PhD thesis

Peer mentors as a transitional and emerging position in alcohol and drug services

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Full bibliographic citation: Soondar, A. 2023. Peer mentors as a transitional and emerging position in alcohol and drug services. PhD thesis Middlesex University

Year: 2023

Publisher: Middlesex University Research Repository

Available online: https://repository.mdx.ac.uk/item/111603

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Title: Peer mentors as a transitional and emerging position in alcohol and drug services

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Submitted as part of the fulfilment for the degree of

Doctor of Philosophy

Middlesex University, London.

Supervisors: Dr Rachel Herring

Professor Betsy Thom

Professor Carmel Clancy

June 2023

Declaration

I declare that I have designed and conducted the research reported in this thesis. I am aware of and understand the university's policy on plagiarism and I certify that this thesis is my own work, except where indicated by referencing, and the work presented in it has not been submitted in support of another degree or qualification from this or any other university or institute of learning.

I declare that this thesis is an original report of my research, has been written by me.

Due references have been provided on all supporting literatures and resources.

Anand Jordan Soondar June 2023

Acknowledgements

I am indebted to my supervisors Doctor Rachel Herring, Professor Betsy Thom and Professor Carmel Clancy for their invaluable support and continued encouragement to carry on during times when I had struggled. They have shown patience and offered continuous guidance during what was a challenging dissertation journey at times. My thanks are also extended to Alcohol Change UK and Middlesex University for funding this scholarship; without this I would not have been able to realise my dream of undertaking research in this field and to have the opportunity to study at a doctorate level.

I would also like to thanks to the Learning Enhancement Team at Middlesex for their support and advice throughout the literature review process.

I am overtly indebted to all those peer mentors, volunteers, recovery champions and staff including the organisation gatekeepers who participated in the research. Without your generosity to give up your time and to share your stories, this research project would not have been possible.

Finally, I could not have completed this thesis without the unwavering support and encouragement from the love of my life, my life partner and greatest supporter, Tony. I will be ever indebted to Jean, Helen and Mitsy, who kindly read and edited my thesis. To my best friends, Laura, Roshni and Suky, who have also been ongoing help and boost when I need it. Equally, I would like to thank my family, especially my mum and dad, who have shown me that there is no substitute for hard work and perseverance; they have been and continue to be my inspiration.

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Terms and Abbreviations

AA	Alcoholic Anonymous
ACMD	Advisory Council on the Misuse of Drugs
APA	American Psychiatric Association
BMA	British Medical Association
CA	Cocaine Anonymous
CCG	Clinical Commissioning Groups
CEO	Chief Executive Officer
CG	Clinical Guideline
COSLA	Convention of Scottish Local Authorities
CQC	Care Quality Commission
DANOS	Drugs and Alcohol National Occupational Standards
DBS	Disclosure Barring Service
DHSC	Department for Health and Social Care
DWP	Department of Work and Pensions
EAP	Employee Assistance Programme
ESA	Employee Support Allowance
ETE	Employment Training and Employment
HEE	Health Education England
HQCA	High Quality Care for All
HR	Human Resources

LET	Lived Experience Team
MEE	Medical Education England
NA	Narcotics Anonymous
NCETA	National Centre for Education and Training on Addiction
NHS	National Health Service
NHSBN	NHS Benchmarking Network
NIAAA	National Institute of Alcohol Abuse and Alcoholism
NICE	National Institute for Clinical Excellence
NMC	Nursing and Midwifery Council
NOS	National Occupational Standard
NSRF	National Service Review Framework
NTA	National Treatment Agency
PCC	Police and Crime Commissioners
PHE	Public Health England
PM	Peer mentor and/or Volunteer/Recovery Champion
PO	Participant Observations
PWID	People Who Inject Drugs
QDAS	Qualitative Data Analysis Software
SAMHSA	Substance Abuse and Mental Health Services Administration
SMART	Self-Management and Recovery Training
SME	Service Mapping Exercise
TRA	Teaching Regulation Agency
UK	United Kingdom

USA	United States of America
WHO	World Health Organisation

Abstract

Peer mentors as a transitional and emerging position in alcohol and drug services

Background and rationale: The thesis explores the role of peer mentors (PMs) and how it is perceived and shaped by PMs themselves and the people they work with in alcohol and drug services in London. The literature review, carried out as part of this thesis, found critical gaps in the published literature, particularly regarding the lack of relevant studies in the United Kingdom. This thesis contributes to understanding how individuals define and carry out the PM role, the transitional nature of the role, and the pathways PMs have taken. It explores how concepts of identity, liminality, and organisational socialisation are useful in describing the pathway from a service user to PM.

Methodology and Methods: The thesis employed a qualitative interpretivist methodological approach to gain a deeper and more nuanced understanding of the participants' experiences of either working as PMs or as service providers and managers in the organisation in which PMs' positions exist. The sample was a convenience one, recruiting those with lived experiences of alcohol dependency and staff working in alcohol and drug services. The data collection method primarily consisted of semi-structured interviews, participant observations, and data from a service mapping exercise. Thematic analysis was used to analyse the data collected, to code, and identify emergent themes. The theoretical framework drew on social-ecological framework theory, combined with Schlossberg's transitional theory in examining the PM pathway, and concepts of self, identity, organisational socialisation, and liminality to understand the changes individuals underwent in transitioning from a service user to a PM.

Findings: This study showed that the role of PMs was regarded as valuable both for the individuals concerned and for the organisations they worked for. The role was

defined by two common denominators: possessing lived experiences and maintaining abstinence; however, it was a role which lacked clear definition, and which varied between organisations. There are several pathways service users may take into and through the PM role, each with the potential to positively enhance or hinder individual progression. The PM role can be seen as a 'transitional' pathway when individuals are adjusting to new roles and opportunities. Given the transitional nature of the PM role, individuals can experience a liminal state which can impact (positively or negatively) on their personal and social identity and their future pathways depending on the socialisation processes offered by their host organisation.

Conclusions: This thesis contributes to new knowledge by offering insights into the benefits and potential risks associated with the role of PMs in alcohol and drug services. PM's positions are not only valued by the alcohol and drug services, but it aids their recovery journey, leading to positive self-identities and social integration within broader societal and organisational settings. This research identifies specific recommendations for further exploration, including the transitional nature of the PM role, the integration of these individuals into the organisation, the role of organisational socialisation in this process, and the development and implementation of a competency framework for the PM role.

