingsbeskrivelser mangler eller er ikke veldig beskrivende. Stress på arbeidsplassen var hovedsakelig knyttet til rollens uklarhet, inkonsekvenser i lønnsrate og stor arbeidsmengde. De fleste følte seg støttet av både kolleger og ledere og følte at de hadde noen å snakke med om de trengte det. Implementering og opplæring er ikke formalisert her i Norge som kan være utfordrende. Erfaringskonsulentene har gjort mye arbeid med sin egen recovery utvikling; de er engasjerte og brenner for arbeidet sitt og for å hjelpe andre. Siden dette feltet er under utvikling var det interessant å oppdage det innovative potensialet som eksisterer gjennom samskaping med ledere og både lokale og landsdekkende overordnede.

Basert på resultatene av denne oppgaven kan ytterligere forskning innen dette arbeidsfeltet potensielt omfatte forskning på samskaping og dets potensial, og rollen som erfaringskonsulenter kan ha for å veilede pasienter gjennom overganger fra institusjoner til samfunnsomsorg i fremtiden.

Abstract

The field of peer support work in the mental health services is Norway is a relatively new field of work. The aim of this thesis was to explore what it was like to be a peer supporter in the Norwegian mental health services. To explore this I chose to use a mixed methods design. This was chosen to achieve both the breadth and depth of the information available. I conducted semi-structured interviews with six informants and sent out an online survey that received answers from 30 participants. I used thematic analysis to analyze my interview data and used SPSS for simple analysis of my survey data.

My main findings were that peer support workers in Norway work in many different settings and performed a wide variety of tasks. The role is quite unclear, job descriptions either lack or are not very descriptive. Stress in the workplace was mostly related to the unclarity of the role, inconsistencies in rate of pay and a large workload. Most felt supported by both co-workers and leaders and felt they had someone to talk to if needed. Implementation and training are not formalized here in Norway which can be challenging. The peer support workers have done a lot of work on their own recovery; they are engaged and passionate about their work and about helping others. As this field is in development an interesting find was the innovative potential that exists through co-creation with managers and both local and national leadership.

Based on the results of this thesis further research in this field of work could potentially include research into co-creative potential and the role peer support workers could have in guiding patients through transitions from institutions to community care settings in the future.

1.Introduction

The theme of this thesis is the experience of peer support workers in the Norwegian mental health care system. I have a bachelor's in psychology and have always been interested in helping people. Just after the start of my studies I started to work in one of Norway's municipalities in a place where we help people to live independently while living with serious mental illness and often addiction issues as well. This work got me interested in how best to reach and help people with mental health challenges and I became interested in recovery work and through that the work of PSWs. I found the work of PSWs to be fascinating and hope giving for this group, people living with issues that will most likely follow them in some form throughout their lives. This type of work is relatively new in Norway, and I wanted to know more about the people that have chosen to work in this emerging field, their experiences, workplaces, and relations with users and colleagues.

1.1 Background and political guidelines

According to the Ministry of Health and Care Service's strategy paper Mestre hele livet, psychological issues and illnesses are quite common in Norwegian society. It is estimated that between 30 and 50% of the population will suffer from some form of mental illness in the span of their lifetime (Departementene, 2017, p.09). With the prevalence of mental illness and issues being fairly common, the government has emphasized the need to include mental health as an equal component of their public health strategy, with an aim to reduce stigmatization of mental health issues both in the general public and in the mental health services (Helse- og omsorgsdepartementet, 2015a, p. 09).

Alongside the emphasis on elevating the status of mental health work there is a longstanding goal in the Norwegian health services to involve the user more in their own treatment no matter what the diagnosis or issue. This is incorporated in Norwegian law in Lov om pasient- og brukerrettigheter §3-1, Pasientens eller brukerens rett til medvirkning (Pasients' or users right to participation). This refers to the right of the user to participate in both the implementation of services, and that the service provided be formulated as far as possible in cooperation with the user (Syse, 2018, p.624).

The WHO's Mental Health Action Plan 2013-2020 states that "…persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health" at all levels of service from planning to evaluation (World Health Organization, 2013, p. 10). Norway's government works in accordance with these goals and towards creating what they call "The patients' health service". This is referred to in their Meld. St. 11, Nasjonal helse- og sykehusplan (Helse- og omsorgsdepartementet, 2015-2016), where the patient is to be at the center of his or her treatment and services. This calls for an active role for the patient, a friendlier health care system where the meeting between patient and system is softer than it has been and more cooperative than in the past (Helse- og omsorgsdepartementet, 2015b, p. 56). The central document for mental health and dependency work in Norway, Sammen om mestring, refers to user involvement as an essential right of users and patients to participate in all decision and plans involving them, their health, and their care. They are to be viewed as equal partners in all decision making, so that their perspectives, experiences, wishes, and needs are expressed, and form the basis for any decisions regarding treatment and care. User involvement is a tool in itself, to ensure the equal and egalitarian status of the user. The aim is not to offer everyone the same treatment but to offer quality treatment that fits each individuals' needs and wishes (Helsedirektoratet, 2014).

In several countries the concept of recovery is used to describe a way for patients, service users and their closest relations to learn to master their everyday lives and participate in treatment and follow-up options. The most widely used definition of recovery was created by Anthony (William A. Anthony in Borg, Karlsson & Stenhammer, 2013, p. 10) and describes it as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles… a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness". With this, recovery moves away from the focus on pathology toward an emphasis on health, strengths, and. Recovery here refers to recovery *in* mental health disorders, it does not require a return to normal function or a complete remission of symptoms but overcoming the effects of being mentally ill. Maintaining some form of control of one's own life and finding new strengths and a new definition of self (Storm and Edwards, 2013 , p. 319). Through the development of recovery-oriented practices different forms of co-operating emerged, advocacy, co-production, and co-selection. Advocacy is work aimed at users' rights, receiving correct information and support in the protection of one's own rights. Co-production is another form of working together with professionals for better services. This involves the users with providers for the betterment of treatment and services offered. These are ongoing processes. Co-selection is the third for of co-operation within the mental health services where the user is involved by receiving the necessary information about different alternatives, to make selections about treatment and medication for example. The aim here is for the user and professional to come to a mutual decision about treatment instead of being told what to do (Karlsson & Borg, 2017, p. 90-91).

A step further on the road to full co-operation between service users and providers is co-creation. Co-creation happens when a user or citizen is involved in designing and implementing services. This is seen as a tool for innovation and for improving the relevance of the services being provided (Aakerblom & Ness, 2021, p. 2). User organizations and users have criticized mental health services for failing to acknowledge users and their experiences with the service provided. One solution has been to involve the users more, to work together to co-create care. This type of innovation becomes increasingly important as care moves from institutions to the community and the recovery perspective gains more acceptance (Clark, 2015, p. 213-214). Through the process of co-creation, the user is involved from the start with defining the issues at hand, developing solutions, choosing the best ones, and implementing them. This makes co-creation something new and different from the old way of doing things.

A vital part of the recovery approach is the use of peer support workers, in Norwegian, erfaringskonsulenter. The inclusion of PSWs in recovery-oriented services is an important facet of co-production and co-creation and viewed by many as a prerequisite for the development of recovery (Karlsson & Borg, 2017, p. 91). peer support workers are recruited and trained in working with users in both institutional and communal settings. The work of peer support workers is based on commonality and equality between people who have experienced similar challenges in life and can be an important supplement to other more traditional health care services (Sjåfjell and Myhra, 2015, p. 144). The role of peer support workers in the Norwegian mental health system is increasing annually, around 27% of all municipalities in Norway reported to have at least one peer support worker employed in their mental health system in 2019 (Ose et al., 2020, p. 19).

1.2 Clarification of central concepts

Peer support and peer support worker.

In a briefing for the Centre for Mental Health in the United Kingdom Repper (2013) defines peer support as “offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations”. Peer support work can be voluntary, in public, private or independent services and can offer a comprehensive and integrated model for care (Repper, 2013, p. 1). In Norwegian there are several words for this type of position, likemenn, erfaringskonsulenter, erfaringsmedarbeidere, and brukermedarbeider are a few examples. Internationally PSWs are sometimes called as peer support specialist or simply peer workers depending on what country and what traditions guide the work title choice to name a couple of examples. For this thesis I chose peer support worker, which is widely used, and will be shortened to PSW throughout. Peers usually share a similar illness and/or background, and the PSW offers support both on a practical and an emotional level (Solomon, 2004, p. 393).

Patient and service user

The terms will be both be used in this thesis, in Norway the word for patient [pasient] is used for one admitted into hospital or psychiatric unit but after a person is discharged or is someone receiving communal services they are referred to as a service user, user or bruker in Norwegian. Since my informants work in many different settings these words will come up in the text.

Psychosocial factors in the workplace

Psychosocial factors can refer to several different aspects that impact a person in their workplace. These can be individual factors or social through the interactions and relationships one has at work. External factors can be our surrounding environment, working conditions, organizational climate, and organization. Internal factors can refer to wellbeing, satisfaction with work, burnout, engagement, and psychosomatic symptoms (Skogstad, 2016, p. 17). In this thesis factors such as stress, roles and social support will be covered further in the chapter on theoretical framework for their impact on how PSWs experience their work and their places of work.

Co-creation and social innovation

Users role in co-creation is a qualitative break from the usual way of providing mental health care, the usual ways of thinking and doing. Krogh, Sørensen and Torfing (2020, p.54) point out that what makes co-creation qualitatively different from users working together with their care providers on the implementation of services, is the early involvement the user has in co-creation. They are involved in the design phase, which is unusual, and this creates a much larger potential for co-creation through the breadth and depth of the work through all of the project's phases, defining the issue, choosing, and implementing the solutions, thus increasing the innovative potential greatly. Social innovation is defined by Voorberg, Bekkers and Tummers (2014) as "…the creation of long-lasting outcomes that aim to address societal needs by fundamentally changing the relationships, positions and rules between involved stakeholders…". This process can involve service users, organizations, government, and other leaders. This is an open process that crosses boundaries to create something new that society needs and values (Voorberg et al., 2014, p. 1334).

1.2 The aim of this study

The aim is to contribute to the knowledge base for recovery work through the use of peer support workers in the Norwegian mental health care system. The way to achieve this was to find out more about how the PSWs experience their workplaces, the working conditions, and relations in the workplace. As this is a new and innovative way of working with mental health service users, I hope to find out in what ways the work is from the standpoint of the PSWs themselves. The aim here is to provide an image of the field as it stands now, what makes it unique and how it affects the people who do the work.

1.3.1 Research questions

The overarching question at the start is:

"What is it like to work as a peer support worker in the mental health services in Norway?"

As this is a new field that is in development and an establishing process, I chose the following themes to better illuminate my main research question.

How do peer support workers perceive their work environment, roles, and psychosocial conditions at work?

How do peer support workers utilize their experience and knowledge?

Have they been involved in innovation or change in their field?

2. State-of-the-art-literature-review

To find previous research I utilized Oria, the University of Stavanger's library search engine that grants access to articles and books from several databases and libraries, I also used Google Scholar and ran a search through SveMed+ to search for articles relevant to peer support in the Nordics. The search words used were peer support, peer support worker, peer support specialist, mental health, and recovery. I only included articles referring to PSWs that give support to service users with mental health issues. The reference lists of articles were also used to inspire manual searches. Most of the articles referred to are literature reviews as this is a widely researched topic internationally, others are national surveys as that compares with the survey done here. The articles are all from the last ten years as the roles of PSWs have become more and more integrated in many countries in the last decade.

In 2011, Repper and Carter published a review of the literature on peer support in mental health. Articles were included if peers offered support for people with mental health problems and if those peers were working in professionally led or statutory services. The articles included had to be published between 1995 and 2010 to qualify. The results were presented as benefits and challenges with peer support work in mental health services. Among the benefits mentioned were reduced rates of rehospitalizations and longer time between readmissions when supported by peer led programs. It appears that PSWs can promote hope, empowerment and increase self-esteem and belief in self-efficacy better than professionals. They seem able to aid in network building, and social inclusion and engagement better than professionals. Being employed as a PSW also benefits the PSWs themselves, increasing self-esteem, confidence, and aid their own personal recovery. Challenges associated with peer support work were setting boundaries, when and how to draw the line as a friend or a professional, lack of power in their positions, low status as a member of a professional team and stress associated with working with mental health service users. Unclear roles were mentioned, as well as the nature of peer support work being different than professionals' roles and the importance of these differences not disappearing with the formalizing of peer support roles.

Vandewalle et al. published a literature review in 2016 identifying PSWs perceptions of and experiences with barriers to the implementation of peer support work in mental health services. Most included studies used qualitative methods and a few also used quantitative methods. The PSWs were mainly employed in community-based services and inpatient services. Integration into the workplace, acceptance, and credibility of the role of PSW were reported challenging due to a number of factors. The role of PSW needs to be somewhat formalized for credibility among professionals and for their own integration but at the same time the roles they have are based on a unique contribution based on lived experience. The implementation of a recovery-oriented culture in the workplace is vital for the implementation and integration of PSWs and their unique roles. If their work becomes too formal, they risk losing what makes their role so effective, the shared experiences, the empathy and understanding of struggles unique to the service users. Relationships with professionals such as nurses is pointed out as important, negative attitudes and lack of confidence in the PSW can make working together challenging. The review points out that information about and acceptance of the role as PSW are central to implementation. Struggle with the identity of the PSW, tensions between PSWs and service users and poor organization can all impact the quality of work for the PSW. The review provides recommendation for more information and training of professionals to break down perceived barriers to working in teams with PSWs.

In 2014 Cronise et al. (2016) conducted a national survey of PSWs in a variety of peer provider positions in the United States. All questions were developed for this survey, no standardized scales were used. The survey was distributed online on iNAPS website, via newsletters and direct email requests to several state mental health officials asking them to share a link to peer support providers in their areas. Those asked to participate were also asked to share the link, creating a snowball sampling. They collected 597 responses from PSWs in 44 different states. The sample was mainly comprised of women that were middle aged, and well educated. Job titles varied with peer support specialist being the most common term used. Most respondents reported having a work role of direct peer support, with tasks commonly mentioned being peer to peer work, support group facilitation and recovery planning and education. More than half of the respondents had received training to qualify for their work, between 20 and 80 hours, which the majority felt was sufficient. Most reported that they worked full time. Respondents said the greatest benefit from working as a PSW came from helping others and through their work aiding in their own recovery. Work satisfaction and intention to remain in the job was high, satisfaction with compensation was not as high though. Most participant felt included and respected in the workplace but many also mention stigmatization and lack of recognition especially from professionals. The study highlights both the breadth and the depth of the PSWs in the mental health system, majority of respondents reported working in community settings but the found that PSWs also worked in a variety of different settings including prisons and inpatient facilities. The survey indicates that peer support work is more widespread in the U.S. mental health system than previously anticipated.

In 2018, Burke et al. conducted a Delphi study with the aim of developing consensus on costs and benefits, barriers, and facilitators in mental health peer support. The Delphi method was employed to collect an expansive list of statements in relation to providing peer support from literature reviews and consulting experienced PSWs. These statements were then evaluated by 147 PSWs in the United Kingdom to reach consensus about the essential components of peer support work, as evaluated by peer supporters themselves. About half of the sample worked in the public services, the NHS in the UK. About 20% of the full sample worked full-time as a peer supporter worker. Around one third of the full sample reported to be the only PSW on their team nearly half of the time, and about half also worked in a clinical team with other professionals. Most participants reported feeling accepted and valued though some reported negative experiences. With regards to training most said they had received six or more days of training to become a peer support worker, and most were happy with the training provided. Consensus was reached on a number of components; role modelling was viewed as essential in peer support work and empowerment regarded as vital. The personal benefits of working as a PSW included improved wellbeing, and social connectedness. Some challenges reported, especially in the public sector, revolved around having few PSW colleagues, and receiving supervision from non-peer professionals. This was linked to the PSW role losing its uniqueness. The study recommends that the PSW role be better defined, while also acknowledging that it requires its own set of skills and competencies.

A qualitative case study by Mulvale et.al (2019) explored the integration of peer support in the mental health sector in both Canada and Norway. The article points to the value of peer support in different areas, for example how PSWs can act as role models for decision making and problem solving, they have an ability to establish rapport with hard-to-reach service users and serve as living examples of the hope of recovery. By advocating for service users, they can foster better patient-centeredness in multi-disciplinary teams, they can offer relationships and build networks with service users who often are lonely and lack familial support. Managers in charge of PSWs mention that having them in their role can contribute to reduced costs by reducing hospital admissions and facilitating transfers into community programs. To establish trust and integrate PSWs on multi-disciplinary teams, information, and training of clinical staff about the role of a PSWs and the role they can play on the team is important. Focus on patient centered care is one component to integrating peers as they have an in-between role that is unique. In conclusion they point out that health care leaders should champion the value of PSWs in their organizations, how it complements existing services and increases patient centered care.

Burr et al. (2019) performed the first national survey of peer support work in Switzerland in 2017. The sample was taken from the German speaking part of Switzerland where it was estimated that 125 PSWs were employed. They received completed questionnaires from 55 participants. The aims of the survey were to gather information about the current situation of PSWs, work conditions, training, job satisfaction and challenges, and to identify possible areas of improvement. The results showed that PSWs mainly worked in personal contact with service users, they were satisfied with work conditions and training, salaries, and their work in general. The main challenges reported were the integration into multi-disciplinary teams, problems with setting boundaries with service users, and lack of communication and co-operation with other PSWs. The greatest challenges with integration were associated with lack of information in the workplace about the role of a PSW, and the PSWs themselves often had unclear role descriptions. One challenge with integration was the lack of experience health professionals had of working with PSWs, which impacted attitudes and communication. Recommendations were made to increase the role of PSWs to educate and prepare institutions and professionals to enable smoother transitions of PSWs into the workplace.

Rossen and Elstad (2021) performed a qualitative study in Norway on how PSWs contribute to the perspectives and practices of professionals in the Norwegian mental health services. They interviewed five professionals that worked in multi-disciplinary mental health teams that included PSWs. They reported that the PSWs helped elevate the service users' perspectives, they changed how they communicated, and improved the cooperation between the service user and the multidisciplinary team. The PSWs helped to increase the patient's feeling of responsibility for their own recovery and helped increase the recovery perspective in general through a focus on the service users' resources and personal qualities. The PSW's focus on daily function and more modest and attainable goals increased the service users' social connectedness and involvement in activities that contributed to recovery. They conclude that involving PSWs in the mental health services contributes to cultural changes within the services.

After a supplementary search related to the terms co-creation and social innovation combined with mental health, I found a relevant study from Australia.

A study by Scholz, Bocking and Happel (2017) on how consumers or users can create value through co-creation suggests three dimensions in which user participation is taking place in the mental health service. This is through organizations wanting and responding to user's perspectives on the services being provided, through organizations providing training, and developmental schemes to increase user leadership and through the organizations providing opportunities for users to participate through dedicated roles and responsibilities. These roles might include being involved in recruitment or assisting in hiring decisions for example. It is important that organizations pay attention to what the user values and feedback from them should be used in a meaningful way in planning, implementation, and service delivery.

Summary

This short overview of existing literature shows that the work of PSWs benefits the service users in a variety of ways, they can help to reduce hospital admissions, lengthen the period between readmissions and facilitate transfers into community programs. PSWs are able to promote hope and empowerment through their shared experiences and unique perspectives and help with network building and social connectedness (Repper & Carter, 2011; Mulvale et al.,2019). They can reach users that are often hard to reach for professionals and serve as role models in decision making and taking responsibility in the service users' road to recovery (Burke et al.,2018; Mulvale et al.,2019; Rossen & Elstad, 2021).

The PSWs themselves appear to benefit from their roles as well, they report satisfaction from being able to leverage their own lived experiences to help others, they report increased wellbeing and self-esteem from their work as well as social connectedness (Repper & Carter, 2011; Cronise et al.,2016; Burke et al.,2018).

In the reviews where they looked at work conditions, integration and training the PSWs seemed satisfied with the amount of training they received, many reported that they worked fulltime or parttime and reported being happy with the amount of work for the most part (Cronise et al.,2016; Burke et al.,2018; Burr et al.,2019). Most of them worked in direct personal contact with service users or on multi-disciplinary teams.

The main challenges reported were the integration into the workplace, negative attitudes from health professionals and a lack of clear roles for the PSW in the workplace (Repper & Carter, 2011; Vandewalle et al.,2016; Cronise et al.,2016).

From this overview it is clear that much is known about the work of PSWs abroad where they are well established, and the literature is so dense that the reviews and studies presented here are just a glimpse into this field of work. This thesis will add knowledge about aspects of the work environment of PSWs in mental health services in Norway by viewing experiences of inclusion, support, stress, and other factors that can impact their workplace wellbeing.

3. Theoretical framework

In this chapter the studies theoretical framework is presented. First the concept of recovery is introduced as the foundation for peer support work. Then the role of the PSW. After that the concept of social innovations and co-creation are explained as these describe the nature of peer work in Norway, it is innovative and different from the classical mental health care models. And lastly, I will introduce psychosocial factors in the workplace as these are important to frame the peer workers experiences in their work.

3.1 Recovery

Recovery is a concept that is used in different ways within the mental health context. It can be viewed as recovery *from* mental health disorders but also as recovery *in* mental health disorders (Storm & Edwards, 2013). Clinical recovery refers to the former definition, recovery *from* symptoms or active illness and increased functionality of the patient. This view can lead to a dichotomous and negative outlook, both from professionals and for the patients themselves who can experience their symptoms and illness as everlasting and debilitating (Slade, Amering & Oades, 2008, p. 129). The focus of this thesis is recovery *in* mental health disorders. This definition comes from the patients themselves, those who have experienced getting better and wish to emphasize that recovery can also be something other than just the absence of symptoms or functional impairment. To refer back to Anthony's definition, this type of recovery is a way of living a satisfying, hopeful and contributing life within the limits of one's illness, to change one's attitudes and to find a new way of existing after overcoming the- sometimes- catastrophic consequences of mental illness (Slade et al., 2008, p. 130). Karlsson and Borg maintain that this type of recovery is both individual and social, these processes can't be separated. Recovery is then the work a person does alone or with others to create and experience meaning in their lives, the feeling of belonging, mattering and being useful. A life filled with opportunities and fun (Karlsson & Borg, 2017, p. 11).

Borg et al. (2013) point out that the uniqueness of recovery as an area of research is due to the fact that its knowledge base is a persons' lived experience with mental health challenges and recovery. Central to recovery is the view that no one is so ill that they cannot live an independent, dignified, and meaningful life in their own chosen environment. What is also important to understand is that the individuals define for themselves what is a meaningful and fulfilling life for them. As Karlsson and Borg (2017, p. 11) write in their book, recovery is not something to be implemented, it is a mutual process with the person living with illness and their support network, private or professional.

As a personal process Davidson et al. (2007, p. 25) described some common aspects, rediscovering hope, and belief in your own possibilities, redefining yourself so that your mental challenges are but a limited part of who you are, accepting your challenges, participate in your community and find support in the people around you and overcoming stigma.

Home, work, education, community, friends, and family are all very impactful for the recovery process. Recovery happens in life, or as Perkins and Slade referred to it “the recovery of a life” (cited in Borg et al., 2013). Social factors can act as both helpers and barriers to recovery, and it is vital to understand what gives opportunities to experience and develop a positive social identity. It is also important that professional settings are respectful and open to individuals’ experiences and preferences. A person and their environment must be viewed in conjunction with each other (Borg et al., 2013).

While recovery is a deeply personal process Leamy et al. (2011) created a systematic review of the available literature on recovery with the aim of creating a conceptual framework that could provide an empirical basis for further research and practice. The framework identified three categories, the recovery journey, the recovery stages, and the recovery processes. The recovery processes have been used widely in the literature and will be further explained here. The processes according to Leamy et al. (2011) can be seen as measurable dimensions of change during recovery and outcomes of these processes. The components of CHIME, as it is commonly referred to, are connectedness, hope and optimism about the future, identity, meaning in life and empowerment. Connectedness refers to social connectedness, peer support and being a part of a community. Hope contains the belief in the possibility of recovery, positive thinking, and the motivation to change among other elements. Identity covers the rebuilding or redefining your sense of identity and overcoming stigma. Meaning in life has many elements, finding meaning in the illness experience, creation of a meaningful life and social roles and spirituality are among them. Empowerment encompasses a feeling of personal responsibility, having or recreating control of one’s life and choosing to focus on one’s strengths.

3.2 Peer support work

> "The belief that **recovery is possible** for all who experience psychiatric, traumatic, or substance abuse challenges is fundamental to the practice of peer support. The likelihood of long-term recovery is increased with effective support" (National Association of Peer Supporters, 2019, p. 1).

Peer support is non-clinical assistance to achieve long-term recovery. The peer support services are inherently designed, developed, delivered, evaluated, and supervised by peers in long-term recovery (National Association of Peer Supporters, 2019, p. 17). Peer support work is a central component of recovery-oriented services. The expectation is that implementation of peer support in mental health services encourages a greater recovery focus within communal health care and institutions with the potential effect of changing organizational culture. Peer support in the health care sector is formalized, it is one person providing support to one or more people that are also receiving services from the municipality or specialist health services. This differs from the operation of for example self-help groups that are often more loosely organized and wherein the peers have a different relationship (Korsbæk & Petersen, 2016, p. 289).

To become a PSW, one has to identify as a person with mental illness, one who is currently or has received mental health services for their psychiatric illness. The PSW is further along in their recovery process, they have gained some valuable insights into their illness and life situation and they use their lived experiences to connect with others receiving mental health care. This support can often be defined as social emotional support, but it can also entail practical support. Through the peer's mutual bond, they can bring about personal and social change (Solomon, 2004, p. 393).

Mulvale et al. (2019, p. 68) describe how peer support differs from traditional models of care. PSWs offer an empathic understanding of the other persons situation based on their own experiences of psychological and emotional pain, they draw on their own experiences to establish trust and thereby gain a unique insight into another's situation. PSWs use their own lived experiences to connect, support and inspire hope in others. They can serve as a connection to more traditional services, offer complementary treatment and help to increase community involvement for users.

Repper (2013) describes the different roles PSWs may have within mental health services, they may work in teams, they can respond to referrals for peer support from other teams, work across transitions, for example help a patient from inpatient care move over to community-based care. They can provide specialist advice regarding recovery-oriented practices or forms of personal recovery planning, and they can also provide workplace-wide functions such as training and informing other staff, reviewing policy documents or provide mentorship for other staff. They can also help patients to plan for life after discharge, support after discharge and plan meetings with contacts important to the patient to facilitate their discharge (Repper, 2013, p. 6). They also mention the valuable roles PSWs have in facilitating self-management, aiding in prevention, and how they can contribute to improving public health and reducing health inequalities (Repper, 2013, p. 3).

Practical and ethical guidelines for PSWs

The National Association of Peer Supporters (2019) have issued practical guidelines based on the core ethical values for PSWs. These have been identified and validated as a basis for this type of work so they will be listed here.

1. Peer support is voluntary; peer support workers support choice for both themselves and for the service user. Recovery is a personal choice, and the voluntary nature of the support makes it easier to build trust and connections with users.

2. Peer support is hopeful. Hope is the catalyst for recovery for many people and peer support worker demonstrate that recovery is real.

3. Peer supporters are open minded; they meet people where they are at and strive to be non-judgmental.

4. Peer supporters are empathetic, they put themselves in another's shoes and listen with an open mind.

5. Peer supporters are respectful; everyone is viewed as valued and unique and thus deserve to be treated with kindness and dignity.

6. Peer supporters facilitate change. They recognize injustices and internalized oppression that peers can face, advocate, and facilitate change where they can.

7. Peer supporters are honest and direct, clear communication is fundamental in peer support. They also respect privacy and confidentiality.

8. Peer support is mutual and reciprocal. Each person gives and receives, each person is seen as having something to teach and something to learn.

9. Peer support is equally shared power. By definition peers are equal and both peers can speak and listen to what is said. A peer supporter does not exercise power over their peer.

10. Peer support is strengths focused. They encourage people to find the skills and talents they have to improve their own lives. They focus on what is strong, not what is wrong in a person's life.

11. Peer support is transparent. They set expectations for themselves and for the person being supported and make clear what can and cannot be offered. They communicate in plain understandable language.

12. Peer support is person driven. All people have a fundamental right to make decisions about the things that matter in their lives. Peer supporters inform about choices and respect decisions. They encourage people to move out of their comfort zones, learn from their mistakes and grow into freedom and inclusion.

3.3 Work environment and psychosocial factors

Psychosocial aspects of the work environment can be divided into psychological and social factors. The psychological factors describe how personal qualities impact someone's experiences, evaluations and how they master work related conditions, while social factors describe the interpersonal relations that impact work environment (Skogstad, 2011, p. 16-17). Here I will give an overview of three different factors that can impact the psychological well-being of employees, stress, roles, and social support.

Stress has many definitions, Skogstad (2011, p. 23) posits that most researchers can agree that stress can be viewed three ways. As impact from outside demands or influences that can be threatening to a person's well-being, as a response to outside influences, and as the processes between outside demands and internal response. The third way of viewing stress, as a process, focuses on the cognitive, emotional, and motivational processes that take place. The job demands-resources model by Bakker and Demerouti (2007, p. 312) classifies factors associated with work stress into two categories. Job demands can be described as the aspects of work that can be associated with certain costs either physical or emotional, this can be high pressure at work or emotionally demanding interactions with clients for example. The demands don't always need to be negative but can turn into stressors if resources become depleted. Job resources refer to aspects that are positive such as satisfying salary, career opportunities, social support, clear roles, skill variety and task significance. These are seen as stimulating for personal growth, learning and development as well as functioning as a buffer against job demands.

Other stress factors that can impact well-being are work demands, roles in the workplace and control. Work demands can for example be the tasks, heavy workload, shift work and responsibility for very ill people. Work demands commonly refers to overload of demands, but it can also refer to underload, which can also have a detrimental effect on employees. Underload is when the employee feels under stimulated, having to few responsibilities and a feeling of not being needed as well as a lack of challenges or opportunities to utilize one's resources and skills. A lack of meaning in a job can lead to stress through underload (Skogstad, 2011, p. 28).

Roles in the workplace can be viewed as a stressor when the roles are either unclear or conflicting. Role ambiguity or unclear roles can come from a lack of job description, lack of training, unclear expectations, or a laissez-faire type of leadership. This can lead to insecurities and discomfort at work. Conflicting roles happen when expectations and demands are hard to satisfy or combine. These can happen when someone wants to perform their job in a different way than instructed, when a leader gives conflicting instructions or demands, when different people within the workplace give conflicting instructions, and when different roles are difficult to combine (Skogstad, 2011, p. 29-30).

Social support har been conceptualized in many ways and is often viewed in conjunction with stress and coping. Buunk divides social support into four sources. Social integration, the number and strength of social bonds within a network. Satisfying interactions, having close and secure relations with co-workers and a good social climate at work in general. Perceived available support refers to how you perceive that assistance is available if needed. Perceived enacted support refers to the support one has available or has already received. The feeling of having support available as needed can have positive effects in reducing stress and increasing well-being (Buunk, 1990, in Skogstad, 2011, p. 34). Support can also come at a personal cost, negative colleagues can impart negative effects, in workplaces with a heavy workload a colleague's own worries and problems can become a negative influence and many feel that needing and receiving help or support is degrading and unbalancing in the relations within the workplace (Skogstad, 2011, p. 35).

3.4. Social innovation and co-creation

Social innovation is defined as new solutions that cover social needs, and creates new or better long-lasting outcomes, better use of resources and skills and can fundamentally change relationships, positions, and rules between involved parties, such as organizations and users (Willumsen, Ødegård & Sirnes, 2020, p.27; Voorberg et al., 2015, p. 1334). Social innovation should represent something new for the user or the market, and not simply the development of new ideas. It should meet a real social need, create measurable changes, and empower service users. It should create new relationships and roles and strengthen services to provide solutions that actually work (Willumsen et al., 2020, p. 28). Social innovation can be seen as more than just a change in the way things are usually done, it represents a step change, a break with the way things are usually thought of or done. These can be small changes or radical changes but must represent a break with the old ways of doing things (Krogh et al., 2020, p. 47).

The need for social innovation in the mental health sector has been increasing, the services provided need to meet the actual needs of the users while working in an environment filled with challenges such as an ageing society with increased care needs and budget cuts from the government (Voorberg et al., 2015, p. 1346). This is where co-creation comes in. Co-creation can bring interested parties together to develope precise and detailed solutions to agreed upon issues. By designing and implementing solutions that the public and professionals agree on, they create something of value for their citizens, that the citizens value (Krogh et al., 2020, p. 45). The highlight is on partnerships, where these new public services build on the principles of democracy, community and civil society. This is thought to make public service and governance more efficient, increase trust in public institutions and better respond to citizens needs (Baptista, Alves & Matos, 2019, p.219-220). Co-creation has a large innovation potential because the different parties to the creative process are involved already in the early stages of the process. How much the effect becomes depends on how the co-creation process is framed, who is involved, when, and how (Krogh et al., 2020, p. 54).

Factors that influence the participation of users in co-creation and co-production can be organizational or from the user’s side. Voorberg et al. (2015, p. 1342) mention that the organizational factors can refer to compatibility, the availability of for example infrastructure being in place to communicate with users, or they refer to attitude of public officials or politicians towards co-creation. The latter is often reported as the attitude that co-production with citizens or users is unreliable due to people being unpredictable or the unwillingness to lose status or control over the users. Furthermore, the lack of tradition in viewing the user or consumer as an equal as opposed to a service-receiver can hinder co-creation. If the aim of co-creation is unclear it can be difficult for administrators to see the benefit of implementing it, especially if economic gain or increased user interest is hard to foresee (Voorberg et al.,2015, p. 1343). On the user side of co-creation and co-production a few determining factors are mentioned. Personal characteristics such as feelings of civic duty, loyalty, and a wish to improve the government influence the willingness of the user to participate in co-creation and co-production. People with higher education seem to be more aware of community needs and more able to communicate their own needs. They also need to be aware of their own abilities to participate and actually influence the services they are receiving. For co-creation and co-production to happen, people need to have trust in the initiative, they have to feel that it gives them something that is of value to themselves and others in the same position (Voorberg et al., 2015, p. 1343).

4. Method and methodological considerations

4.1 Design

The study used a mixed methods design including a combination of a questionnaire and semi-structured interviews to answer my research questions. The use of mixed methods allows for multiple ways of seeing the phenomena and gain better understanding of a topic (Creswell & Plano Clark, 2011, p.4).

The philosophy behind the study design was first and foremost pragmatic. Tashakkori and Teddlie (2003, p.81) state that pragmatism can be a method for selecting inquiry methods and that the method is appropriate when it achieves its purpose of answering the research questions. The research field of the work environment of a PSW is relatively new and spread throughout Norway so I considered interviews alone would not give me breadth of understanding, but also that a questionnaire would not give me the richness of description of the work being done here either. With both a questionnaire and interviews I expected to receive a triangulation of data that can increase both validity and trustworthiness. The design was deductive, I had themes guiding both the questionnaire and my interviews.

The study design was a convergent parallel design. I used a form called concurrent nested design where instead of both qualitative and quantitative data have equal weight, one is given more weight than the other (McBride, MacMillan, George & Steiner, 2019, p. 701). I utilized qualitative priority for my study so that the qualitative method and interpretation had a greater emphasis, and the quantitative results had a supplementary role (QUAL + quan). Both data collection methods took place concurrently due to time limits on the collection of data, this allows the data analysis to be done independently. This design is used to obtain different but complementary data on the same topic (Creswell & Plano Clark, 2011, p.4). The interviews were open-ended questions about the nature of the work environment, and different facets of the work. The questionnaire was used to gather demographic information such as age, gender, previous experience for example. The bulk of questions focused on work environment, such as perceptions of stress and social support.

4.2 Preconceptions

Malterud (2001, p.484) wrote that everyone comes to a project with previous personal beliefs and experiences as well as perspectives and theoretical foundations related to one's education and interests. To avoid undue bias I looked at my own preconceptions for this project. I did not know very much about the subject beforehand but learned a great deal in my early research. Through the course of my work with mental health patients at the municipal level, I began to appreciate the value that PSWs could have for my own clients. I hope that by being aware of my general positive regard for this work I was aware of my use of language with my informants so that I was able to avoid influencing their responses in the interview process, and by following a semi-structured interview guide I had my questions to guide me.