Chapter 1: Introduction

1.1 Research aim, research questions and research objectives

An initial scoping of the literature identified a paucity of published research on how PM roles are defined and performed, and what status these individuals hold within alcohol and drug service settings. These initial findings informed the formulation of the research aim, questions, and objectives, and this thesis seeks to address this gap in the literature.

The study aimed to explore the role of PMs (PMs) in delivering alcohol and drug services from the perspective of PMs and their colleagues. This thesis is concerned with understanding how these roles are defined and performed, and what status PMs hold within alcohol and drug service settings. In doing so, the study attempts to understand what influences how these roles are enacted and what transitional factors are at play to progress or hinder individuals from moving into the PM role, both on a personal and organisational level. The research focuses on the individual and the immediate organisational environment, but also considers the broader policy and systems context in which alcohol and drug services operate.

The research questions were:

1. How are the roles of PMs in the delivery of alcohol and drug services defined and perceived by PMs themselves and by other workers in their organisations?

2. How is the role of PMs in the delivery of alcohol and drug services enacted by PMs themselves?

3. What key personal and organisational factors influence the transition from service user to PM?

Research objectives were:

1. To understand what roles PMs currently perform in alcohol and drug services.

2. To examine how these roles are perceived by PMs themselves and by other workers within those organisations delivering alcohol and drug services.

3. To identify what personal and organisational factors may facilitate or impede transitioning into a PM role.

4. To investigate whether PMs and other staff regard the PM role as a developmental or career pathway within or beyond their current organisation.

1.2 Theoretical framework

This thesis employs several theoretical perspectives to guide the study and further understanding of the findings. At the broadest level, I draw on the social ecological theory (Bronfenbrenner, 1979; Dahlgren and Whitehead, 2007) to locate the personal and organisational factors influencing the PM's role within a wider social, cultural, and policy context. Social identity theory (Stets and Burke, 2000) is used to explore how individuals make the transition from service users to PM and whether this transition includes an aspiration to achieve professional status or develop a career pathway. Arguably, this transition will involve a passage through a 'liminal' stage (Van Gennep, 1960; Turner, 1967), where the individual experiences and responds to the changes in self-image and identity needed to adapt successfully to the PM role. These changes occur within the organisational framework of alcohol and drug services in which the PM is located. The concept of organisational socialisation (Van Maanen and Schein, 1990; Bauer and Erdogan, 2011) is a valuable tool to aid understanding of the organisational factors that shape the PM role and facilitate or impede the passage

through the liminal stage. These identity changes, transitional processes, and the theories used as explanatory frameworks are discussed in detail in Chapter 3.

The next section of this chapter provides an understanding of the macro-level changes- informed by national alcohol and drug polices by successive governments- that have impacted on the emergence and development of the PM role within the alcohol and drugs field. It is important to note that the next sections will concentrate on England rather than on Wales, Scotland, and Northern Ireland. The rationale behind this focus is that policies in England have a direct impact on the study and participants involved. However, as briefly mentioned below, I am aware that alcohol and drug policies differ in Wales, Scotland, and Northern Ireland.

1.3 Factors influencing the peer mentor role: an overview

Macro influencers of the role of peer mentor

The alcohol and drug workforce has undergone fundamental changes in the United Kingdom and internationally over the past two decades. Several national policies and initiatives have resulted in changes to the alcohol and drug workforce (DANOS, 2005; DH, 2008; HM Government, 2010, 2012a, 2017, and 2021; DHSC, 2021).

The first of these was the Drugs and Alcohol National Occupational Standards (DANOS, 2005). This national occupational standard (NOS) was introduced around the mid-2000s with the primary aim of creating a benchmark and standardisation of staff competencies aimed at individuals working within the alcohol and drug sector (Skills for Health, 2014). These national occupational standards (NOS) outlined 'the skills, knowledge and understanding needed to undertake a particular task or job to a nationally recognised level of competence' (Skills for Health, 2014:2). Since its implementation, the framework focus has shifted to a desirable rather than an essential occupational competency applicable across the entire health care sector and not solely within the alcohol and drug field (Skills for Health, 2014). The DANOS framework continues today and is recognised by the health regulatory body, the Care

Quality Commission (CQC), as a basic knowledge requirement within the alcohol and drug field (CQC, 2018). However, the DANOS training programme was optional for staff in alcohol and drug services. As a result, this relied on each organisation to invest in the financial and skill development of its staff, resulting in an uneven uptake of the DANOS competency-based framework. Arguably, increasing financial pressure, coupled with a reducing financial envelope within commissioning budgets, may have contributed to this.

The government white paper, High-Quality Care for all: NHS Next Stage Review (DH, 2008), was launched as another attempt to improve general healthcare settings and client outcomes through staff development. The paper advocated a concerted effort in workforce planning and for central government to better support local NHS providers and other agencies as part of the National Service Review Framework [NSRF] (DH, 2008). The main aim of the NSRF project was to make health professionals, such as nurses and members of graduate professions, use recognised standards and competencies supported by a preceptorship programme to embed learning. To achieve this, Medical Education England (MEE) was established as an advisory group within the medical profession to build and deploy a workforce that is responsive to service demands. This independent advisory group was launched in 2008 to plan for doctors, pharmacists, and other health professionals to take a national focus on training. Again, this initiative was discontinued prematurely due to changes in the political direction in 2010 with the new coalition and then conservative governments. Under these governments, comprehensive healthcare reforms, austerity and efficiency savings were ushered in (DHSC, 2015).