4.3 Sampling

4.3.1 Qualitative sampling

For my interviews I aimed to interview PSWs with at least one year's experience of working in the field. I decided on at least a year of experience, so my informants had managed to learn their jobs and had gotten some experience from the workplace. I used convenience sampling to recruit informants. This was a volunteer sample where my contact in peer support advertised for people willing to be interviewed, this method requires the potential recruits to come forward and identify themselves as they did with my contact (Polit & Beck, 2017, p. 492). I then contacted each person via email, sending them information and consent forms. Because I wanted to reach PSWs from all over Norway and not just locally this type of sampling was the most convenient. With my interviews being conducted via telephone I had more geographic spread than would have been otherwise possible. I had six informants, four women and two men. They came from three different regions in Norway and worked in different settings. Three of them worked for inpatient psychiatric units, one worked as a research assistant for a national project, one worked for a communal care service and the last one was working on a system level in a developmental center for psychiatric services. Their roles were varied and will be talked about more in my analysis of the interviews.

4.3.2 Quantitative sampling

The sampling method was a non-probabilistic one, as the aim was to contact PSWs (Polit & Beck, 2017, p.252). After reaching out to peer worker organizations through email I got introduced to a person with long experience and wide contacts in the field of peer support work in Norway. The advice I received due to the geography of Norway, the fact that only about 27% of Norwegian municipalities employ PSWs (Ose et al.,2019), and PSWs being a hard-to-reach population was to use a snowballing method via social media. Hard-to-reach population here referred to the fact that the target population was small and widely spread throughout Norway. I was looking for representative results as opposed to generalizable results and use of social media allowed for a time efficient and easy method to reach my target population (Baltar & Brunet, 2011, p.58).

I reached out to the three main organizations that contain PSWs here in Norway via email, as well as my contact person who introduced me to their Facebook site administrators, to get help in distributing the survey. Three Facebook pages shared the electronic link for my survey using the digital tool Survey Exact. These were the pages for the «Nationalt senter for erfaringskompentanse innen psykisk helse», «Erfaringsnettverket» and «Kompetansesenter for brukererfaring og tjenesteutvikling – KBT». The inclusion criteria for participation was to work as a peer worker and as these sites were closed for anyone outside the field, they ensured that my population was representative.

4.4 Data collection

4.4.1 Qualitative data collection

After approval from NSD I contacted my potential informants via email where I sent them a letter with information about the project and a consent form for them to sign and send to me. We agreed to a time for the interviews which were all conducted over the telephone and recorded. I chose to do interviews over the telephone as travel was not an option to meet my informants. Kvale and Brinkmann (2017, p. 178) spoke of this type of interview style and though the acess to non-verbal information is missed using the telephone a geographical spread was reached that would otherwise not have been possible.

The interviews were in the form of semi-structured individual interviews. By semi-structured I am referring to a guide that has an overview of the topics I wish to explore and questions to be used (Kvale

& Brinkmann, 2017). I followed an interview guide I developed beforehand to keep the interviews flowing while also keeping to the themes I wished to know more about. I wrote down a good number of questions into the guide even though the aim of semi-structured guide is to open up a conversation about the topics but many of them are follow up questions and used to remind myself of what is of interest, and not intended to follow religiously. I had a PSW from Norway read through and comment on my interview guide before starting interviewing and received helpful input. Malterud (2017) emphasizes the need to establish trust between interviewer and informant and that the interviewer does not enter the conversation with the answers already established in their own mind. The information should be rich and relevant, and I hoped by establishing themes for my interview guide I would be able to get this type of relevance.

The themes I was interested in for my thesis were, work environment and conditions, relations at work and stress factors. I tried to keep the questions both thematic- relating to what I wanted to know about, but also dynamic to keep the conversation flowing in a natural manner. An aspect of that was to create questions that would give me information that would lend itself to analysis and interpretation later (Kvale & Brinkman, 2017).

The aim was to collect information rich in individual experiences and narratives that can give deeper insight into the work of PSWs and, to create a situation where the informant can share the meaning of the experience as they it and to share in a way that is loyal to their perspective (Malterud, 2017).

The interview questions were developed after reading reviews of the literature from other countries where peer support work is well established. I was inspired by the results of two reviews in particular: Vandewalle et al.'s (2016) Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review; and A review of the literature on peer support in mental health services by Repper and Carter (2011). I also received input from a PSW that is active in the field with long standing experience of the work. The interview guide is in appendix 4.

Table 4.2. Examples of questions from my interview guide:

Work conditions and environment	**Training**	**Relations**

Tell me about your work as a PSW	How did you experience your training and introduction to your role at work?	How do you use your own experiences for your work?
Do you view your workplace as inclusive?	Do you receive guidance from other PSWs?	How do you experience being personal and yet professional in your relations with users or patients?
Can you tell me about your relationship with your leader	Do you regularly meet other PSWs for exchange of ideas and experiences?	How have you experienced the work as impacting your own health or situation?

My experience after interviewing my informants was that the guide came in handy, as not everyone was equally talkative, and I received the richness of information I was seeking. I had originally intended to perhaps develop the interview guide underway, but I felt that asking everyone the same questions would provide me with better chances at comparing and analyzing the large amount of data that an interview accumulates. I ended up with over six hours of interviews, after transcription I had 81 pages of text or just over 35000 words. I did a pilot interview with my first informant, that was also the longest interview conducted. My informant talked very much, and it didn't feel comfortable or appropriate to interrupt them. They did end up giving me a rich material to work with and my other informants were not as talkative. The pilot interview flowed well so I felt no need to change my interview guide after. The recording device worked as intended so sound quality over the phone was excellent.

4.4.2 Quantitative data collection

The questionnaire was created in a program called Survey Exact; a resource used to create surveys available at the University of Stavanger. This is an internet-based resource where you can create your own survey, share through email or via the internet and do simple analysis of your results. It is an intuitive and simple tool for an inexperienced researcher and easy for participants as well.

Interested participants were able to click on a self-creating link. These electronic links were self-generated, every time someone clicked on the link shared on Facebook, a new untraceable personal link was generated for their answers. These links do not collect any personal information or trace anyone's IP addresses.

The survey consisted of 55 questions in total, however part of the questionnaire was for other purposes so only parts of the results are utilized in this thesis. The relevant questions covered the following areas: socio-demographics, training, employment and roles, social support, and work-related stress. The entire questionnaire is in appendix 5.

Table 4.1. Examples from my survey questions:

Demographic information	**Training information**	**Employment and roles**
Age	Have you taken a course to work as a PSW?	What type of organizations or institution do you work for?
Education	What kind of course did you take?	What is your role in your place of work?
Previous experience	What was the focus in the course?	Are you utilized in training or hiring at your place of work?

The questions on socio-demographics, training and employment and roles were inspired by questionnaires used in a survey in the USA in 2014. These are discussed in the article The Peer Support Workforce: Results of a national survey (Cronise et al., 2016). For the questions about social support, I used a scale created by QPS Nordic. This is The General Nordic Questionnaire for Psychological and Social Factors at Work, a questionnaire that has been validated and reliability tested in two different studies conducted in four Scandinavian countries (Skogstad, 2001, p.1). This questionnaire was developed in co-operation between Norway, Sweden, Denmark, and Finland.

The questions were divided into: Support from your supervisor; Support from colleagues; and Support from friends and family. Examples of questions are: If you need it, is your supervisor willing to listen to you when you have challenges at work? Have you noticed disturbing conflicts among your colleagues? If you need to, can you speak with your partner or other close friend about challenges at work? The questions on social support have a high internal consistency. Questions on support for your supervisor have a Cronbach's alpha of 0.83 and 0.81 for test-retest reliability. Questions on support from colleagues have a Cronbach's alpha of 0.80 and 0.72 for test-retest reliability. Questions on support from friends and family have a Cronbach’s alpha of 0.75 and 0.83 for test-retest reliability. The test-retest interval was evaluated in two studies between five and eight weeks (Skogstad, 2001, p.10).

The questions about work-related stress come from a questionnaire from the book The Stress Check – Coping with stresses in life and work by Cary L. Cooper (1981). Cooper wrote about the effects stress in both life and work can have on a person and wished to both examine those effects and introduce strategies to alleviate those effects (Cooper, 1981, p.5). Though the book is old the questionnaire is still relevant today and worked well for the purpose of illuminating my samples experience of stress in the workplace.

4.5 Analysis

4.5.1 Qualitative analysis

I used thematic analysis to analyze my interview data set. Braun and Clarke (2006, p. 78) describe thematic analysis as a method that should be viewed as foundational for qualitative analysis. According to them, this is a method that is not connected to a theoretical framework such as grounded theory for example, and as such can be used with different theoretical frameworks. They define it as “a method for identifying, analyzing, and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). Themes in thematic analysis reflect a central organizing concept and are often organized around a central concept or ideas. They can unite data that otherwise might seem disparate, they can explain larger portions of the dataset and are built from smaller meaning units or codes (Braun, Clarke, Hayfield and Terry, 2019, p. 845). I had my recorded interviews transcribed for me so first of all I went over the transcribed pages while listening to the interviews to correct any discrepancies. The transcribed pages were well written so there were no issues. After this I sent three of my interview to my thesis supervisor so that we could compare notes on codes and salient features of the material.

Thematic analysis is divided into six phases. Phase 1 is familiarizing yourself with the content. I started highlighting in different colors after a couple of read-throughs sentences and paragraphs that I felt could become codes. In phase 2 I started to come up with initial codes, this generated many codes across all the data. In phase 3 the search for themes begins. Codes become sorted into initial themes and I used excel sheets to help me keep a visual overview of the coding and theming process. At this stage I also started to look for overarching themes, and subthemes that fit in with the overarching themes. At the end of this phase I had coded all extracts of my data. In phase 4 a review of the themes begins. The candidate themes had been chosen, I had four initially. I reviewed what belonged where and eventually concluded that three overarching themes had emerged and for the first two main themes I chose two sub-themes. The third theme has no sub-themes. In phase 5 it was time to define and name my themes. This entails identifying the essence of each theme and what aspects this theme captures. For each theme a detailed analysis was written to tell the story of the data. The 6th and final phase is then producing the report, illuminating the essence of each theme with examples, and simplifying the data for ease of understanding (Braun & Clarke, 2006). A challenge when the reporting started was translating my themes into English for the thesis. I needed to be careful here as this is a fragile phase, formulating and translating from one language to another runs the risk of information getting lost or misunderstood so care must be taken (Van Nes et al., 2010). Going back to the codes to re-check meaning and keeping the language Norwegian until the final phases was followed as recommended by Van Nes et al. (2010).

As I started writing up the results of the analysis, I had four initial themes, these eventually merged together into three overarching themes with interconnected subthemes that illuminated the overarching themes. The process was a lot more complex than expected, since I had themed my interview guide, I felt these would coincide with those topics, but other themes came out quite clearly during the analyzing phases.

Table 4.3. Examples of my analytical process, from data to overarching theme:

Data extracted	**Coded for:**	**Subtheme**	**Overarching theme**
It used to be very stressful, because I did the same as I did now, but only got paid for a 50% position, I had to many users to follow up, and I wound up working a lot more hours than my positions demanded	Organizational factors Role clarity Framework	The role of peer support worker	Being a peer support worker
Yes, it can happen at times you get a reminder of some stuff, and you kind of have to just be in the situation and be able to give support but help the user to reflect on the matter. This also helps you work on yourself as	Characteristics of the peer supporter Self-awareness Well-being	The person behind the professional	Private, personal, and professional – a tightrope balance

giving support in this type of situation helps you mature			
Like the Erfaringscafe we started, other district psychiatric units wanted to start up the same so we work together (PSWs) and can use each other for help	Interdisciplinary Co-operation between PSWs Co-creation	Co-creation	Co-creation and innovation through grassroots work

4.5.2 Quantitative analysis

For my analysis I chose to use SPSS, a statistical program. Survey Exact results were downloaded as an excel-file and then opened up in the SPSS program for further analysis. I excluded all unfinished questionnaires as people seemed to only answer the first few background questions at the start. To have a meaningful way of analyzing it did not suit to include the unfinished ones. I was mostly interested in frequencies, as correlations or factor analysis were not relevant to my dataset. I analyzed my demographic questions as single items and calculated percentages. Where multiple choices were available, I created simple tables to display the results. For the questions on social support and stress respectively I created stacked bar charts to show percentages for each value. The values went from Very rarely or never to Very often or always for social support and from Not relevant to Always stress on the questions about work related stress.

4.6 Ethical considerations

Whenever people participate in research it is vital to protect them from any potential harm and ensure the protection of their rights. This is governed by laws and ethical principles in Norway and ensured by applying for approval by a governing body. In this case, NSD, Norwegian center for research data. NSD is a national center and an archive for research data and give advice on data management and data protection in research. Whenever personal data is processed in a research project NSD must be notified if the data can in any way be linked to a person as in voice recordings, or through the combination of information traced through the study (www.nsd.no).

To ensure anonymity and data safety I sent an application to NSD, after developing my project plan which included a copy of my questionnaire and my interview guide, as well as written information given to applicants before participation. I sent in my application, with reference number 155769 on the 12.11.2020 and got approval for my study 30.01.2020 (appendix 6). As this project didn't collect personal health information, it was assumed that approval from REK (Regionale komiteer for medisinsk og helsefaglig forskningsetikk) was unnecessary.

Confidentiality in this study was achieved through thorough information given about participation both in answering my questionnaire anonymously and by consenting to being interviewed and recorded The links to the survey retained no information about participants or their IP numbers, the data was stored on my personal account on Survey Exact and downloaded as an excel file to my locked home computer. No personally identifying information was included in the questionnaire.

Interview informants signed a declaration of consent before being interviewed. All recordings and transcriptions were kept on an encrypted memory stick. A home computer was used for the writing, it was password protected and no information was stored on shared drives or online. All participants received information about the storage of their data beforehand. All the information collected will be coded and anonymized so as no one will be recognizable. Information about the survey, information about the interviews and declaration of consent are in appendices.

5. Results

As this thesis was based on mixed methods research the results were divided into two chapters. First the results of my interview analysis are presented. The qualitative results are a mixture of my retelling and description of the informants' experiences, and direct quotes from my informants. In the second part I present the results from my questionnaire in both figures and tables and summarized by text for ease of understanding and discussion.

5.1 Qualitative results

I will be presenting my results from my interviews in this chapter. The aim was to explore the experiences of being a PSW in the Norwegian mental health system, both in specialized health care and community care as well as research. The focus was on how they perceived their roles, leadership, and implementation at work. I was also interested to know how they experienced psychosocial conditions, utilized their previous experiences and knowledge, and if they had been involved in change and innovation during their time as a PSW.

All my interviews were conducted in Norwegian, so all text and quotes have been translated into English and adjusted slightly for ease of understanding by removing hesitation and filler words used in spoken language. The act of transcribing means to transform from one form to another and the use of spoken language on paper can become both unintelligible and dull to read (Kvale & Brinkmann, 2017, p. 205).

To anonymize my data I use the singular form of they instead of he/she to gender neutralize my data. This is a common use of a singular they to indicate gender neutrality (Lexico.com, n.d.). For example: Interview participant 1 told me they were unhappy at work.

Throughout I will refer to my interview participants as peer 1, 2, 3, 4, 5, 6.

Three overarching themes emerged after analyzing the interviews. These three main themes are presented along with their subthemes.

Theme 1: Being a peer support worker. In this chapter I will discuss the subthemes of the different roles, training and pay, and leadership, supervision, and implementation in the workplace.

Theme 2: Private, personal, and professional – a tightrope balance. In this chapter I will discuss the subthemes the person behind the PSW, and how they leverage their lived experiences in contact with their peers.

Theme 3: In this chapter I will discuss co-creation and innovation through grassroots work.

5.1.1 Theme 1: Being a peer support worker

The role of peer support worker

All my interview participants were asked about their work situation, this varied from being in a leadership role and fulltime employment to working part-time in different places. Peer 6 had a leadership role working fulltime for the municipality where they live. They worked at the system level and in an advisory capacity. They didn't have a job description and described the work as being a chaos pilot at times. While two other PSWs also worked full time only one, peer 2 was hired on a permanent basis and divided the work between a psychiatric unit and a team for professional development in the same hospital. Peer 4, also in a fulltime position divided their time between two different instances, the municipality and a professional team in addiction work, however, both of those position were temporary, and project-based so future employment was not guaranteed. Peer 3 was hired on a project basis as a research assistant and employed as long as funds allow. Peer 1 had a 30% position in a psychiatric unit. They also had a project-based role in a center for rehabilitation and recovery and a self-created position in running a monthly meet up called Erfaringscafe alongside a few other PSWs in the same area. Peer 5 worked 60% in a psychiatric unit, split between two units as well as running an Erfaringscafe in their area. I will talk more about this Erfaringscafe in a later section.

Training was neither formal nor a requirement for the jobs my interview participants had. Only one peer had taken a course before starting. Many spoke of taking different courses on their own initiative or through the workplace on different themes during the course of their employment, but none on peer support specifically. Peer C spoke of how they felt an education or training should be required. "I don't think you automatically become a good PSW just because you have experience". They go on to explain their thinking:

> *I feel like one has great responsibility in one's role as PSW, and it's easy to put a foot wrong. I feel like one must have a self-awareness in relation to one's role, and should have good training, and possibly an education as well. That's my opinion.*

None of my informants had a specific job description to follow, although most had a rudimentary framework for the workday. Peer 6 spoke of both having flexibility in not having a clear-cut role but also stress at not knowing if they were doing a good job. Many talked of stress at work, trying to get through a lot of work in the time they had at their disposal, and the feeling they describe of the need for more PSWs was ubiquitous. Peer 4 described the relief from getting a second 50% position:

> *It was quite stressful, I did the exact same work as I do now, but only in a 50% position and I had way too many users to follow up on, and it made me work a lot more than what my positions indicated.*

Peer 1 described well the frustration that not having a clear role can create for themselves and co-workers, "I am a peer support worker, don't you know what that means?". They went on to explain how they felt their leader didn't understand the role of a PSW or how to use them. Several informants describe how both they and the workplaces need to know more about the role, what does and doesn't a PSW do?

The workday doesn't look the same for any of my informants, tasks run the gamut from just hanging with people in their homes to having one on one conversations. Most are in direct contact with service users, inform and advise on matters related to being a user of the mental health system. Others help with the change from being an inpatient to outpatient, help them get in touch with support systems and networks out in the municipality. All talk about their role in empowering the patients and service users, helping them navigate a complex and large system.