At the same time, the ‘Drug Strategy 2010, Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life’ was enacted, which championed a paradigm shift from treatment interventions based on harm reduction to recovery (HM Government, 2010). Researchers have contended that there is no universally accepted definition for 'recovery'; instead, they advocated that it is a person-centred, individualised, and continuous approach guided by an individual's choice to address their substance misuse, incorporating broader factors such as housing, employment, and well-being (HM Government, 2010, 2012; Timpson et al., 2016). This drug strategy meant that service treatment was focused on service users

potentially living alcohol and drug-free lives rather than being reliant on treatment services throughout their lifespan. This drug strategy also steered the decentralisation of power and accountability, where the UK government gave ownership to Scotland, Wales, and England to deal with their own presenting alcohol and drug issues (Scottish Government, 2008; Welsh Government, 2008; Strang, 2011; HM Government, 2012c). Furthermore, this policy saw the creation of new departments and roles, such as Police and Crime Commissioners (PCCs), the formation of Public Health England (PHE), and the NHS reforms through NHS providers of services were also established. In addition, the drug strategy pledged an injection of a 'transitional fund of one hundred million pounds … to help support the sector and build capacity' (HM Government, 2010:24). This 'transitional fund' also included investments specifically targeted at voluntary, community groups and organisations, as they were best positioned to build capacity and to support the former service users through volunteering programmes. As a result, the alcohol and drugs sector in England experienced an exponential shift in service delivery from the NHS to third-sector providers, where PM roles appear to be more established today.

Furthermore, there was a strong emphasis on building 'community recovery champions' where former service users were able to work as mentors to help others combat their dependence on alcohol and drugs (HM Government, 2010:21). Consequently, this was a further catalyst for alcohol and drug services to start to explore the care pathways and how those with lived experience could be actively involved in their service's treatment offer. The 'Government's Alcohol Strategy 2012' (HM Government, 2012a) was legislated shortly thereafter. Significantly, although some ad hoc attempts have been made to incorporate staff development activities into the larger healthcare environment, this does not appear to have extended to alcohol-specific treatment guidelines. Equally unsatisfactory, the alcohol strategy lacked coordinated workforce development crossover with the drug strategy at the time which referred to championing PM provision. Rather, the alcohol strategy sought to regulate the number of licenced premises, increase the levy on stronger alcohol, and reduce the supply of cheaper alcohol by introducing a minimum unit price (HM Government, 2012a). It could be argued that perhaps this was another missed opportunity to explore how the alcohol and drug workforce could be more fit for purpose. It is worth

noting that the 2012 Alcohol Strategy was the last alcohol strategy which focused exclusively on alcohol treatment and directives.

As part of the '2017 Drug Strategy', the then Home Secretary, Amber Rudd, purported that 'treatment service commissioners should ensure that the services they commissioned have a workforce which is competent, motivated, well- led, appropriately supervised and responsive to new challenges' (HM Government, 2017:30). In addition, commissioners were required to adopt an integrated approach to address both alcohol and drug issues rather than separately which was historically the case. Subsequently, this led to alcohol and drug services being commissioned jointly, with a greater focus on the individual's presenting substance misuse- alcohol or drugs- which, in many cases, often presented concomitantly. This meant that frontline alcohol and drug staff, including PMs, supported service users across both alcohol and drug interventions, rather than within a given speciality. Building on the principles of an integrated approach to supporting those with substance misuse issues, there was a close synergy with of the 'Five Year Forward View for Mental Health' strategy (NHS England, 2016). Given the preponderance of evidence indicating a strong correlation between mental health and substance misuse, the government at the time recommended that services worked in collaboration with Health Education England (HEE) and other stakeholders 'to support the development of an appropriately trained and competent workforce to meet the needs of people with co-occurring substance misuse and mental health conditions' (HM Government, 2017:34). The 2017 drug strategy mirrored the views of the preceding 2010 strategy in terms of the need to 'build recovery' and the necessity for service user involvement in service design and their development. However, the policy remained vague and unformulated, leaving room for interpretation by the local commissioners and service providers. Therefore, it might be argued that this may have contributed to the increased number of PMs and their expanded duties in alcohol and drug services. These national policies also had a negative impact on the commissioning processes. The interpretation of the strategy had given rise to reduced funding, the commissioning of substance misuse services being impacted by competitive tendering processes, and shorter contract awards with poorer outcomes, as evidenced in the 2017 report by the Advisory Council on the Misuse of Drugs [ACMD] commissioned by the UK

government (ACMD, 2017). Arguably, the combination of these national policies resulted in high staff turnover and increasing caseloads within alcohol and drug services. To cope with increased workloads and fewer specialist resources, alcohol and drug services have turned to various forms of support such as PMs.

The most recent drug strategy 'From Harm to Hope: a 10-years plan to cut crime and save lives' proposes the development and delivery of a comprehensive substance misuse workforce strategy but provides few details on how this will be achieved (HM Government, 2021). A report (DHSC, 2021) completed by Dame Carol Black also reinforced the recommendations for collaborative working between the Department of Health and Social Care (DHSC) and HEE on the issue of workforce development. To achieve this, she suggested that these two departments should focus on driving up occupational standards by providing appropriate training as part of a comprehensive approach. Furthermore, the Government's 2021 drug strategy is committed to increasing alcohol and drugs budgets with a 'total treatment and recovery spend to more than £2.8 billion over three years and £780 million expenditure in the first three years' to transform treatment and recovery programme in England (HM Government, 2021:32). Eight million pounds of this total will be used to fund 'peer mentoring programmes' (HM Government, 2021:38). This drug strategy mentioned explicitly the need for a workforce strategy through 'rebuilding the professional workforce' and 'delivering world-class treatment and recovery services' (HM Government, 2021:80). This encompasses an undertaking to improve employment opportunities for those completing structured treatment. PM roles are to be encouraged to promote both active participation in service development and services informed by the lived experiences of former alcohol and drug service users. In addition, this strategy also advocated for rebuilding the workforce by having an increased mix of professionals as part of the alcohol and drug workforce composition. Both the 2021 drug strategy and the Dame Carol report championed a need for workforce development through the restoration of the substance misuse commissioning services which had previously been dismantled due to local authority cuts and lack of ring fencing of substance misuse funding (HM Government, 2021; DHSC, 2021).

In summary, several factors, such as revisions to the commissioning of services, the introduction of new policy strategies, and economic pressures, have influenced these service transformations. Similarly, successive governments have changed alcohol and drug policies which have seen a shift from harm reduction to recovery, where individuals are empowered and play an active role in their care and treatment journey. Furthermore, traditionally, alcohol and drug commissioners have procured these treatment services separately, but in recent years, commissioners have opted for an amalgamated model of treatment provision. As part of these changes, there has been a greater focus on using service users' lived experiences to inform service development and support service delivery. Lastly, PMs are able to add to current treatment interventions in ways in which other professionals are not, due to their unique position and past experiences.