The way PSWs are paid doesn't follow any national guidelines and creates a large gap between the highest paid and the lowest, the pay can go from around 200 thousand NOK annual salary for a full time position up to around 500 thousand NOK. The PSWs describe great disparity in how their pay is calculated, some receive compensation for their education and previous experiences while others don't. Peer 1 describes how the pay negotiations went for her:

> *I am a trained nurse with a degree in psychiatric work as well, but it makes no difference for my position. When I requested higher pay, they just pointed to my contract, you are an*

> *assistant in psychiatry. We didn't require you to have an education, so you don't get any higher pay, period.*

Other informants have much higher wages, they get compensated for any education they have to increase the pay rate as in the case of peer 4 who received compensation for being a plumber. The issue here is that there isn't a specific work title in the state systems for a PSW same as one has for nurse or psychologist for example so the way to figure out how to pay a PSW becomes up to the instance hiring them. In on region in Norway they have formalized the position, created a title in the system and a rate of pay specifically for PSWs. This however is not nationwide though peer 6, who also works in a national organization for PSWs says this is being worked towards. He describes the issue well:

> *The issue is that people don't recognize the competency that is lived experience, and tariffs don't exist for the role, and there are a lot of discussions about how the PSWs should be compensated. In many areas the title doesn't exist in the system which makes it hard for the national organization to gain an overview of how many PSWs there are, you are called assistant, you get called helper, and this is something we are working to correct.*

The issued described above were echoed by nearly all my informants so the issue is well known and problematic for the peer support workforce.

Leadership, supervision, and implementation

Having a leader you can trust and seek out for support seems to have a large impact on my interview participants wellbeing and satisfaction with work. Most of the PSWs interviewed describe good relationships with their leaders. Peer 2 describes being consulted on principal matters being introduced to the unit they work in, being consulted on most matters involving patients and experiencing that their leader cares for their wellbeing. They describe being sent home by their leader in a period with great personal stress and told to relax a bit and think about anything but work for the rest of the day. In another instance they were both interviewed about a situation that had arisen at work, as peer 2 explains it:

> *My boss and I got set up as adversaries in a newspaper article once. My boss was asked how long they were going to let me behave like this. And she said to her I was doing exactly what I was hired to do, if I couldn't bring out the patients' perspective, I wasn't authentic in my job.*

Peer 5 also describes how their leader has supported and directed the professional staff to respect the role of the PSW when met with resistance to include them in for example group therapy sessions and team meetings.

> *The boss told them 'They are to be included in everything you are, have the same access to journals you have, they do everything you do.' This is what made everything work so well, because the leadership has been clear on the fact we are hired as equals to everyone else.*

This led to the staff becoming more accepting and more likely to come to them for discussions, advice, and ideas about handling patients. Peer 1 tells a different story, the leader in their workplace could be difficult to talk to, seemed unclear on the role of the PSW they hired, and didn't include the PSW in any meetings aside from the Monday morning report. They didn't have direct contact with service users in any formal capacity, and in their own words, "I feel like I'm on display, I'm the symbol of hope, but I shouldn't do all that much". Peer 1 also describes having had mental health issues while working, because of the attitudes they meet from both leader and co-workers, and the lack of respect and dignity that comes with working under such uncertain conditions.

It is clear that in order for the PSW to thrive in their role they need support from leadership, clear directions, and open communication. Leaders who regard the addition of PSWs as positive seem to be able to smooth out the implementation process somewhat but more information for all parties would ease implementation. Peer 5 who lives in a region where the role is formalized believes the contributing factors to the wide acceptance and use of PSWs there and the fact that the region runs its own training program for PSWs, is due to political leadership, mental health administrators and managers in the region encouraging and championing this type of work.

Since there is no formal system in place for the hiring practices of PSWs in Norway my informants tell different stories about how they were hired and what happened in the start of their employment. Only one PSW, peer 5, came to be introduced to their workplace through a trainee position where they spent seven weeks working for the unit they then later got hired at. The others had no formal training before starting work. However they also spoke of how the various employees seemed uncertain of PSWs before receiving an introduction to both them and the work:

> *What made this work was the fact I was invited to talk a little about myself. Who am I? How do I think I can contribute? Why am I here? So I had a short talk in front of everyone in the department and after that I felt things started to work much better…After my half hour or*

> *forty-five-minute talk I felt things easing up a lot and I got included in a lot more things, got more responsibilities and dragged into all sort of projects.*

Several interview participants describe how some co-workers, often with decades of working experience challenged the inclusion of PSWs in the therapeutic work, they were unsure if someone with a diagnosis of mental illness could work in a psychiatric unit. Peer 5 describes how this can change:

> *When you get to know one another and understand that we need to work together, that there needs to be space for the both of us, the need from one working from the inside and one from the outside things started to work better.*

The majority of my interview participants describe starting their jobs without really knowing what they were supposed to do, for some it became evident quickly but for others they had to figure it out for themselves, as peer 2 describes it:

> *I felt like I was up against a poorly developed professional environment when it comes to using lived experiences and the start was a lot of trying this and that to see what worked. The staff needs time to both get to know the PSW and see that they mean well.*

Peer 4 told how they had sat in an office waiting for someone to come in and start to guide them on what to do for a couple of months before going out and creating work for themselves by seeking out service users and forging connections.

Supervision or guidance is not formalized in Norway for PSWs. Some peer support workers have good relationships with the mental health staff and their leaders and use them for guidance, while others look to other peer support workers as sounding boards as they see the work in the same way, don't have loyalty conflicts to the workplace and can see things differently. All report having someone they can turn to when they are met with challenging cases or feel some mental strain of their own connected to work. Peer 1 described well how supervision or guidance from a non-peer can clash with workplace loyalties:

> *At the start I got guidance from one co-worker, one I had worked a lot with through the years. At the start I felt it worked well but then whenever I brought up something like attitude problems among the staff, she got defensive saying for example: 'You have to understand these things take time, it probably wasn't meant like that'. So instead of listening and understanding that what I said was true, it made me feel lonely and misunderstood. I feel a guide like that should be impartial and probably work elsewhere.*

In summary of theme 1, Being a peer support worker it becomes clear that the field of peer support is still quite new, though it has existed in some form in Norway for over a decade, and there remains much work ahead to formalize the role, rate of pay, and not least to set up guidelines for workplaces to smooth the transition of adding PSWs for both the PSWs and their prospective co-workers. To quote peer 2:

> *There isn't a central authority to lean on, no one to tell us which direction to focus on now? We don't have one school to train us, no one authority, we have a bunch of different employers that work on premises in a way they understand them, and most employers have no idea what they are doing when hiring a PSW.*

5.1.2 Theme 2: Private, personal, and professional – a tightrope balance

The person behind the professional

My interview participants all talk of the experience of trying to exist in the gap between being an employee in the mental health system and being an ally and advocate for the patients and service users they are in contact with. All seem to have reflected deeply on why they do the work, how and for whom. They talk of how they do the work because they want to bring hope to people suffering the way they themselves have experienced it, to show them there is a way forward. They wish to empower patients to know their rights and to advocate for themselves, and to inform them about their options for community care, aftercare, and possibilities within the treatment setting. At the same time there is a duality to the role of PSW as peer 2 explains so well:

> *I am clear on the fact that I receive a salary, and I am an employee that is there to bring forth the patient's perspective. This can challenge both the organization, the professional side of things and feel contradictory, which for me means we necessarily have intersecting loyalties.*

Some also describe how they needed for their experience to mean something, how they thought about what they would have wanted for themselves while they were admitted to hospital and see this as the way to help. At the same time all but one talk about how having a job, being an expert in this case -on life with mental issues- is good for their own sense of wellbeing as well as feeling like they are contributing to society and being useful. Peer 1 however has had a different experience:

> *I have had many second thoughts about staying on due to conflicts and my unclear role, but I am passionate about user advocacy and mental health work, so I keep carrying on. I have had several relapses in my years here and I blame unclear direction from my leader.*

Other interview participants speak of being relapse free for years and thank the job for that fact. The importance of social support and a positive psychosocial environment at work emerge as important wellness factors here. When asked it they wanted to remain in their position as a PSW all of my interview participants said yes. Some stated that they might not stay in the same place or in the field forever but for the time being all had intentions to remain PSWs.

When asked about wellness and self-care the PSWs generally seemed quite conscious of the need to work with their own history and what they need to do to keep themselves in recovery. As peer 2 put it:

> *I felt the need to take back my story and my life, I didn't want the psychiatry to own my story, my prognosis, and diagnoses. The illness can become so all-consuming and take over your personality. So in my recovery I discovered the importance of rebuilding your identity and your voice, that's what I want to support people in doing. Empowerment, meaning, hope and identity are the cornerstones of recovery.*

They also mention the importance of self-care, having the tools to deal with whatever comes up through work and the importance of being aware of feeling either under-activated or overactivated at work. Another informant spoke of how they had felt triggered into feelings of sadness and frustration but turned to a colleague for help to work through the issues. This sentiment was echoed by others, how situations could touch upon old wounds but that they quickly turned to someone to help work things through. A few do mention stress from feeling inadequate or not being as good as the more educated professional staff, but all go on to say that the feedback from service users is so overwhelmingly positive and thankful that those feelings tend to be fleeting. All my informants report that despite stress and pressure their engagement to the service users has greater rewards than challenges.

The work to uphold boundaries and practice self-care features prominently in all my interviews. Many of my informants speak of the difficulties especially at the start in upholding boundaries. Mostly these boundaries refer to time management. Leaders, co-workers, and peers infringing on their time outside of working hours or themselves working more than they are required. They contribute their tendency to overwork to their feelings of there being a huge need that would otherwise go unmet. Most report that they have learned over time that this is a boundary that is important. Peer 5 told of relief at more peers starting in their region as the workload was immense at times. "At the start it was hard to say no to people asking for help. Where do I draw the line? Who shall I help?". When asked about stress it was universally contributed to the demands on their time and attention, where more PSWs have started working, they feel the pressure being relieved. Other boundaries mentioned were being careful about not connecting on social media with service users or co-workers and peer 2 described how it would feel strange being involved socially with their health care colleagues and then going back to being the patient's spokesperson the next day at work.

Leveraging lived experience

When it comes to helping a person in a mental health crisis ethics and a careful approach come through clearly as fundamental values in my interviews. One of my informants has a background in social work and describes their thoughts on being on the other side of the table:

> *I just started thinking, good lord! Where is all the stuff I learned in my social studies about the good dialog and ethics? The ethics in mental health care seemed a lot different from the ethics I had trained in, the focus on the patient's perspective and what was ethically important seemed missing and for me that told me these things were not quite as they should in the health care sector.*

They also talk about how the power wielded by the professional to diagnose and define a person based on this illness aspect of their personality can have very negative consequences for the person in treatment. The feeling of a need for more equality and democracy when it comes to treatment is mentioned more than once. Peer 6 talks about how they are always conscious of bringing in the user perspective into all projects, and how this repetition is needed to keep bringing this perspective to the forefront in matters that are centered on and around patients. In a system that has the power of coercion in treatment settings the PSWs are very conscious of not being the ones doing any coercing. Peer 2 explains well how in having a position on staff creates a power imbalance over time that needs to be made conscious to the PSWs for them to do the job as intended. A few of my informants supported this by emphasizing the need for proper training to create this type of self-awareness and expressed the need for clear ethical guidelines.

When speaking of how they use their experience they all agree that they are not there to tell their stories incessantly, their story provides them with a common ground, empathy, and openness to the person behind the illness. Peer 3 who is a research assistant says their experience works well a door-opener. They believe patients being interviewed open up much more to someone they view as a peer. All of my PSWs say that they are there to listen to the patient, if asked about their own experiences they choose to be open up to a certain extent and seem quite aware of where the line is. The goal is to validate the patients experiences and feelings, listen openly and give advice should that be called for. When it is relevant and valued as important in relations to certain patients some informants use their own story. Peer 5 who works in a psychiatric inpatient unit has given staff permission to use them as an example:

> *I usually eat in the cafeteria with staff and patients, so we talk a lot. Often patients will say something like "So you are what they call a PSW, but you can't have been as sick as I am, that is obvious". Then after chatting for a bit the mental health worker will say "Actually, they may even have been worse than you, they couldn't even get out of bed in the morning". So the patient's curiosity is piqued, and they ask and ask questions. Later that day the same patient comes back to me and tells me how energized they felt from the hope they got from our talk and how that hope felt so authentic. So yes, we use my story actively, the staff can say they know me from my worst days, and this inspires a lot of hope.*

Others give talks to both staff and patients on a regular basis about their story but when they are in one-on-one interactions their story gets packed away and the service user is in the center. The common sentiment is that the PSW is there to be the voice of the patient, bring the patients perspective into all aspects of the mental health work and be a living symbol of recovery.

In summary of theme 2: Private, personal, and professional – A tightrope balance the work of using your experiences and your history can come with some challenges but at the same time seems to give PSWs a strong sense of engagement to keep going. The common sentiment of there being such a need for their work seems to spur them on. The informants I have interviewed talk of stress and finding a balance through setting boundaries but also a sense of camaraderie with their fellow PSWs and trusted co-workers and leaders.

5.1.3 Theme 3: Co-creation and innovation through grassroots work

Co-creation and grassroots work within the field of peer support seems part of most of my informant’s work. Peer 6 tells of how they alongside other PSWs have developed different programs to increase the services provided in the mental health sector. One of those is aimed at youths and aims to make the services more youth friendly and they work with all of the city’s boroughs to create a more coordinated and user-friendly service. Peer 4, after sitting around waiting for guidance that never came about their role started to seek out users, find out what they needed or were missing from the services on offer and created both a football team and a meeting place where they have a place to go in the daytime to meet others and talk to someone if they needed support. This informant talks of the support they felt from the leadership in his municipality to do the work and the faith placed on him to increase the role of peer support there. Peer 5 started up a program in their psychiatric unit called Discharged to...

> *On Tuesdays I escort patients to Fontenehuset (a meeting place for aftercare – authors note), where those who want to can see how the place is. Discharged to…is a project where we escort the people interested to Fontenehuset there, so they get to know the place well before they are discharged. They are much more likely to use it after they are discharged if we do that instead of just on the day of discharge go ‘good luck, you can now go to this place, its great there’. No one does that. But it they get the escort, feel safe and see what it is about, sign up and show up, they are a lot more likely to use it. They did a survey at Fontenehuset on who came from this project and how many had been inpatients at the district psychiatric hospital and 40% of new members came from this project.*

Both peers 1 and 5 have started up what is called Erfaringscafe with other PSWs, peer 5 has been involved in helping to start up several of these cafes in the region where they live; “Like the Erfaringscafe we started, other district psychiatric units wanted to start them up to so we work together (PSWs) and can use each other for assistance”. These cafes are meeting places for professionals, patients, and service users alike where they explain the competency built on lived experience, why it has value as well as the use and need for PSWs, this feels like it opens people up to this new and unknown role a bit better. Psychiatric professionals also speak at these gatherings so there is a wide and mutual exchange of knowledge. This is a place where everyone is invited to have a cup of coffee or a bite to eat and learn more about one another. This is a good example of innovative cooperation at the grassroots level. Peer 1 described trying to start a similar project as Discharged to… in their psychiatric unit, to become a connection between being an inpatient and moving to communal care. They received a firm denial from their leader even though they had a plan in place to approach the municipality for cooperation. So not all leaders are as supportive of efforts to co-create.

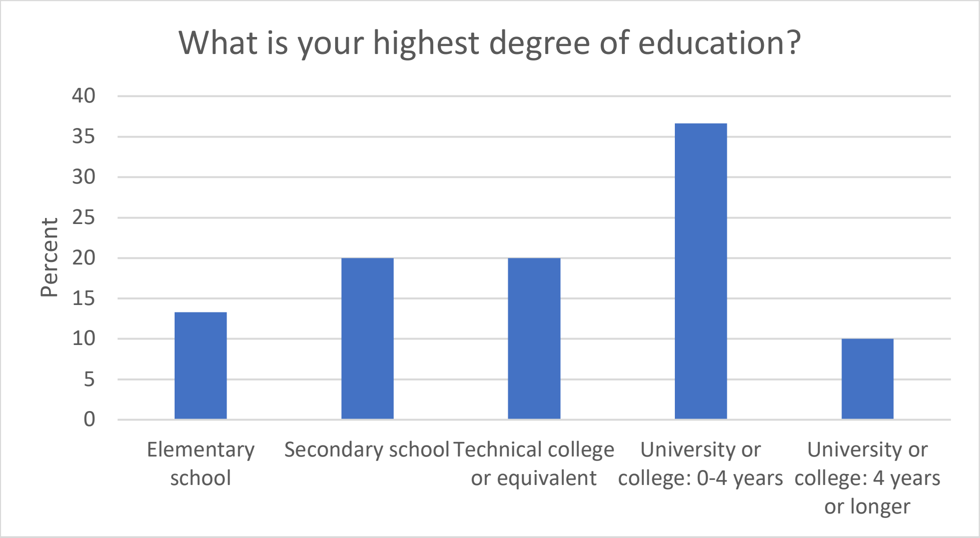
Through their need to improve the conditions of mental health patients and service users PSWs design and implement innovative solutions that serve the users, with the back-up of leadership where it is in place. The PSWs I spoke with seem uniquely situated to sense and hear the needs of service users, both through their lived experiences and through their work, and seem motivated to find solutions and implement where possible.

6. Quantitative results

6.1 Demographics and background

After the survey was closed, I had a total number of 30 participants that had completed the survey. This gives me a 14% response rate. Of those who participated the majority were women, 25 out of 30 respondents. The median age was between 41 and 50, 13 respondents were in that age group. Eleven were between 31-40, four between 51-60 and only one respondent in each age group 18-30 and over the age of 60.

Figure 6.1. Respondents' highest degree of education?



Eleven people had finished a 0–4-year university degree, six had finished technical college or the equivalent, six had finished secondary school, four had graduated primary school and three had finished a master or doctorate degree.

Nineteen participants chose to answer my open-ended question about former careers. Five had worked in the education sector, seven had worked in the health care sector and the rest came from diverse fields.