Although not the main focus of this study, these macro level factors – the broader policy and systems context – have been important in shaping organisational workspaces and service provider roles including PM's experience at an individual level.

Organisational factors influencing the role of peer mentors within alcohol and drug services.

As noted above, these policies have led to the wholesale restructuring of the health and social care infrastructure. Alcohol and drugs treatment systems have had to change and adapt their workforce composition to include other types of professionals working in this sector (HM Government [Drug Strategy], 2010; HM Government [Alcohol Strategy], 2012a; Measham et al., 2013; Public Health England, [PHE], 2021a; Best et al., 2021; DHSC, 2021). Traditionally, the workforce composition within alcohol and drug services consisted mainly of professionals such as psychiatrists, nurses, clinical psychologists and, to a lesser extent, social workers, as well as specialist alcohol and drugs workers; but this has evolved to include peer support workers. As discussed later, different terms have been used to describe peer support workers; however, in this thesis, the term PMs is used. Even before the pandemic, other factors contributed to the adaptation and change in alcohol and drug services

due to reduced budgets. Austerity measures under the coalition government (2010-2015), coupled with competing health and social care policy drivers, caused a reduction in local authorities' funding and a heavy reliance on the third sector to provide services using less traditional staff composition (Measham et al., 2013). 'From harm to hope: A 10-year drugs plan to cut crime and save lives', DHSC (2021) recognised that shorter treatment contracts have led to organisations struggling to build stable recovery networks, contributing to poor treatment outcomes and disjointed treatment approaches. All of the above have contributed directly or indirectly to PM roles becoming more popular within alcohol and drug service delivery interventions (HM Government, 2012a; Best and Lubman, 2012; El-Guebaly, 2012; White et al., 2012; Cairns and Nicholls, 2018). Subsequent sections will discuss how shifts in the structure of service delivery and workforce composition impact on how those working in organisations construct, maintain and challenge role boundaries, how this affects workers' sense of identity and how organisational factors are important in influencing transitional processes, in this case specifically for PMs.

Peer mentor role at an individual level

Increasingly, PM roles have become critical to the delivery of services, not only within drug and alcohol services but also in other areas of health and social care (Sheedy and Whitter, 2013; Myrick and Del Vecchio, 2016; Cronise et al., 2016). The popularity of the PM role reflects a greater emphasis on the significance of lived experiences in delivering healthcare interventions (Cronise et al., 2016, PHE, 2021b; Best et al., 2021; DHSC, 2021*).* These 'experts by experience' can provide several supportive functions, such as mutuality of experience, empathy, and social and emotional support to help service users achieve or maintain sobriety.

However, current research indicates that the terminology used to describe the role of PMs is variable. Across the health and social care sector, varied terms have been adopted and used to describe those who have come from a lived experience background and now provide support to others. More commonly used terms are peer support, peer workers, PMs, volunteers and recovery champions, to name a few. Therefore, this raises issues regarding the role of the PM, how it works in practice,

how it is perceived and experienced by PMs and others working in alcohol and drug service organisations, and how it is shaped by those working in the services. While the PM role requires some common characteristics (such as lived experience and abstinence, as discussed in Chapter 5), individual traits and individual's specific backgrounds and current situations are also important in how individuals adapt to and manage the shift from service user to PM.

A key concept used in this research is 'pathway' which I use to refer to the change from being a service user to becoming a PM. The concept of 'pathway' emerged from other fields, notably the defence industry (Kelley Jr., 1961) and medicine (Zander et al.,1987; Li et al., 2014). While there is no clear definition of what a 'pathway' means, it generally refers to a process whereby individuals move from one position (or status) to another (improved or more favourable) position with the help of supportive interventions, policies and organisational procedures (Vanhaecht et al., 2007; Li et al., 2014). For occupational groups, such as PMs, use of the concept 'pathways' highlights the need to consider crucial indicators of support for individuals progressing along a particular pathway; it provides transparency around the processes involved and helps to identify facilitators and barriers to successful progression.

1.4 Study participants

Given the changes in the structure of service provision, no alcohol-specific service was identified in any of the services included in this study. PMs work with service users who experience alcohol or/and drug-related problems and research has shown that PMs' roles extend across both alcohol and drug services (Hind, 2011; Tober et al., 2013; Breedvelt et al., 2014; Bagnall et al., 2015; Parkman and Lloyd, 2015; Dugdale et al., 2016; Moyes et al., 2016; Tracy and Wallace, 2016; Barker and Maguire, 2017; Hay et al.,2017; Dugdale et al., 2017; Edwards et al., 2018; Harrison et al., 2018; Paterno et al., 2019; Nixon, 2020; Bryant et al., 2021). However, this PhD was supported by a bursary from Alcohol Change UK and to meet the funding criteria,

it had to concentrate on individuals who had experienced problems with alcohol in the past and now delivered peer mentoring functions within the alcohol and drug service organisations. Therefore, all the PMs interviewed for this study worked with service users attending for both alcohol and drug-related problems (such as cocaine, heroin and benzodiazepine misuse) as the services were provided together. However, the PMs who were interviewed had previously been dependent on alcohol. Similarly, the other staff interviewed (nurses, service managers, team leaders) worked with individuals who had both alcohol and drug problems. Both key workers and PMs have caseloads of service users who could present with simply alcohol problems or both alcohol and drug problems.

1.5 The structure of the thesis

The current study was born from an interest in the PM role in a changing alcohol and drug workforce in the UK. In this chapter, I have indicated the important influence of factors at macro level, at organisational and at individual levels. I have highlighted the need to consider the PM's pathway through transition from a service user role to a PM role and beyond, and I have suggested the possible importance of understanding identity change as part of the process.

Chapter 2 presents the literature review, which offers an analysis of previous studies and research conducted on the role of PMs in the alcohol and drugs field and highlights issues for further exploration in this thesis.

Chapter 3 sets out the conceptual framework and the theories that informed the design of the study and the data collection. While the research started from a broad social systems perspective – looking at factors influencing the PM role at macro, meso and micro levels, over the course of the (iterative) data collection and analysis, theories drawing more specifically on identity, 'liminality' and on organisational socialisation

emerged as important and were used to further understanding of the transitional process and the role and status of PMs.

Chapter 4 will discuss the methodology, the choices made in terms of methodological approach, data collection, and analysis, including the ethical considerations guiding this research.

Chapter 5 presents the concept of 'PM', what defines and motivated those who carry out this role. The theme of organisation socialisation is also explored, and I discuss how organisational procedures and cultures shape these roles.

Chapter 6 continues the findings, detailing the varied PM pathways and stages that an individual may undergo to transition into the PM role. Two further themes associated with the PM pathways will also be explored- Enablers and Barriers to PM's pathways.

Chapter 7 will explore the findings on the impact of the PM role on the individual's sense of self and identity which is adapted and changes over the course of the transitional period.

Chapter 8 discusses the study findings, situating them within the relevant literature and drawing out the theoretical insights emerging from the research.

Chapter 9 summarises the implication of the findings for practice and future policies. It comments on the contribution this research has made to new knowledge regarding the role of PMs within alcohol and drug services. The limitations of the research are acknowledged. The thesis concludes with recommendations based on the study findings, along with suggestions for future research.

Chapter 2: Literature Review

2.1 Introduction

This chapter presents the literature review on the role of PMs in general and specifically those within alcohol and drug services. For this thesis, a scoping review was employed, which is an effective tool for understanding a broad range of literature on a specific subject (Mays et al., 2001; Anderson et al., 2008; Davis et al., 2009; Levac et al., 2010; Daudt et al., 2013; Pham et al., 2014). The primary aim was to map and synthesise the existing evidence on the topic (Arksey and O'Malley, 2005; Munn et al., 2018). There is a vast amount of literature on PMs that spans a diverse range of sectors, and it is essential to gain an overview prior to examining the literature on PMs specifically in the alcohol and drug field. A scoping review also offered the opportunity to explore and identify emerging or developing concepts or evidence on a given area of interest (Mays et al., 2001; Anderson et al., 2008), in this case, the role of PMs in the broadest sense. Similar to systematic reviews, the scoping review applies explicit inclusion and exclusion criteria to published research to focus on the search. Finally, for systematic reviews, Mays et al. (2001) recommend careful documentation of the methods used to conduct a scoping review so that it can be reproduced by others. Ultimately, regardless of the research design, the main requirement of a scoping review is to identify all the relevant literature.

The chapter also includes a detailed description of the literature search strategy, highlighting the inclusion and exclusion criteria (see Table 2.2), the databases used, keyword search terms (see Table 2.3), and the major themes which have emerged from the review.

2.2 Inclusion and exclusion criteria

This review covers the literature that focuses on adult PMs in substance misuse services and excludes studies that featured young people (including adolescents) participants or services, as defined below. Adults were defined as individuals aged 18 years and above, while young people and adolescents were defined as those below the age of 18. In addition, posters, meeting excerpts, newspaper articles, and conferences were omitted from the scoping review to enhance the quality and rigor of the research. Furthermore, given the limited time and resources associated with a PhD, only articles written in English were included in the review. Lastly, journal papers, books, and grey literature published in the five years before August 2019 were analysed. However, the search was extended to ten years as the initial search yielded limited results. The initial literature search was concluded in January 2019, and a second literature scoping exercise was performed in September 2021 to capture any new research (Figure 2.4, The Literature Search Flowchart) below. Lastly, there was a strong focus on alcohol misuse and PMs within alcohol and drug services to meet the criteria of Alcohol Change UK, who part-funded the study.

Table 2.2 Inclusion and Exclusion criteria

Inclusion criteria	Exclusion criteria
a. Studies on articles which included alcohol, drugs and PMs. b. Studies on articles which discuss the definitions, roles and responsibilities of PMs. c. Studies in the English language. d. Studies on adult (18 years old and above) services on PMs. e. Literature between 2009 and 2019 and between 2019-September 2021.	a. Studies in Non-English languages. b. Studies which included young people or adolescent (below 18 years old) participants or services. c. Studies that did not include alcohol and drugs services. d. Literature prior to 2009 and after September 2021.

2.3 Search Strategy

To identify literature on the role of PMs in general and specifically those within alcohol and drug services, a comprehensive search strategy was employed. The electronic databases used were CINAHL, MEDLINE, PsycINFO, Cochrane, PubMed, Web of Science and Social Care Online. Keywords used are shown in Table 2.3 below. Specialist addiction libraries and websites, including local and national charity publications, reports, and conference reports, were thoroughly searched for 'grey literature' and journals which were not included in the specified databases. A 'Google search' on the use of PMs in the alcohol and drug field identified similar articles to those found via the formal literature search. Search terms were derived from keywords of relevant articles, consultation with colleagues in the alcohol and drug sector both in statutory and non-statutory organisations, and PhD supervisors. The research used a combination of the search terms, where an asterisk indicated that all forms of that word were included. For example, synonyms of PMs included terms such as 'peer supporter*', 'peer support worker*,'peer mentor*', 'peer worker*', 'peer educator*', 'peer engagement*', 'peer outreach*' 'volunteer*', 'social supporter*, 'consumer*', 'substance misuse recovery*', 'recovery champion*' and 'recovery coach*' to accurately reflect the terminology used in the alcohol and drug service care sector. In addition, this review attempted to account for publication bias by extensively searching published, unpublished, and grey literature (Song et al., 2010).

The searches performed were rigorous and comprehensive and were divided into two major stages, with the priorities of objectivity, transparency, and minimisation of bias (Chambers et al., 2009). They included:

> ***Stage 1-*** The first stage involved surveying titles and abstracts against the defined inclusion and exclusion criteria to identify relevant studies to be reviewed in full.

Stage 2- The second stage involved retrieving the full-text papers of the selected studies.

Prior to completing the above searches, one of the Middlesex University specialist liaison librarians was consulted. This was done to seek advice and guidance to ensure that the search terms used in this scoping review were comprehensive and to identify all relevant papers.