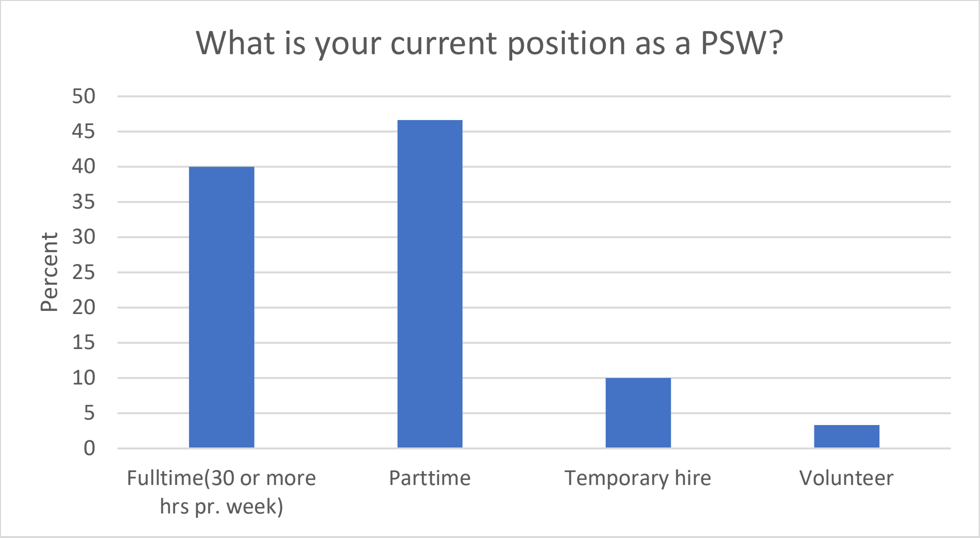
Courses for work as a PSW

The respondents were asked about taking a course for their work as PSWs. Nine out of thirty answered yes to having taken a course. The courses mentioned were: MB (Medarbeider med brukererfaring), KBT (Kompetansesenter for brukermedvirkning og tjenesteutvikling), a-larm, Veiviser and Det levde liv. Course length varied from a couple of days for the shortest courses up to 40 weeks.

An open-ended question asked those who had taken courses to specify what the courses contained. The answers given were: Information about laws and regulations (7 mentions), how to separate the personal from the professional (7 mentions), recovery (6 mentions), communication and sharing your own experiences (6 mentions), and user involvement in treatment (2 mentions).

Employment and the role of a PSW

Figure 6.2 Current position as a PSW?



Fourteen of my respondents work parttime (47%), twelve are employed fulltime (40%), three work as temporary hires or on short term contracts (10%) and one responded that they were volunteering (3%).

Table 6.1 Institution, organization, or place of employment

NAV	Hospital	District psychiatric institution	User organi-zation	ACT or FACT team	Municipal program or institution	Independent organization	Other
1	4	5	1	3	11	1	4

Most of the PSWs in my study reported working within a municipal program or institution or 36,6%. 16% work for a DPS or a district psychiatric institution, 13% report working for a hospital, and 13% report working for another type of institution or organization. 10% of respondents work in ACT or FACT teams. One each respectively answered that they work for NAV, the social service office in Norway, a user organization, and an independent organization. For those who chose other they had the option to write in their answer, their answers were; rehabilitation center, a non-profit organization and administration.

Table 6.2 Work performed

Case work	Social and life skills training	Peer to peer work	Peer support work	Family liaison	Social support	Teaching or training	Research	Other
4	18	12	24	12	2	14	10	9

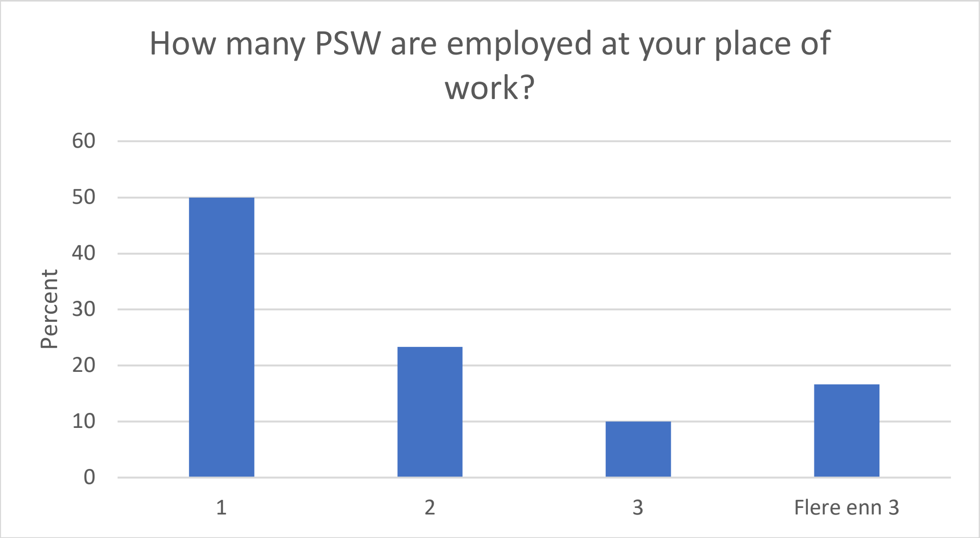
It is clear from the above table that the work performed by the study participants is quite varied and many have different roles that they perform. Aside from the responses to the possibilities in the survey other answers were: Erfaringskafe, a café meet-up for both PSWs, users, and professionals where they come together to share experiences and learn from each other. One on one counseling, organizational work, and clinical work.

Table 6.3 Challenges PSWs can help with

Reduce loneliness	Make and keep appointments	Health guidance	Prevent relapses	Admittance to a psych ward	Admittance to a hospital	Discharge from hospital	Network building
20	8	4	10	9	1	7	22

As mentioned in reviews of the literature surrounding peer support work, they can help with a variety of different challenges, the most important of which seem to be the reduction of loneliness and network building. Help with admittance and discharge is also important. Relapse prevention and helping users to make and keep appointments is also a big part of what a PSW can provide help with.

Figure 6.3 How many PSWs are employed in the same workplace



Most places where my respondents work, they are the only one employed as a PSW. Fifteen of them report that they are the only PSW, seven answered that there was one other employed, three said there were three of them working in the same place, and five said they were more than three in the workplace.

I was also interested to see if they in their capacity as PSWs were used for training or hiring. Twenty-one of them were utilized for training and educational purposes or 70% in total. They were much less utilized in hiring processes, only seven responded yes to that question. I was also interested to know if they received guidance from other PSWs, only six responded that they did.

In summary the results from the questionnaire showed that the majority of PSWs appear to be women, mostly between the ages of 31 and 50, they are generally well educated with 66% having a higher education. Of the nineteen that answered a question about former careers twelve had backgrounds in education or health care. Only 30% report having taken any sort of course to become a PSW and the courses varied in both content and length.

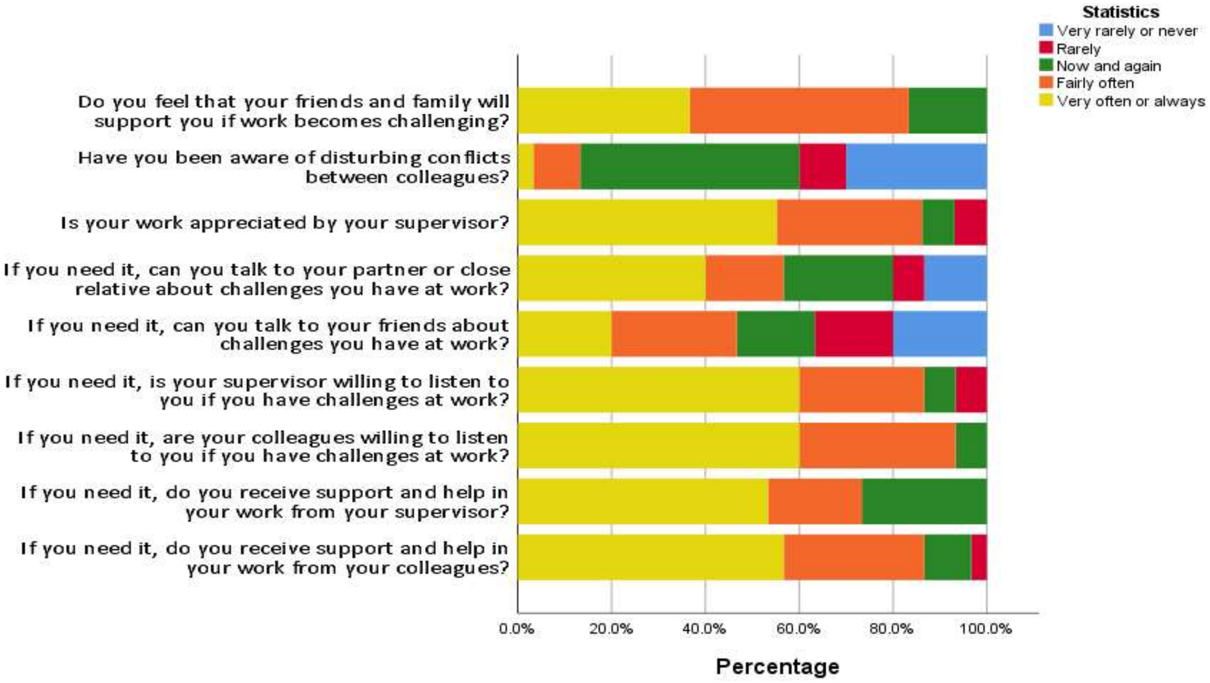
When it comes to employment it was close to evenly split between having fulltime work and working parttime or on a project basis. The workplaces employing these PSWs are mainly psychiatric units, in district psychiatric units and hospitals, and the communal care services. When asked about the work performed the answers indicate highly varied tasks with direct peer support work, social and life skill training being most common, followed by training or teaching and family liaison and research.

When asked what challenges they could help with network building and reducing loneliness were prominent, prevention of relapses, help with admittance and discharge and making and keeping appointments. So the work, tasks and aims are quite varied for the PSW in Norway. Most of the PSWs say they are the only one working in this capacity at their workplace and many of the have a role in teaching and training in their workplaces.

6.2 Social support

In this segment I will go over the results of the survey that cover the experience of social support at work from friends and family, partners, colleagues, or supervisors. The scale I used comes from QPS Nordic and ranges from 1=Very rarely or never, 2=Rarely, 3=Now and again, 4=Fairly often, and 5=Very often or always.

Table 6.4 Social support

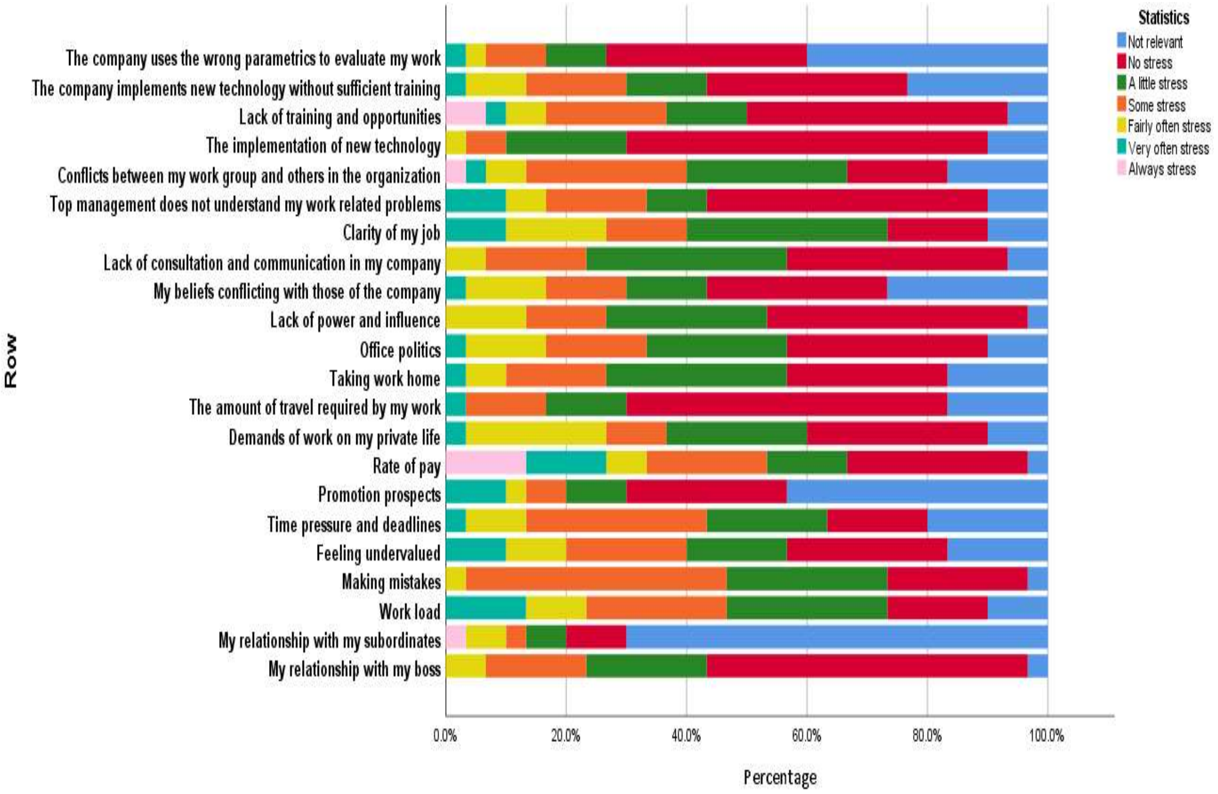


Most of the respondents feel quite supported by family, friends, colleagues, and leaders. Colleagues seemed quite willing to lend an ear or 93%. Most also report receiving support when needed from colleagues or nearly 97%. The majority of respondent report feeling supported and appreciated by their leader. A few report feeling unsupported and unappreciated and that was by their leader, four of thirty report feeling appreciated or listened to now and again or rarely. When asked about being able to confide in friends or partners or family about challenges at work many responded with rarely of never, this should not be surprising as this type of work is usually confidential. Disturbing conflicts at work seem relatively uncommon, many say they are aware of conflicts now and again, but most responded with rarely or never.

6.3 Work related stress

These are the results of the segment where respondents were asked about their experience of work-related stress. This is defined as stress created by your work requirements exceeding your resources. They were asked to evaluate on a scale from Cooper´s book Stress Check (1981) where 1=Not relevant, 2=No stress, 3=A little stress, 4=Some stress, 5=Fairly often stress, 6=Very often stress and 7=Always stress.

Table 5.5 Work related stress



To summarize, on most items most respondents report either feeling little stress, no stress or that the item is not relevant to their work. Relations with colleagues, promotion prospects, travel for work, new technology and evaluation parametrics don’t seem to be large drivers of stress with answers of not relevant and no stress featuring heavily.

Office politics, lack of understanding from top management, conflicting beliefs, relations with leader and taking work home are sources of some to very often stress for around 30% of my survey participants.

On a few items stress scores from some stress and higher are 40% or higher, lack of training and opportunities, conflicts within the organization between the PSWs and others, clarity of the role, time pressure seem to cause a fair amount of stress. Feeling undervalued also features here. Rate of pay, workload and fear of making mistakes all feature as quite stressful for participants.

7. Discussion

In this chapter I will discuss my main findings in light of previous research findings and theory. The discussion will be divided into three main chapters based on the overarching themes from the qualitative analysis and triangulated with the quantitative findings. After that I will discuss methodological considerations of doing a mixed methods research, the strengths and weaknesses associated with this type of research and the implications for this thesis.

The aim of the thesis was to explore what it is like to be a PSW in the Norwegian mental health services. In my discussion I will first focus on theme 1, the role of the peer support worker and leadership factors in light of previous research and the theoretical frameworks of recovery, peer support and psychosocial factors. Next, I will discuss my findings from theme 2 about the person behind the peer worker and how they utilize their lived experiences. These will be viewed in light of psychosocial factors and the CHIME concepts of recovery. And lastly, I will discuss how PSWs contribute to innovative change within the field.

7.1 The role of the peer support worker

One of my main findings was that the field of peer support work in Norway is still under development and changing from year to year. Both in my online survey and in my interviews, women are in the majority of PSWs in Norway, they are mostly between 30 and 50 years of age, and well educated, 75% of survey participants responded they had a higher education. This corresponds with data from the USA (Cronise et al.,2016), and Switzerland (Burr et al.,2019) and the survey *Erfaringskonsulentundersøkelsen 2018* [The peer support worker survey, 2018], done here in Norway (Nasjonalt senter for erfaringskompetanse innen psykisk helse, 2018).

The framework seems quite varied, from both my interviews and survey, peers work in psychiatric units, hospitals, community care settings, in research and projects. Between 40-50% work fulltime and the rest work either parttime, on a project basis or voluntary. Worldwide these number seem to vary, in Cronise et al.'s (2016) national survey from USA, most PSWs report working fulltime. In a study from Switzerland Burr et al. (2019) point out that the most common position for PSWs was around 35%, they suggest this could be due to PSW employment is not a legal obligation in Switzerland like it is in some other countries. Korsbæk and Petersen (2016) in their article on peer support review the status of how it is formalized for example in USA where Medicaid has demanded it be offered as part of any mental health services as best practice since 2007. It has been a central strategy since 2012, in England, that patients in the mental health system have access to a PSW. In Denmark this work was formalized and funded as a project between 2014-2018 by the government to increase peer to peer support and user involvement. This formalizing seems to have an effect on both the number of PSWs hired and how much they work (Korsbæk & Petersen, 2016; Cronise et al.,2016).

A part of the formalization of the PSW role is formal training or certification. The need for training is discussed in the research literature. Hurley et al. (2018) speak of how lived experience is insufficient on its own for a PSW to fulfil the role of PSW. According to their results PSWs themselves speak of their experience as only one area of expertise and other areas need to be covered as well. Kent (2019) speaks of education and training as essential as well, how communication, social skills training, illness and relapse prevention and professionalism for example would be important topics to cover. The training in Norway is not centralized or a prerequisite for employment. Nine out of thirty of my survey participants reported to have taken courses related to peer support work, the courses varied in length and what they contained. Only one of my interview participants had taken a course before being employed although others reported having taken different courses while employed, none were specific to peer support though. One of my informants echoed the results from Hurley et al. about how experience alone doesn’t make a good peer support worker.

The tasks performed by both my survey and interview participants were varied, peer support work was most common, life and social skill training was also common, teaching and training and network building. The work also included reducing loneliness, preventing relapses, helping users make and keep appointments, and both admittance and discharge from hospitals or psychiatric units. These are all supported by the recovery literature (Storm et al.,2020; Repper & Carter, 2011). The presence of PSWs in teams can help to work across transitions such as moving from inpatient to community care and providing specialist advice on personal recovery and recovery practices (Repper & Carter, 2011). This is echoed by Mulvale et al. (2019), where they talk about how PSWs can serve as connections to traditional services and can increase community involvement for users and offer complementary treatment. This was also my finding, where PSWs helped with transitions service users were more likely to use the community care services.