Table 2.3 Keyword Search Terms

Operator	**Definition**
1. Keywords: Population	Adult OR over 18 OR older adult
2. Keywords: Population	Alcohol* OR drugs* OR substance misuse* OR substance misuse disorder* OR addiction* OR substance misuse rehabilitation* OR dual diagnosis* OR Harm reduction*
3. Keywords: Population	Peer supporter* OR peer support worker* OR peer mentor* OR peer worker* OR peer educator* OR peer engagement* OR peer outreach* OR volunteer* OR social supporter* OR consumer* OR substance misuse recovery* OR recovery champion* OR recovery coach*
4. Boolean Operator	1 AND 2 AND 3
5. Language Limit	English
6. Selection	Removal of duplications through title sifts, abstract sifts, full text sifts, review reference lists and articles citing.

2.4 Results from the literature search

As indicated in the 'Literature Search Flowchart' (Figure 2.4), the searches identified 3012 research articles from various countries across the world. This was reduced to 764 when the search focused only on substance misuse interventions. After applying the exclusion criteria and screening research titles, abstracts, and duplications (see the Eligibility section below), the number of articles was reduced to 402. Of these 402 articles, most of the results referred to 'volunteer' as individuals who participated in a clinical trial as opposed to someone who provided a service; therefore, they were not applicable to this study. Similarly, some articles focused exclusively on PMs in mental health settings, harm reduction interventions such as needle exchange, or information on the prevention or treatment of sexual transmission diseases; therefore, they were excluded. Using the inclusion and exclusion criteria, 21 articles were identified. Six of these were identified by searching the reference lists and citations from other articles (see Figure 2.4 below for the Literature search flowchart).

These collected research papers had a combination of qualitative and systematic review research methodologies. Qualitative techniques, such as semi-structured interviews and focus groups, were utilised for data collection. Fourteen of the twenty-one published research studies were conducted in the United Kingdom (UK), five in the United States of America (USA), one in Australia, and one in New Zealand. The number of participants in these studies ranged from 8 to 4389. A summary of the reviewed research articles is provided in Appendix 1 (see Table 2.4). Table 2.4 shows the authors of the journal article, the name of the article, the DOI address in one column, and author(s) abstract summary overview in the other column.

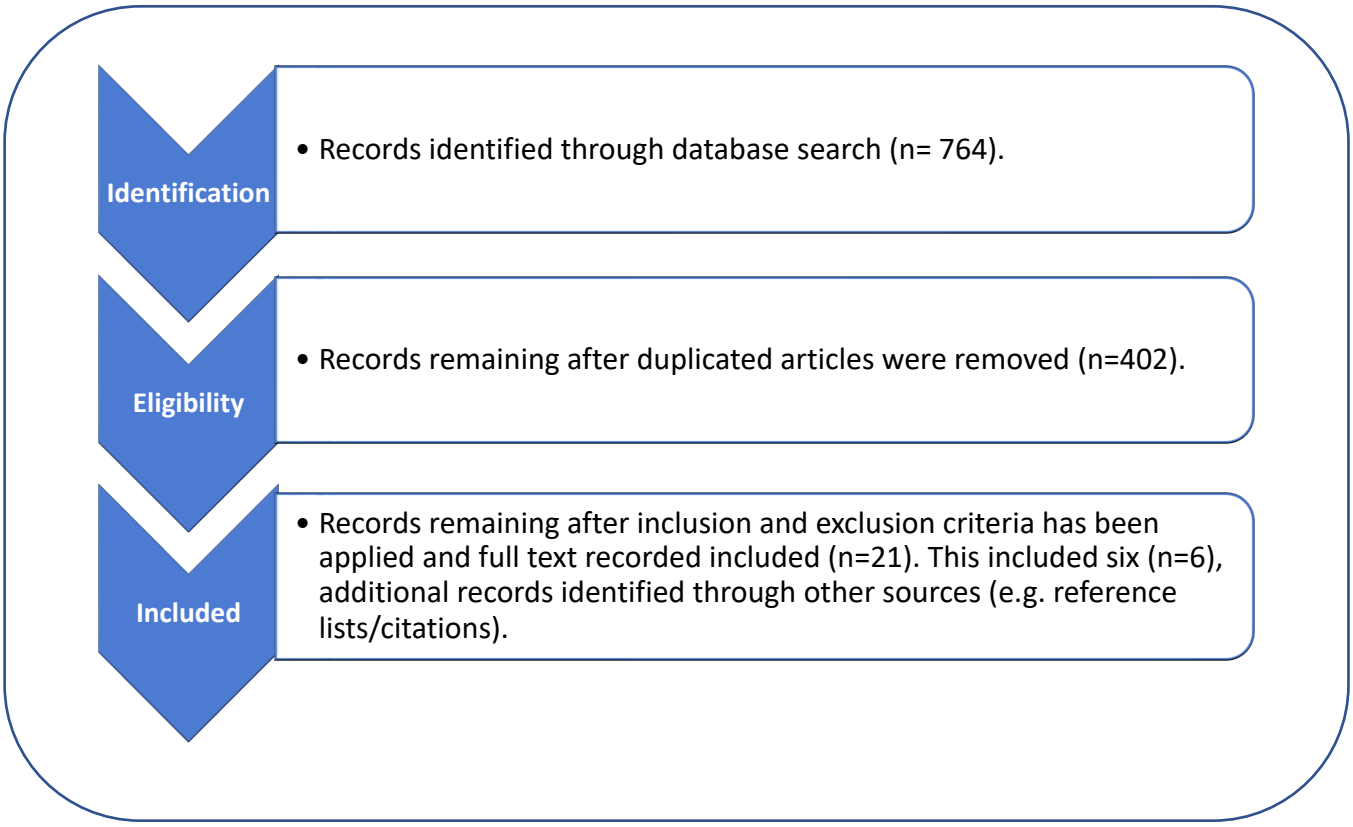

Figure 2.4 Literature Search Flowchart (source: compiled by the author).

In addition, the publications frequently referred to participants with a current or past history of 'substance misuse' or 'alcohol and drug' dependence, with most of the articles with greater emphasis on heroin users rather than alcohol alone. Only four articles focussed solely on alcohol misuse and PMs. From the twenty-one published research articles included, the analysis demonstrated that there was little published or grey research on PMs in the alcohol field. Consequently, this study aims to fill in some gaps in the existing literature.

2.5 Themes emerging from the literature review

The results of the review are presented in the following sections. First, the role of PM is discussed in broad terms across a range of sectors including health, social care,

and criminal justice. Second, the various terminologies used to identify these roles were examined. Then, how individuals who fill this role are defined and what attributes or characteristics are used to distinguish them from others are discussed. This is followed by an examination of the literature to determine what assumed or performed tasks PMs in alcohol and drug services execute. Finally, I consider how the review findings and themes informed the research objectives, questions, and methodology.

The wider context of the role of PM

Across the globe, there is a growing appreciation of the value of supporting individuals who have previously used services to enter the health and social care workforce as PMs. From the literature, the presence of PMs is evident in a variety of settings targeting a wide range of service sectors from criminal justice, education, mental health, sexual health and including the alcohol and drug field. The role of the PM and its prominence have changed over the decades, but its origins can be traced back to Alcohol Anonymous (AA)[1], mutual aid and user involvement movements. In the 1960s, user involvement, in the shape of AA, emerged and this was followed in the 1970's by a range of self-help groups offering support to people with problems, such as drug use and depression (Robinson, 1979). These groups all provided peer support to those in similar circumstances and, as in the case of AA, were often linked to statutory alcohol services and provided on-going support to service users after hospitalisation. This peer support approach came as a challenge to mental health treatment which was seen as outdated, stigmatising, and disempowering (Faulkner et al., 2012; Noorani, 2013; Midland District Health Boards Mental Health, 2014). As a result, PMs' roles are now more evident within mental health settings today (Scott, 2011; Piat and Sabetti, 2012; Faulkner et al., 2012; Walker et al., 2014; Gillard et al., 2015). Other service areas in which PMs have been noted are criminal justice

[1] Alcoholics Anonymous is an association of both men and women who come together to share their experiences and give strength with each other that may support problem solving of problems and encourage recovery from alcoholism.

(Barrenger et al., 2018), housing (Cook and Willetts, 2019), and education (Colvin and Ashman, 2010; Douglass et al., 2013; Leidenfrost et al., 2014). Within these service areas, co-production and using the PMs' knowledge of services enables a better understanding from a service user perspective. Furthermore, research has also highlighted a strong presence of PM roles within sexual health services (Layzer et al., 2014), and harm reduction (Thangsing, 2012; Jain et al., 2014; Penn et al., 2016; Hay et al., 2017; Ashford et al., 2018; Wilson et al., 2018; Ashford et al., 2021). In these areas, the focus has been two-fold guided by the concept of harm reduction and by its implications for the delivery of targeted interventions or programmes. First, within both sexual health and substance misuse services, PMs engaged in interventions which centred on safer injecting practices and health promotion to prevent or reduce HIV and hepatitis. Second, the harm reduction philosophy advocated the use of policies which informed service design and development with an emphasis on reducing harm and less on reducing drug use itself. Although harm reduction literature provides insightful information about the roles, definitions, and challenges that PMs may experience, they are mainly focused on drugs rather than alcohol misuse which highlights gaps in the relevant literature surrounding alcohol dependency.

The range of terminology used

The review highlighted that there was a plethora of terms used to describe individuals who provided some form of peer-related support to those using substance misuse services. Terms found in the literature included 'peer support', 'peers', 'PMs' 'peer support workers' and 'peer providers', with these terms being frequently used to describe the same PM roles (Hind, 2011; Tober et al., 2013; Breedvelt et al., 2014; Parkman and Lloyd, 2015; Bagnall et al., 2015; Dugdale et al., 2016; Moyes et al., 2016; Tracy and Wallace, 2016; Barker and Maguire, 2017; Hay et al.,2017; Dugdale et al., 2017; Edwards et al., 2018; Harrison et al., 2018; Paterno et al., 2019). Less commonly used terminology included 'graduates' which were used within a prison setting (Breedvelt et al., 2014). Peer support and peer support workers were the most common of all the terminology used across all the sectors. 'PM' and 'mentor' were the

second most popular terms to be used. Interestingly, within alcohol misuse literature, 'PM' or 'mentor' were more commonly cited term used to describe to identify individuals who carried out these roles (Hind, 2011; Tracy et al., 2012; Tober et al., 2013; Parkman and Lloyd, 2015; Moyes et al., 2016; Dugdale et al., 2016; Tracy and Wallace, 2016; Dugdale et al., 2017; Paterno et al. 2019). The terms were often used interchangeably, with no specific connection to a given sector, with the exception of services in criminal justice and mental health settings. Within these settings, term such as 'ex-prisoner' and 'ex-service users' were used in conjunction with 'mentors' to describe those individuals who are in the early stage of their recovery who may still be using services or recently discharged (Parkman and Lloyd, 2015; Stott and Priest, 2018).

In the USA, there was a similar inconsistency in the use of terminology to describe individuals who have had previous 'lived experiences of using services (Tracy and Wallace, 2016; Paterno et al., 2019). In addition, in the USA, the terms 'peer supporter', 'peer support worker', 'peer provider' and 'consumer' were used reciprocally with PMs more frequently than in the UK (Tracy et al., 2012; Reif et al.,2014; Tracy and Wallace, 2016; Chapman et al., 2018; Paterno et al., 2019). It may be argued that these latter terms reflect the more commercially oriented treatment services in the USA compared to other parts of the world, especially the UK.

With regards to the term 'volunteer', the literature review only identified one study which used the term 'volunteer' conversely with 'ex-prisoner' and 'PM' (Moyes et al., 2016). The term 'volunteer' was found only in the UK and referenced within drug strategies and policies, such as the Drug Strategies - HM Government (2010 and 2017) and National Treatment Agency [NTA] (2012). Volunteers or volunteering were mainly used to indicate a function that individuals performed post-treatment within a supporting capacity and as part of the next stage of the individual's recovery pathways. Furthermore, in line with the paradigm shift from a harm reduction towards a recovery approach, successive UK government substance misuse strategies and policies since

2010 (HM Government, 2010; NTA, 2012; HM Government, 2017) have introduced the term 'recovery champions'. Strang (2011:4) argued that the term was used to:

> '… make visible those people who have successfully exited by explicitly linking your service to a recovery community or employing ex-service users or using them in a volunteer capacity as recovery mentors and coaches'.