In my interviews, peers mention doing much more work than their position contract stated. The same became apparent from my survey, participants reported feeling great amount of stress from workload and time pressure. In other countries the PSWs report being happy with the amount of work they have, whether fulltime or parttime (Cronise et al.,2016; Burke et al.,2018; Burr et al.,2019). So there seems to be a discrepancy in the organizational framework in Norway that needs addressing in peer supporters experiencing demands exceeding their capabilities or position size and rate of pay. Repper and Carter (2011) discussed this in their literature review, they spoke of the importance for PSWs to monitor their own workload and demands made on them and to feel able to take time out if necessary, to manage their own wellbeing.

A main finding when it comes to the role of PSW in Norway is that job description and roles are quite unclear, especially at the start of employment. None of my interview participants had a clear job description if they got one at all when they started. This is a common issue reported for PSWs, this is widely discussed in the literature and frequently mentioned in discussions as something that needs to be addressed. The roles being unclear creates insecurity among both the PSWs themselves and the staff that works with them (Repper & Carter, 2011; Burke et al.,2018; Vandewalle et al., 2016; Karlsson et al.,2017; Nasjonalt senter for erfaringskompetanse innen psykisk helse, 2018). Hurley et al. (2018) even suggest that this type of uncertainty and stress can threaten a PSW's personal recovery, so this is something that needs addressing. An interesting point on the same matter came from Nossek et al.'s (2021) longitudinal study of PSWs. They discuss the issue of role unclarity but also how their participants become more secure in the understanding of their role over time. They further state that the initial ambiguity can be an asset to the PSW's ability to tailor their job to their unique approach and background. They also discuss how a role that is too fixed can downplay the PWSs authenticity, a central feature of peer support work. I find this is echoed in my findings, though the unclear role descriptions can be a challenge at the start this seems to have allowed for innovation and creativity from some of my interview informants that might otherwise not have emerged.

An important driver for successful implementation of PSWs in the workplace is information about the work a PSW does, what their role in the workplace is and what their duties are (Burr et.al, 2019), as well as getting integrated in the team they work in. If the integration process is difficult it can increase stress and challenge the PSW's own recovery (Kent, 2019; Hurley et al.,2018). Another finding related to the roles and a consequence is that rate of pay is highly variable and can lead to lower satisfaction and intention to stay in the job (Kent, 2019). My findings show that rate of pay is very diverse and a frequent source of stress or dissatisfaction, about half of my survey participants responded that this was a source of stress some or more of the time and some of my interview participants echoed that sentiment.

7.2 Leadership, supervision, and implementation

Burke et al. (2018) identify managers and supervisors as facilitators for the provision of peer support work in mental health services. They emphasize the importance of managers supporting the well-being of their PSWs, ensure their perspectives are respected, as well as their input and making sure their involvement is not tokenistic. They also report the importance of management ensuring that the peer support roles are valued on par with other work in the wider care teams in mental health units. This was evident in my findings; leadership is vital for how the role of PSW is experienced by both the PSWs themselves and their co-workers. The PSWs both from my survey and my interviews reported to generally feel supported by their leaders, with few notable exceptions. Those that reported not experiencing support from their leader in my survey also reported they didn't feel listened to. Others also experienced their position as tokenistic, they felt they were there for show more than to actually do any work. Most said that their input was valued and when faced with negative attitudes they were both defended and championed by their leader. Most talk about an open-door policy with their leaders and felt they could trust them with any thoughts and issues that came up in the course of the workday. According to Skogstad (2011) social support is an important psychosocial factor for well-being in the workplace and can help to mitigate effects of stress and pressures at work. Even just perceived support, a feeling that its available if needed, can have an effect on well-being. In my survey I found that PSWs generally feel supported by both family, friends, co-workers, and leaders. Nearly all reported colleagues were willing to lend an ear and give support when needed and most reported the same from their leader. My quantitative findings indicate that social support, both perceived and given, can mitigate stress factors related to relations to both colleagues and leaders as these were reported as mostly irrelevant or sources of little or no stress for participants.

Mulvale et al. (2019) talk about how managers need to communicate clearly and early in the process of implementing peer support work in the workplace. They also report that education about the role of PSW, addressing concerns and stigma is important as well as the leaders themselves understanding what the role is. This need for information to reduce stigma and negative attitudes from staff came through clearly in my finding. When a PSW was criticized for speaking out about patients and the conditions in their psychiatric unit their leader defended them by explaining that this spokesperson role was exactly why having PSWs was important in the hospital. The need and wish for patient centeredness and recovery orientation is vital for the integration of PSWs in mental health care (Vandewalle et al.,2016). In places where the leadership is clear and on board with having PSWs as part of their workforce the attitudes of others in the workplace seem to change for the better. Repper and Carter (2011) suggest that attitudes of staff that worked with PSWs versus staff that did not showed that PSWs are their own best advocates, they can change attitudes through working alongside non-peer staff. This was clear in my findings were some of the PSWs spoke of how attitudes changed dramatically after giving talks to staff about themselves, the role of PSW and what use it could have for both patients and staff. They described how they were included and consulted by co-workers afterwards in a different way.

The National Practice Guidelines for Peer Specialists and Supervisors (National Association of Peer Supporters, 2019) in the United States was originally developed for peer supporters. However the rising numbers of PSWs in USA in the last 15 years or so led to an increase in supervisors with no direct experience or knowledge of the work of peer supporters or their values. In 2018 these concerns were addressed. They talk about how ideally PSWs have supervision from others with lived experiences of recovery and peer support, but this is not always available or possible. For this reason they updated their guidelines to include supervisors, so the supervision aligns with the values of recovery and peer support (National Association of Peer Supporters, 2019). These concerns about supervision by non-peer supporters are echoed elsewhere in the literature. Burke et al. (2018) discuss how supervision by non-peers can lead to so called co-optation of the PSWs into the dominant workplace culture and thus peers risking losing what is unique and different about their role. Repper and Carter (2011) also talk about the risk of PSWs getting socialized into the ‘usual way of doing things’. So the need for supervision, and especially supervision and guidance by other PSWs is clear. I found that most of my interview participants did not receive formal guidance other than from their leader or colleagues and many of them express missing having more training and guidance by other peers. Some talk about using other PSWs in their region as sounding boards if anything comes up. In my findings it seems that an important aspect of using another peer instead of a colleague for example, can be avoiding loyalty conflicts with the workplace. My interview participants talk about how PSWs share similar views of the work and the patients or service users and see things in a different way than non-peer co-workers. Burr et al. (2019) and Nossek et al. (2018) talk of the importance of hiring more than one peer per psychiatric unit. This is viewed as important for guidance and supervision by peer colleagues, mutual support, and the exchange of experiences. This is also my finding, my interview participants who had gotten more peer colleagues spoke of the benefits of shared workload, guidance, and reflections with peers.

7.3 The person behind the professional

The foundation peer support work is built on is recovery work. The PSW is providing peers with non-therapeutic help based on their lived experiences of mental illness. As Solomon (2004) described it, the PSW is further along in their recovery and have gained valuable insights into their own situation and illness. But for the PSWs themselves, giving peer support can also be beneficial to the PSW, it can lead to an increased sense of self-esteem, confidence and can further aid in their own continuing recovery (Repper & Carter, 2011). This is supported by Burke et.al (2018) who report that consensus was near unanimous on peer support as a personal benefit improved personal mental health and well-being, increased self-acceptance and hope, and aided in personal growth. My findings support this, when asked about personal well-being some interview participants described how they found it important for their experience to mean something. How going through illness and difficulties could become meaningful and useful when they were able to use it to help others going through similar issues as they had. Most also talked about how beneficial it was for them to have a job where they felt they were contributing to society.

One of the National Guidelines for Peer Specialists and Supervisors (National Association of Peer Supporters, 2019) is that peer support is mutual and reciprocal, each peer gives and takes in a fluid manner as opposed to the traditional relation of carer and cared-for. This is also mentioned in Storm et al. (2020) where a PSW talks of this difference between peer and professional and the reciprocity of the peer-to-peer relationship. This is mirrored in my findings where some of my interview participants talk about how doing this work has kept them relapse free for a lot longer than ever before.

When it comes to boundaries the literature mostly refers to boundaries between the PSW and the patient or service user (Burr et.al, 2019; Repper & Carter, 2011) and issues related to being too personal or friendly, the line becoming blurred. However, my interview participants don’t appear to find it challenging to maintain friendly relations with service users, or they chose to stay firmly professional. Some also spoke of the need to keep a distance from non-peer colleagues outside of work but did not find this challenging per se. The most widely described boundary issue for my interview participants referred to their time and efforts. Many spoke of how hard especially in the beginning it was to keep work to working hours. They spoke of leaders, co-workers and even service users contacting them outside work, but also how they found themselves working more that their position stated they should. Many felt that the need for help from service users and patients was so great that they struggled to say no, but most said this either became a part of their lives or they learned to be firmer about contact outside work and working hours. All agreed this was a large stress factor. This was echoed in my quantitative data where time pressure and workload were large stress factors as mentioned previously.

As the CHIME components of recovery are fundamental to the work of peer support workers (Leamy et al.,2011) I will discuss the results of my interview participants about their personal lives and wellness in light of these components here. The five CHIME elements are connectedness, hope, identity, meaning and empowerment.

My interview participants talk of connectedness, connecting users to others with similar experiences, and also for themselves to be a part of a team or a workplace gave a sense of accomplishment. All speak of bringing hope to patients and service users, this hope has been described as of a different quality than hope given by non-peers. That hope is also something that has brought them to the place they themselves are now. Identity featured in many interviews, building a new identity that was not based on diagnosis and illness. Peers spoke of taking back their story and their life and how the power wielded by professionals to define a person can be so damaging to one's self-image and well-being. Meaning can involve finding meaning in the illness and creating a meaningful life and social roles. My findings show that this is important to my interview participants. They speak of the importance of being able to use their lived experiences with mental illness to help others, and how doing the work of peer support helps them feel useful and needed. Empowerment is the fifth component of CHIME, it can encompass feelings of personal responsibility, having or recreating control over one's life and choosing to focus on one's strengths. This come through clearly in my interviews, the peers I spoke to took responsibility for their well-being and through their own recovery showed other patients and service users how to utilize their strengths instead of focusing on weaknesses and diagnoses. My interview participants all spoke of the importance of empowering service users and patients and help them connect with others with similar experiences.

7.4 Leveraging lived experience

Repper and Carter (2011) spoke of the challenge of keeping the relationships between PSW and patient or service user egalitarian and meaningful while also therapeutic, this is echoed by Oborn et al. (2019) who talk about how the subjective knowledge that comes from lived experience can be challenging for formalized relations within the health care system. The National Guidelines for Peer Specialists and Supervisors (National Association of Peer Supporters, 2019) address this, they talk of the need for the relations being voluntary and the need for transparency, and clear expectations for both PSW and user. My findings show that my interview participants are very aware of this. They speak of being aware of the need for more equality and democracy into the services, the need to bring forth the patient's perspective at every turn and to not be the ones doing any coercing, such as medicating for example, to avoid damage to the relationships. This was also reflected on when it comes to power and the imbalance that can arise in relationships based on one peer being employed and the other receiving treatment. Some of my interview participants mention the need for ethical guidelines and training to avoid this becoming an issue. This is consistent with the literature, Repper and Carter (2011) reported on how formalizing peer support inevitably would lead to power imbalance and if PSWs aren't reflected and aware this could lead to issues both with the employers and the users they have relations with.

When it comes to relations with patients and users the PSW uses their knowledge that comes from having lived with mental illness, been inpatients, having been medicated and dealt with different aspects of mental illness. (Oborn et al.,2019; Burke et.al, 2018). A part of this is the feeling users describe of feeling a better connection to the PSW than non-peer staff, being listened to differently, being met with care, warmth, and dignity, feeling understood and receiving a different more appropriate feed-back (Karlsson et al.,2017). My findings only reflect the experiences of the PSW, but all my informants are clear on the fact that their story is not the most important. They talk about how it gives them a better understanding, but for them the act of listening and allowing the patients to feel heard and validated is the main thing in relations with the users and patients. They speak of having reflected on when it is appropriate and needed to share their own story, to inspire hope in recovery for example, and talk of how it creates a common ground and more openness. All of my informants are very clear on the fact that they are working to be the voice of the patient, to lift up and empower patients and make sure the patient's perspective is at the forefront of any discussions about patients and users and the services on offer.

7.5 Co-creation and innovation through peer support

Social innovation is a process where users and organizations, or governments or others in control, come together to create something new. It should be something new for the users, represent better use of resources and has the potential to change relationships (Willumsen et al.,2020; Voorberg et al.,2015). When social innovation happens through co-creation, interested parties come together, as in this thesis, the PSWs and leaders of mental health services at both specialist and community level, to develop solutions on an agreed upon issue. They are creating something of value to citizens. This is echoed by Scholz et al. (2017) who describe in their study on co-creation how leadership and organizations need to pay attention to what the users value and use that feedback in planning, implementation, and service delivery. An unexpected finding when analyzing my data was the co-creation my interview participants were involved in. The PSWs saw a need and initiated, designed, and implemented solutions. Two of my interview participants describe starting up and running Erfaringskafe along with other PSWs in their workplace. They created a space for users and professionals to meet and exchange information and meet in a social setting. Another example is Discharged to…a program to introduce inpatients to community care centers for aftercare, this has been shown to help increase patients use of outpatient services after discharge. These examples show the innovative potential when you have a user that is engaged and has a wish to improve on the services on offer. These have been described in the research literature (Voorberg et al., 2015) as people who are aware of the community's needs, often well-educated, as my survey and interview participants mostly are, able to communicate both their needs and are aware of their abilities to participate and influence. They also require their colleagues and leaders to have faith in the initiative and willing to cooperate (Voorberg et al., 2015), which was the case in both my examples above. I also had an example of a PSW trying to initiate a solution for transitions from hospital to community care but received no support from leadership, so the initiative went nowhere. In what has been discussed in the literature (Voorberg et al., 2015) as a time of increasing need for social innovation in the mental health sector due to budget restraints and increasing needs of the population seeing this type of work happening in my findings was quite exciting.

7.6 Strengths and limitations

Through the whole process of choosing to do a mixed methods study I have been aware of different challenges associated with choosing such a complex method for a master's thesis. This type of work is usually done in teams so the scope of it can be quite complex and overwhelming (Creswell & Plano Clark, 2011). However through keeping the scope of questions and themes narrow I feel like I gained the information aimed for at the start to my satisfaction.

When starting out with a question about the essentially subjective experiences of a group of people the most logical approach was to do in-depth interviews. At the same time I became aware of how few peer support workers there are in Norway and how spread out geographically. So a survey to reach a wider sample felt logical to supplement the interview data from my six informants. My survey was shared in a few relevant social media groups for my target sample, and I ended up with 30 respondents. Though this is not a very large sample, for a master's thesis this is viewed as an acceptable result. As convenience sampling and a snowball method were used to find my respondents there is always a risk of a non-representative sample and a lack of information-richness (Polit & Beck, 2017), but as a student with a hard-to-reach sample as I discussed in my methodology chapter, and limited time and resources this was the best way forward (Baltar & Brunet, 2012).

I created my questions based on previous research on peer support work, from validated scales for social support and on stress so my hope is that the reliability for my questionnaire is acceptable. As for validity, as with any research, the question is if I got the answers to my questions and I did. For my interview guide I was inspired by previous research in the field and had input from a peer support worker as well. As the focus of my thesis was the personal experiences of peer support workers, a focus I have not found much of in the literature other than objective reports on work conditions and such, I hope to have established validity through the fact of the data answering all my questions and more. As I wrote my discussion, I tried to triangulate my qualitative data with quantitative data wherever I found it applicable to enhance and confirm the results I had gotten from my interviews (McBride et al., 2019). By explaining my methods in as much detail as possible I hope to have reached validity and reliability or trustworthiness through the transparency of the process of both methods used.

Another challenge that became apparent in the analysis and results phase was the fact of writing a thesis in English on data that was written in Norwegian. Van Nes et al. (2010) discussed this issue, and I followed their recommendations to keep the translations to a later phase of the analysis, so my initial few steps of coding were all done in Norwegian, I also went back and forth to the codes to compare meaning. I am also not a native Norwegian speaker so some translation mistakes and misunderstandings may have slipped me by, local metaphors and spoken language can be very challenging to translate. My thesis supervisor has guided me throughout the whole process with guidance, input and with reading over material in both Norwegian and English, but I can only hope this hasn't been a source of any misinterpretations. This is clearly a weakness when it comes to qualitative analysis even though my data was not being mined for latent meaning but rather used descriptively.

Strengths of this study and the mixed methods used is the added information about background and organizational framework, support and stress received from my survey data. This added to the validity of my in-depth interview data that would have otherwise only been representative for those few I spoke with (Creswell & Plano Clark, 2011). Another strength was the spread of my qualitative sample, I spoke to six individuals from six different municipalities in three different parts of Norway, so I didn't just have information from one region or municipality. Even though I may have lost some situational information from speaking on the phone, and not sitting face to face with my interview participants, for me the ability to speak to participants spread throughout Norway was more of a strength than challenge, this is supported by Kvale and Brinkmann (2017). These individuals also worked at different levels, system level, community level and in specialist health care which also give a broader picture of the experiences in general of peer support work. As the personal experiences of peer support workers were what I was interested in I feel the uses of mixed methods gave me both a breadth and depth insights that I might not otherwise have gained.

8. Conclusions

The aim of this thesis was to explore what it’s like to work as a peer support worker in the mental health services in Norway. As a field that is growing and changing it was interesting to see how the peers who participated felt and experienced their work with patients and users, co-workers, and leaders. The field of peer support has not had time to become formalized, legalized and embedded in the work of the mental health services here in Norway. My main findings echo a lot of what is known internationally about peer support work.

The work environment for a PSW is very diverse, they work at different levels, in varied settings and their tasks are highly variable, both between workplaces and day-to-day. An important feature in my findings is the help PSWs can give during discharge from an inpatient setting to community care. These seem to be potentially experiences for patients and users and the PSWs can act as network builders and support by introducing them to aftercare by escorting and introducing them to these places.

The role of peer support worker is in its nature quite different from the traditional roles in health care and this comes with its own set of challenges. Non-existent or unclear job descriptions, misunderstandings about what the work is or should be between the peer support workers and other staff and a lack of understanding from leaders that can create stress in an already uncertain environment. Increased information about the role and its place alongside traditional services for leaders, non-peer staff and patients would make the work easier, implementation smoother and can help to improve attitudes in the workplace.

The role is not formalized so the issue of unclear roles was described as a stress factor for most of my survey and interview participants. Another stress factor for most was a heavy workload, at times under often uncertain conditions as much work is either parttime or on a project basis. Where the role of PSW is more formalized these conditions seem to become more certain. The workload was attributed to an enormous need for the type of service and assistance a peer supporter supplies by my interviewee participants. Rate of pay featured heavily as a stressor, with the role here not having any formal status when it comes to pay there is a large discrepancy between regions in what people get title as, what they get paid and what background counts towards wage rates. However the majority of my informants both from my survey and my interviews feel that support from both coworkers and leaders is mostly in place, something they appreciate.

In reading over my findings one feature that stood out to me was how much the interview participants impressed me with their self-awareness and the amount of reflection that lies behind their work. They speak of having worked out what they need to keep themselves in recovery, how to respond when faced with reminders of their own past the importance of having tools to deal with issues that inevitably come up when working with a group with shared history. When feelings come up related to work, they all talk about seeking guidance from either leaders or colleagues to work things out, so they seem very aware of their mental health and how to take care of it to keep from relapsing.

Although PSWs in Norway don’t have any formal ethical or professional guidelines they work in line with guidelines and recovery elements as describe in the literature. They also struck me as very conscious of their power imbalance in the relationship with peers that are still patients or service users, wanting to make the patient’s perspective heard and fighting to make them feel seen, heard, and respected regardless of any diagnosis or illness.

All of my informants have a high level of engagement for the work, they want to increase user’s involvement and rights, lift up the voices and viewpoints from the patient and user’s perspective and wish for a better service. One interesting finding was the work done in the grassroots to develop services that the PSWs have perceived as wanted and lacking. With the support of government and local leaders this co-creative initiative can create services people want and need while also aiding economically by reducing costs elsewhere. It has been really impressive to see what is possible when someone is positioned correctly to see a need and does something about it.

8.1 Further research

It will be interesting to see if the role will become formalized here in Norway and PSWs will be placed in most services that deal with mental health care.

Another area that would be interesting to explore further is the role PSWs can play in the transitions from inpatient settings to community care. How they can help patients find social support and connections once on their own at home is an interesting subject. Can they help to reduce admissions, shorten stay in inpatient units and help users work on their own recovery as a non-therapeutic addition to traditional services? It would be interesting to get both the PSW and service users’ perspectives on these type of transition services where they exist here in Norway.

Another interesting area to explore is how the unclarity of the role of PSW can be utilized for co-creation and innovation, how the PSWs have used it to their advantage in creating a role based on their unique backgrounds and experiences and what solutions are created in this liminal space between a person with lived experience and a formal employee of the mental health care services.

References

Aakerblom, K. B., & Ness, O. (2021). *Peer support workers in co-production and co-creation in public mental health and addiction services: Protocol for a scoping review.* doi:https://doi.org/10.1371/journal.pone.0248558

Bakker, A. B., & Demerouti, E. (2007). The Job Demands-Resources model: state of the art. *Journal of managerial psychology, 22*(3), 309-328. doi:10.1108/02683940710733115

Baltar, F., & Brunet, I. (2012). Social research 2.0: virtual snowball sampling method using Facebook. *Internet research, 22*(1), 57-74. doi:10.1108/10662241211199960

Baptista, N., Alves, H., & Matos, N. (2020). Public Sector Organizations and Cocreation With Citizens: A Literature Review on Benefits, Drivers, and Barriers. *Journal of nonprofit & public sector marketing, 32*(3), 217-241. doi:10.1080/10495142.2019.1589623

Borg, M., Karlsson, B., & Stenhammer, A. (2013). *Recoveryorienterte praksiser: en systematisk kunnskapssammenstilling*. Drammen: Nationalt kompetansesenter for psykisk helsearbeid.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic Analysis. In P.Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences.* Singapore: Springer Singapore.

Burke, E. M., Pyle, M., Machin, K., & Morrison, A. P. (2018). Providing mental health peer support 1: A Delphi study to develop consensus on the essential components, costs, benefits, barriers, and facilitators. *International Journal of Social Psychiatry, 64*(8), 799-812. doi:10.1177/0020764018810299

Burr, C., Rother, K., Elhilali, L., Winter, A., Weidling, K., Kozel, B., & Gurtner, C. (2020). Peer support in Switzerland – Results from the first national survey. *International Journal of Mental Health Nursing, 29*(2), 212-223. doi:10.1111/inm.12665

Clark, M. (2015). Co-production in mental health care. *Mental Health Review Journal, 20*(4), 213-219. doi:10.1108/MHRJ-10-2015-0030

Cooper, C. L. (1981). *Stress Check: Coping with Stresses in Life and Work (A Spectrum Book)*. Prentice Hall.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed. ed.). Los Angeles: Sage.

Cronise, R., Teixeira, C., Rogers, E. S., & Harrington, S. (2016). The peer support workforce: Results of a national survey. *Psychiatric Rehabilitation Journal, 39*(3), 211-221. doi:10.1037/prj0000222

Davidson, L., Tondora, Janis, O'Connel, Maria J., Kirk, Thomas. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal, 31*(1), 23-31.

Departementene. (2017). *Mestre hele livet. Regjeringens strategi for god psykisk helse (2017-2022).* Retrieved from www.regjeringen.no

Helsedirektoratet. (2014). *Sammen om mestring: veileder i lokalt psykisk helsearbeid og rusarbeid for voksne: et verktøy for kommuner og spesialisthelsetjenesten*. Oslo: Helsedirektoratet.

Helse- og omsorgsdepartementet. (2009). *Samhandlingsreforment. Rett behandling - på rett sted - til rett tid. (Meld. St. 47 (2008-2009)*. Retrieved from www.regjeringen.no

Helse- og omsorgsdepartementet. (2015a). *Folkehelsemeldingen. Mestring og muligheter. (Meld. St. 19 2014-2015)*. Retrieved from www.regjeringen.no

Helse- og omsorgsdepartementet. (2015b). *Nasjonal helse- og sykehusplan. Meld. St. 11 (2015-2016)*. Retrieved from www.regjeringen.no

Hurley, J., Cashin, A., Mills, J., Hutchinson, M., Kozlowski, D., & Graham, I. (2018). Qualitative study of peer workers within the 'Partners in Recovery' programme in regional Australia. *International Journal of Mental Health Nursing, 27*(1), 187-195. doi:10.1111/inm.12308

Karlsson, B., & Borg, M. (2017). *Recovery: tradisjoner, fornyelser og praksiser*. Oslo: Gyldendal akademisk.

Karlsson, B. E., Borg, M., Ogundipe, E., Sjåfjell, T. L., & Bjørlykhaug, K. I. (2017). Aspekter ved samarbeidsrelasjoner mellom erfaringsmedarbeidere og brukere i psykisk helse- og rustjenester: En kvalitativ studie. *Nordisk tidsskrift for helseforskning, 13*(2). doi:10.7557/14.4214

Kent, M. (2019). Developing a Strategy to Embed Peer Support into Mental Health Systems. *Administration and Policy in Mental Health, 46*(3), 271-276. doi:10.1007/s10488-018-0912-8

Korsbek, L., & Petersen, L. (2016). Peerstøtte i de etablerede psykiatriske og psykosociale indsatser - hvad siger litteraturen om effekten? *Tidsskrift for psykisk helsearbeid, 12*(4), 288-304. doi:10.18261/issn.1504-3010-2016-04-02

Krogh, A. H., Sørensen, E., & Torfing, J. (2020). Samskabelse af innovative offentlige løsninger. In E.Willumsen & A. Ødegård (Eds.), *Samskaping – Sosial innovasjon for helse og velferd* (p. 45-65). Oslo: Universitetsforlaget.

Kvale, S., Brinkmann, S. (2017). Det Kvalitative Forskningsintervju. Oslo: Gyldendal.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry, 199*(6), 445-452. doi:10.1192/bjp.bp.110.083733

Lexico. (N.D). *Oxford Dictionary.* Retrieved from https://www.lexico.com/definition/they on the 20.08.2021.

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *Lancet, 358*(9280), 483-488. doi:10.1016/S0140-6736(01)05627-6

Malterud, K. (2017). *Kvalitative forskningsmetoder for medisin og helsefag. 4. utgave.* Oslo: Universitetsforlaget.

McBride, K. A., MacMillan, F., George, E. S., & Steiner, G. Z. (2019). The Use of Mixed Methods in Research. In P.Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences.* Singapore: Springer Singapore.Singapore: Springer Singapore.

Mulvale, G., Wilson, F., Jones, S., Green, J., Johansen, K. J., Arnold, I., & Kates, N. (2019). Integrating mental health peer support in clinical settings: Lessons from Canada and Norway. *Healthc Manage Forum, 32*(2), 68-72. doi:10.1177/0840470418812495

Nasjonalt senter for erfaringskompetanse innen psykisk helse. (2018). *Erfaringskonsulentundersøkelsen 2018*. Retrieved from https://erfaringskompetanse.no/wp-content/uploads/2019/01/erfaringsunders%C3%B8kelsen-2018.pdf

National Association of Peer Supporters. (2019). National Practice Guidelines for Peer Specialists and Supervisors. Retrieved from www.peersupportworks.org.

Nossek, A., Werning, A., Otte, I., Vollmann, J., Juckel, G., & Gather, J. (2021). Evolvement of Peer Support Workers' Roles in Psychiatric Hospitals: A Longitudinal Qualitative Observation Study. *Community Ment Health J, 57*(3), 589-597. doi:10.1007/s10597-020-00741-1

Oborn. E., Barret, M., Gibson, S. & Gillard, S. (2019). Knowledge and expertise in care practices: the role of the peer worker in mental health teams. *Sociology of Health & Illness,* 41(7), 1305-1322. doi:10.1111/1467-9566.12944

Ose, S. O., & Kaspersen, S. L. (2020). *Kommunalt psykisk helse- og rusarbeid 2019: årsverk, kompetanse og innhold i tjenestene* (9788214064988). Retrieved from www.helsedirektoratet.no

Ose, S. O., Kaspersen, S. L., Hilland, G. H., Kalseth, J., Ådnanes, M., & Sintef. (2019). *Kommunalt psykisk helse- og rusarbeid 2019: årsverk, kompetanse og innhold i tjenestene* (9788214062489). Retrieved from www.helsedirektoratet.no

Polit, D. F., & Beck, C. T. (2017). *Nursing Research: generating and assessing evidence for nursing practice* (10th ed. ed.). Philadelphia: Wolters Kluwer.

Repper, J. (2013). *Peer Support Workers: Theory and Practice*. Retrieved from www.imroc.org

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392-411. doi:10.3109/09638237.2011.583947

Rossen, B., & Elstad, T. A. (2021). Erfaringskonsulenters bidrag til faglige perspektiver og praksis hos fagutøvere i psykisk helsevern. *Tidsskrift for psykisk helsearbeid, 18*(1), 60-71. doi:10.18261/issn.1504-3010-2021-01-07

Scholz, B., Bocking, J., & Happell, B. (2017). How do consumer leaders co-create value in mental health organizations? *Australian Health Review, 41*(5), 505-510. doi:10.1071/AH16105

Sjåfjell, T.L. & Myhra. A-B. (2015). Selvhjelp og likemannsarbeid – mulige verktøy for å oppnå mestring og empowerment? *Tidsskrift for psykisk helsearbeid, 12(2), 139-148.*

Skogstad, A. (2001). *Brukerveiledning QPS Nordic: generelt spørreskjema for psykologiske og sosiale faktorer i arbeid* (Vol. 2(2001) nr 1).

Skogstad, A. (2011). Psykososiale faktorer i arbeidet. In S. Einarsen & A. Skogstad (Eds.), *Det Gode Arbeidsmiljø (2. utg.)*. Bergen: Fagbokforlaget.

Slade, M., Amering, M., Oades, L. (2008). Recovery: An International Perspective. *Epidemiologica e Psichiatria Sociale, 17*(2), 128-137.

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-401. doi:10.2975/27.2004.392.401

Storm, M., & Edwards, A. (2013). Models of User Involvement in the Mental Health Context: Intentions and Implementation Challenges. *Psychiatric Quarterly, 84*(3), 313-327. doi:10.1007/s11126-012-9247-x

Storm, M., Fortuna, K. L., Brooks, J. M., & Bartels, S. J. (2020). Peer Support in Coordination of Physical Health and Mental Health Services for People with Lived Experience of a Serious Mental Illness. *Frontiers in Psychiatry, 11*, 365-365. doi:10.3389/fpsyt.2020.00365

Syse, A. (2020). *Norges lover: lovsamling for helse- og sosialsektoren 2020-2021* (30. utgave. ed.). Oslo: Gyldendal.

Tashakkori, A., & Teddlie, C. (2003). *Handbook of mixed methods in social & behavioral research*. Thousand Oaks, Calif: SAGE.

Van Nes, F., Abma, T., Jonsson, H., & Deeg, D. (2010). Language differences in qualitative research: is meaning lost in translation? *European Journal of Ageing, 7*(4), 313-316. doi:10.1007/s10433-010-0168-y

Vandewalle, J., Debyser, B., Beeckman, D., Vandecasteele, T., Van Hecke, A., & Verhaeghe, S. (2016). Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. *International Journal of Nursing Studies, 60*, 234-250. doi:10.1016/j.ijnurstu.2016.04.018

Voorberg, W. H., Bekkers, V. J. J. M., & Tummers, L. G. (2015). A Systematic Review of Co-Creation and Co-Production: Embarking on the social innovation journey. *Public management review, 17*(9), 1333-1357. doi:10.1080/14719037.2014.930505

Willumsen, E., Ødegård, A., & Sirnes, T. (Eds.). (2020). Sosial innovasjon og samskaping. In E.Willumsen & A. Ødegård (Eds.), *Samskaping – Sosial innovasjon for helse og velferd* (p. 45-65). Oslo: Universitetsforlaget.

World Health Organization. (2013). Mental Health Action Plan 2013-2020. Retrieved from who.int. ISBN: 9789241506021.

Appendix 1: 3 pages

Universitetet
i Stavanger

Forespørsel om deltakelse i mastergradsprosjekt

Hei

Mitt navn er Elin Edda Karlsdottir og jeg er masterstudent ved Universitetet i Stavanger, Fakultet for helsevitenskap. Jeg arbeider med min masteroppgave: «Erfaringer av erfaringskonsulenter og likepersoner i arbeid for det norske psykiske helsevesen». I mitt prosjekt har jeg fokus på erfaringene erfaringskonsulenter og likepersoner har av å jobbe innenfor det psykiske helsevesen her i Norge.

Jeg er veiledet av professor Marianne Storm ved UiS. I tillegg til mine studier jobber jeg som miljøarbeider ved Avdeling psykisk helse og rus i Klepp Kommune.

Jeg ønsker med dette skrivet å invitere deg til å delta i mastergradsprosjektet mitt.

Prosjektets formål

Formålet med mitt prosjekt er å innhente kunnskap om opplevelser og erfaringer av arbeidet til personer med brukererfaring. Jeg ønsker å se på arbeidsmiljø, relasjoner, positive erfaringer og utfordringer som disse ansatte står overfor.

Hvorfor får du spørsmål om å delta?

Jeg ønsker å intervjue informanter som jobber innenfor psykisk helse på forskjellige arbeidsplasser og ble informert om at du var interessert i å delta.

Jeg ønsker å prate med personer med egenerfaring som har jobbet en stund i sin stilling for å få nyansert innblikk i dette formet for arbeid. I intervjuet blir du bedt om å dele erfaringer og opplevelser du har hatt igjennom ditt arbeid.

Hva innebærer det for deg å delta?

Dersom du takker ja til å delta innebærer det et individuelt intervju med meg som tar mellom 30-60 minutter cirka. Jeg ønsker å ta samtalen opp på lydfil. Jeg ønsker ikke noen personlige opplysninger om deg, men kun om dine erfaringer. Sammen med dette skrivet følger samtykkeskjema og skjema med spørsmål om bakgrunn. Intervjuene er planlagt gjennomført des 2019-jan 2020. Vi kan møtes hvor det passer for deg.

Ditt personvern – hva skjer med din informasjon

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket (NSD). Det er kun meg og min veileder Marianne Storm som kommer til å ha tilgang til datamaterialet.

Det vil ikke knyttes noen personopplysninger til intervjumaterialet. Disse vil gis kode som kobles til hver deltaker. Koblingsnøkkel oppbevares separat fra øvrig data.

Alle deltakere anonymiseres og vil ikke kunne gjenkjennes i masteroppgaven. Prosjektet skal etter plan avsluttes 31.12.2021 og da vil lydfiler slettes og datamateriale anonymiseres.

Resultatene fra prosjektet vil bli presentert i min masteroppgave og eventuelt også inngå i en vitenskapelig forskningsartikkel.

Jeg ønsker også å informere at prosjektet er meldt til NSD – Norsk senter for forskningsdata, og godkjent.

Deltakelse er frivillig

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil da bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Om du takker ja vil jeg be deg signere vedlagt samtykkeerklæring før vi starter intervjuet.

Hvis noe er uklart eller du ønsker mer informasjon om prosjektet kan du ringe eller sende e-post til:

Elin Edda Karlsdottir, student (UiS), mobil: 970 28 227, e-post: elinedda@hotmail.com

Marianne Storm, professor (UiS), mobil: 481 33 750, e-post: marianne.storm@uis.no

Tilbakesending av svar

Jeg håper at du på bakgrunn av denne informasjonen velger å takke ja til å delta i mitt prosjekt.

Dersom du takker ja ber jeg deg ta kontakt med meg ved å ringe, sende sms, eller sende e-post.

Jeg håper du kan sende svar tilbake så snart som mulig, senest en uke etter mottatt forespørsel.

Utfylt samtykkeskjema og skjema med bakgrunnsinformasjon bes tas med til intervjuet.

Med vennlig hilsen

Elin Edda Karlsdottir Kleppe, 11/11-2019

Appendix 2: 1 page

SAMTYKKEERKLÆRING

Navn på student ved Universitetet i Stavanger som skal utføre intervju: Elin Edda Karlsdottir

Jeg bekrefter herved at jeg har mottatt, lest og forstått informasjonsskriv om masteroppgave «The experience of working as a peer support worker in Norway». Og takker ja til å delta i dette prosjektet.

Jeg samtykker til å bli intervjuet: JA

Navn på deltaker: ___________________________ Dato: ______________

Signatur: ___________________________________

Navn på mastergradsstudent: Elin Edda Karlsdottir Dato: ______________

Signatur: ___________________________________

Appendix 3: 3 pages

Intervjuguide

Erfaringer med å være erfaringskonsulent/likeperson i psykisk helse or rus i Norge

Arbeidsforhold og miljø

Kan du fortelle litt om ditt arbeid som erfaringskonsulent?

Kan du utdype hva som er din bestillingsbeskrivelse?

Hadde du forventninger til din stilling før du startet? Kan du fortelle litt om dem?

Hvordan opplever du å bli inkludert på arbeidsplassen? Kan du gi eksempel?

Blir du tatt på alvor når du sier din mening eller gir råd? Kan du utdype eller gi eksempel?

Føler du tilhørighet på ditt arbeidssted? Kan du fortelle litt om det?

- Inkludert i møter på arbeidsplassen
- Tilgang til alle datasystemer som fagpersoner har tilgang på?
- Dokumenterer du tiltak for brukere?

Føler du at du er del av personalgruppen? Kan du utdype eller gi eksempel?

Kan du fortelle litt om din relasjon til din nærmeste leder?

Kan du fortelle om samarbeid med brukere?

Opplæring

Hvordan har opplæring og innføring i ditt arbeid foregått?

Får du regelmessig veiledning når du har behov for det? Hvem fra? Kan du gi eksempel?

Møter du andre med brukererfaring for å dele på erfaringer eller reflektere sammen på deres oppgaver? Kan du utdype litt om det?

- Hvis nei, er det noe du savner, f.eks. nettverk/organisasjon/samarbeidsgruppe i kommunen/arbeidsplassen

Relasjoner

Hvordan bruker du dine personlige erfaringer i arbeidet ditt?

Kan du fortelle litt om hvordan det har vært for deg å snakke om egne erfaringer i møtet med

- Brukere?
- Kolleger?

Hvordan finner du ut hvilke av dine erfaringer som er relevante i de spesifikke situasjonene?

Har du jobbet sammen med tidligere behandlere/miljøpersonale? Hvis ja, kan du utdype hvordan det opplevdes?

Hvordan opplever du å holde personlig forhold, men også profesjonell distanse?

- Har du opplevd utfordringer med å skille mellom det å være personlig og profesjonell? Kan du utdype hva som hendte? Evt. hvorfor du opplever det ikke som en utfordring?
- Hvordan opplever du å skille mellom dine egne erfaringer og brukenes erfaringer?
- Hvordan skiller du mellom jobb og privatliv?
- Har du erfaring av å jobbe med brukere som ikke vil samarbeide, kan du fortelle litt om det?
- Har du opplevd stress eller belastning i forbindelse med din stilling? Hva opplever du som stressende?
    a. Arbeidsmiljø? På hvilken måte? Eksempel?
    b. Enkelte brukere? På hvilken måte? Eksempel?
    c. Din egen opplevelse av jobben? På hvilken måte? Eksempel?
    d. Økonomi? På hvilken måte? Eksempel?

Opplever du at din stilling påvirker din egen situasjon eller psykisk helse?

Hva har du opplevd som spesielt positivt med å være i din stilling?

- Formidling av håp
- Rollebilde for brukere
- Selv-tillit /selv-følelse
- Være av nytte for andre
- Gi hjelp til folk som trenger den

Er der noen utfordringer du vil løfte frem i forbindelse med din rolle?

Appendix 4: 1 page

Spørreskjemaundersøkelse med erfaringskonsulenter

Det Helsevitenskapelige fakultetet ved Universitetet i Stavanger utfører en nasjonal undersøkelse med erfaringskonsulenter innen rus og psykisk helse. Formålet med undersøkelsen er todelt: 1) å få kunnskap om det å være erfaringskonsulent, og 2) å få kunnskap om bruk av teknologi.

Vi ønsker at erfaringskonsulenter fra hele landet deltar i denne undersøkelsen. Det tar rundt 10 minutter å svare på spørreskjema.

Undersøkelsen har til hensikt å innhente informasjon fra erfaringskonsulenter over 18 år. Undersøkelsen kan besvares uavhengig av din nåværende arbeidsstatus eller type stilling du er ansatt i (erfaringskonsulent, likeperson, brukerkontakt, ansatt med brukererfaring o.l..).

Alle svarene dine vil bli anonymisert og de vil bli behandlet konfidensielt. Hvis du samtykker til å delta vil du ikke måtte oppgi navn. Vi kommer til å spørre om alder og kjønn. Å delta i denne studien er frivillig. Du kan velge å svare på de spørsmålene du vil svare på. Vi gjør oppmerksom på at jo mer komplette undersøkelsen er besvart jo bedre vil vi bli istand til å forstå erfaringene dine.

Marianne Storm, professor ved det Helsevitenskapelige fakultetet er ansvarlig for undersøkelsen. Det vil kun være Marianne Storm og Elin Edda Karlsdottir, masterstudent i Helsevitenskap som vil ha tilgang til data fra undersøkelsen. Data fra undersøkelsen vil inngå i mastergradsoppgaven til Elin Edda Karlsdottir. Data fra undersøkelsen kan også bli brukt i vitenskapelige publikasjoner og presentasjoner uten at du vil bli identifisert.

Hvis du ønsker mer informasjon om denne studien kan du ta kontakt med Marianne Storm gjennom e-post, marianne.storm@uis.no.

Appendix 5: 16 pages

Questionnaire questions

Jeg har lest informasjonen og samtykker til deltakelse i spørreskjemaundersøkelsen

Ja

Kjønn

Kvinne

Mann

Annet

Alder

18-30

31-40

41-50

51-60

Eldre enn 60

Hva er din høyeste utførte utdannelse? (sett et kryss)

Grunnskole

Videregående skole

Fagutdanning, etatsutdanning

Universitet og høyskole: 0-4 år

Universitet og høyskole: mer enn 4 år

Vil du oppgi tidligere arbeidserfaring?_____________________________________

Har du gått på kurs for å jobbe som erfaringskonsulent?

Ja

Nei

Hvilket kurs var det?

Hvor lenge varte kurset? (antall timer)

Hva inneholdt kurset? (f.eks. informasjon om lovverk, rocovery osv.)

Hva er din nåværende stillingsandel som erfaringskonsulent? (sett et kryss)

Heltid (30 eller flere timer i uken)

Deltid

Ekstrahjelp

Midlertidig ansatt/vikar

Frivillig

Hvilken type virksomhet jobber du for? (sett et kryss)

NAV

Sykehus

DPS

Brukerorganisasjon

Kommunale boliger

ACT, FACT Team

Åpent dagtilbud, f.eks. en Møteplass eller Frivilligsentral

Kommunalt tilbud

Kriminalomsorgen

Eget foretak

Akademia

Annet

Hvilken arbeidsoppgaver utfører du? (sett kryss ved alle som passer)

Saksbehandling

Miljøarbeid

Likepersonsarbeid

Erfaringskonsulent

Pårørendearbeid

Støttekontakt

Undervisning

Forskning/utviklingsarbeid

Annet

Hva opplever du som de tre største utfordringene erfaringskonsulenter kan bistå brukerne med?

Redusere ensomhet

Lage avtaler og følge personen til lege eller helsepersonell

Veiledning angående kroniske helsetilstander (som diabetes eller overvekt)

Forebygge rusmisbruk

Bistå ved innleggelse på psykiatrisk sengepost/avdeling

Bistå ved innleggelse på somatisk avdeling

Bistå ved utskrivelse fra sykehus

Bistå med nettverksbygging

Er du medlem av en brukerorganisasjon?

Ja

Nei

Hvor mange erfaringskonsulenter er ansatt ved ditt arbeidssted?

1

2

3

Flere enn 3

Blir du som erfaringskonsulent benyttet i undervisning eller opplæring av personell i din virksomhet?

Ja

Nei

Blir du som erfaringskonsulent benyttt ved ansettelser av personell i din virksomhet?

Ja

Nei

Får du veiledning av en person med brukererfaring?

Ja

Nei

Nå følger noen spørsmål om din bruk av teknologi.

Eier du smarttelefon? (mobil med mulighet for å laste ned apper)

Ja

Nei

Hvor ofte bruker du din smarttelefon? (sett et kryss)

Hver dag

Nesten hver dag

3--5 ganger i uken

Hva bruker du din smarttelefon til? (sett flere kryss)

Jeg bruker den i mitt arbeid som erfaringskonsulent/likeperson

Ringe familie

Ringe venner

Videochat

Sms beskjeder

Høre musikk

Spille spill

Skritteller

Sosiale medier (f.eks. Facebook, Twitter)

Gå på internett

Annet

Synes du der er noe som gjør det vanskelig å bruke smarttelefon (sett kryss ved alt som du er enig i)?

Kostnad ved å eie smarttelefon

Det er vanskelig å lese på en smarttelefon

Det er vanskelig å skrive på en smarttelefon

Jeg vet ikke hvordan en bruker smarttelefon

Annet

Eier du nettbrett (f.eks. bærbar pc med touch skjerm)?

Ja

Nei

Hvor ofte bruker du ditt nettbrett? (sett et kryss)

Hver dag

Nesten hver dag

3--5 ganger i uken

Bruker du teknologi i ditt arbeid med brukere?

Ja

Nei

Hvilken teknologi? (sett flere kryss hvis aktuelt)

Smarttelefon

Nettbrett

Fitbit

Telefon

Bærbar PC

Annet

Hvordan bruker du teknologi i arbeid med brukere? (sett flere kryss hvis aktuelt)

Sende sms påminnelser

Bruker apps for å kommunisere med brukere (Messenger, Facetime o.l.)

Deltar i grupper på sosial medier (Facebook, Twitter, Instagram o.l.)

Deltar i selvhjelpsgrupper på nett

Annen måte:

Hvordan tenker du deg at smarttelefoner eller nettbrett kan støtte opp om likepersonsarbeid?

Denne delen av undersøkelsen inneholder spørsmål angående sosial støtte.

Om du trenger det, kan du få støtte og hjelp i ditt arbeid fra dine arbeidskolleger? (sett et kryss)

Meget sjelden eller aldri
Nokså sjelden
Av og til
Nokså ofte
Meget ofte eller alltid

Om du trenger det, kan du få støtte og hjelp i ditt arbeid fra din nærmeste sjef?

Meget sjelden eller aldri
Nokså sjelden
Av og til
Nokså ofte
Meget ofte eller alltid

Om du trenger det, er dine arbeidskolleger villige til å lytte til deg når du har problemer i arbeidet?

Meget sjelden eller aldri
Nokså sjelden
Av og til
Nokså ofte
Meget ofte eller alltid

Om du trenger det, er din nærmeste sjef villig til å lytte til deg når du har problemer i arbeidet?

Meget sjelden eller aldri

Nokså sjelden

Av og til

Nokså ofte

Meget ofte eller alltid

Om du trenger det, kan du snakke med dine venner om problemer du har i arbeidet?

Meget sjelden eller aldri

Nokså sjelden

Av og til

Nokså ofte

Meget ofte eller alltid

Om du trenger det, kan du snakke med din partner eller en annen nær person om problemer du har i arbeidet?

Meget sjelden eller aldri

Nokså sjelden

Av og til

Nokså ofte

Meget ofte eller alltid

Blir dine arbeidsresultater verdsatt av din nærmeste sjef?

Meget sjelden eller aldri

Nokså sjelden

Av og til

Nokså ofte

Meget ofte eller alltid

Har du lagt merke til forstyrrende konflikter mellom arbeidskolleger?

Meget sjelden eller aldri

Nokså sjelden

Av og til

Nokså ofte

Meget ofte eller alltid

Føler du at du kan stole på at venner og familie vil støtte deg hvis det blir vanskelig på jobben?

Meget sjelden eller aldri

Nokså sjelden

Av og til

Nokså ofte

Meget ofte eller alltid

Siste del av undersøkelsen inneholder noen spørsmål om arbeidsrelatert stress. Vi definerer arbeidsrelatert stress som en opplevelse av at arbeidskravene overskrider de ressursene du har. Hvor mye arbeidsrelatert stress opplever du når det gjelder følgende:

Forhold til min leder

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Mitt forhold til medarbeidere jeg har et lederansvar for

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Arbeidsmengde

Ikke aktuelt

Ikke stress

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Å gjøre feil

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Å føle meg undervurdert

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Tidspress og frister

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Muligheter for forfremmelse

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Lønnens størrelse

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Den belastning arbeidet fører mitt privatliv

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Mengden reiser arbeidet krever

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Å ta med arbeid hjem

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Virksomhetens politikk

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Mangel på makt og innflytelse

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Mine og virksomhetens verdier er motstridende

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Mangel på samarbeid og kommunikasjon i min avdeling

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Uklarhet forbundet med mitt arbeid

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Ledelsen forstår ikke utfordringene forbundet med mitt arbeid

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Konflikter mellom min yrkesgruppe og andre profesjoner

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Innføring av ny teknologi

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Manglende læring og utviklingsmuligheter

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Virksomheten innfører nye tekniske systemer uten å gi tilstrekkelig opplæring

Litt stress

Noe stress

Ganske ofte stress

Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Virksomheten bruker feil parameter for å måle kvaliteten på mitt arbeid

Litt stress

Noe stress

Ganske ofte stress

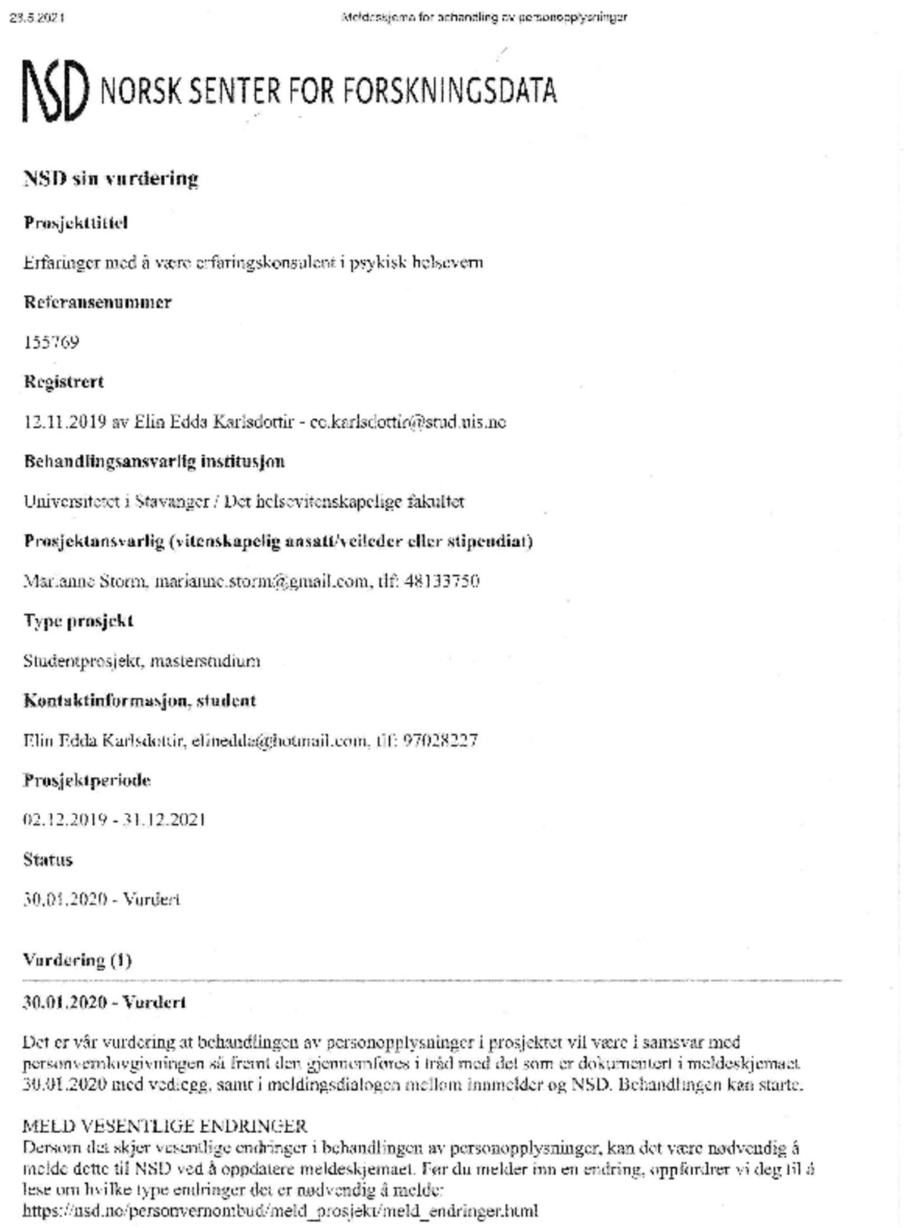
Svært ofte stress

Mye eller alltid stress

Ikke aktuelt

Ikke stress

Appendix 6: 2 pages



23.5.2021 Meldeskjema for behandling av personopplysninger

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

Erfaringer med å være erfaringskonsulent i psykisk helsevern

Referansenummer

155769

Registrert

12.11.2019 av Elin Edda Karlsdottir - ee.karlsdottir@stud.uis.no

Behandlingsansvarlig institusjon

Universitetet i Stavanger / Det helsevitenskapelige fakultet

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Marianne Storm, marianne.storm@gmail.com, tlf: 48133750

Type prosjekt

Studentprosjekt, masterstudium

Kontaktinformasjon, student

Elin Edda Karlsdottir, elinedda@hotmail.com, tlf: 97028227

Prosjektperiode

02.12.2019 - 31.12.2021

Status

30.01.2020 - Vurdert

Vurdering (1)

30.01.2020 - Vurdert

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet 30.01.2020 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde:
https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html

TYPE OPPLYSNINGER OG VARIGHET

Prosjektet vil behandle særlige kategorier av personopplysninger om helseforhold og alminnelige kategorier av personopplysninger frem til 31.12.2021.

LOVLIG GRUNNLAG

Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a, jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

PERSONVERNPRINSIPPER

NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:

- lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER

Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).

NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER

NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

Survey Exact er databehandler i prosjektet. NSD legger til grunn at behandlingen oppfyller kravene til bruk av databehandler, jf. art 28 og 29.

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og eventuelt rådføre dere med behandlingsansvarlig institusjon.

OPPFØLGING AV PROSJEKTET

NSD vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til med prosjektet!

Kontaktperson hos NSD: Kajsa Amundsen
Tlf. Personverntjenester: 55 58 21 17 (tast 1)