Literature after this period also started to adopt similar terms of 'recovery coach' and 'peer-based recovery support' (Roberts and Bell, 2013; Reif et al., 2014) respectively. There was only one article which used a variation of the recovery coach term namely 'life coach'; this placed a similar emphasis on individuals who had previously used services and had embarked on a recovery journey (Schinkel and Whyte, 2012). The term 'peer educator' was only observed in harm reduction literature, mainly with respect to drug use amongst people who inject drugs (PWID), and it was not widely used in other service settings. Finally, it is significant to note that within the alcohol and drug sector, the terms PMs and peer support are commonly used to describe those individuals who have previously used alcohol and drugs at a dependent level and now offer assistance to others.

What defines a PM?

Alcohol and drug services are increasingly required to explore new and innovative approaches for service delivery. Some of these changes have been driven by a focus on aftercare as a vehicle to maintain recovery and achieve improvements in successful completions, as argued by McLellan et al. (2000). There is also acknowledgement that health professionals alone are not always capable of meeting the diverse needs of the service user population. Therefore, there is an increasing trend to harness self-help partnership arrangements with service user groups within the health and social care sectors (Tang et al., 2011). Current literature highlighted that there is no consensus regarding the definition used to describe PMs. Similarly, there appears to

be a scarcity of specific information in the UK on the role definition of PMs, especially with a clear focus on alcohol treatment. More studies appear to focus on substance misuse as a whole, encompassing substances such as heroin, crack, stimulants, and alcohol combined (Tober et al., 2013; Moyes et al. 2016; Tracy and Wallace, 2016; Barker and Maguire, 2017; Dugdale et al., 2017; Edwards et al., 2018), or heroin alone (Bagnall et al., 2015; Hay et al., 2017; Harrison et al., 2018). These included studies from the USA, Australia, and New Zealand (Bagnall et al., 2015; Harrison et al., 2018; Tracy et al., 2012) respectively. However, the literature review identified two key characteristics which distinguish the role of PM: having lived experiences and maintaining abstinence.

Centrality of lived experience

Notably, in all the studies, there was one predominant characteristic; lived experiences of using alcohol and drug services which seems to be used to describe those who provide peer mentoring support. For instance, for individuals who were in receipt of substance misuse support within criminal justice, Schinkel and Whyte (2012) and Breedvelt et al. (2014) described how 'ex-prisoners' were able to use their lived experiences to support other prisoners upon release, helping with community re-engagement and signposting to vital support. Similarly, research conducted by Tober et al. (2013) and Parkman and Lloyd (2015) within alcohol and drug services described how having lived experiences was used as a unique factor to differentiate them from other members of the team. However, in both these cases, having lived experiences were inferred rather than explicitly stated to define a 'mentor' or 'ex-service user'. In addition, at the macro level, NHS England (2017) highlighted that individuals are actively encouraged to provide peer support to others by sharing their experiences and engaging them in shaping service designs. Furthermore, as part of this strategic initiative, the government commissioned a Lived Experience Team (LET) and hub nationally with a strong focus on health in criminal justice settings. Its main aim is to foster and harness individual's lived experiences to drive service development and improvement (NHS England, 2017). Strategic initiatives have highlighted the significance of using lived experiences and this represents a major shift from a service-led towards a co-production approach. Scott (2011) also argued that there is a

uniqueness which helps to define this group of individuals as peers. That distinctiveness lies in being individuals who share a commonality of having previous experience with those who currently use alcohol and drug services. There is also a distinction in the relationship that PMs have with service users that differs from the relationship between service users and professionals (Barker et al., 2017). What distinguishes this relationship is the shared experiences which provide the basis for building rapport, trust, and self-identification which cannot be achieved as easily by professional groups (Barker et al., 2017). Therefore, for the purpose of this research, the following definition of a 'peer mentor' was adopted:

'A peer mentor is a person who offers help and support to others based on their personal experiences with similar challenging alcohol or drug misuse situations'.

This definition draws on those used in the literature and on cited papers in particular (Best and Laudet, 2010; Scottish Government, 2010; Faulkner et al., 2012; Parkman and Lloyd, 2015; Barker and Maguire, 2017).

Abstinence

Another common trait shared by PMs was achieving or working towards abstinence from alcohol and drugs. Abstinence was seen as a key criterion for being accepted to become a PM and needed to be achieved to commence the role. Seven of twenty-one studies (Tracy et al., 2012; Reif et al., 2014; Parkman and Lloyd, 2015; Dugdale et al., 2016; Tracy and Wallace, 2016; Harrison et al., 2018; Paterno et al., 2019) made specific reference to this being a key criterion to be able to carry out the PM role. Others also inferred that PMs needed to be either in the maintenance stage of their recovery or able to demonstrate a level of stability to continue in that role (Tober et al., 2013; Barker and Maguire, 2017). Most of the studies did not explicitly state what length of time individuals needed to maintain stability or abstinence in their recovery. One article, Parkman and Lloyd (2015) mentioned that 'mentors' and 'ex-service users' may have been abstinent for several years but did not define what several years

represented. Moreover, the definition of stability in recovery appears to be subjective and lacks clearly defined criteria. As will be discussed further below, given that the PM was viewed as a role model for others and a visible emblem of recovery, abstinence was viewed as a measurement of successful substance misuse intervention. Abstinence and being able to maintain abstinence also perceived to be a measure of individual transition in the recovery journey from one status (service user) to another (stability) and a move away from a previous life where they had constantly used substances.

The terminology used to define a PM and the key characteristics associated with the role are intrinsically linked to the roles they carry out within alcohol and drug services. The next section will explore and describes these roles.

The PM role: providing emotional and practical support

The published literature reviewed found that PMs' roles varied depending on the type of service in which they were based. There was a wide variety of tasks which PMs were expected to carry out. These included providing practical support to current service users and professionals to assist with service delivery, whether they were based within an 'inpatient' or community setting. Research by Schinkel and Whyte (2012), Roberts and Bell (2013), and previous and current drug strategies (HM Government, 2010; 2017; 2021) acknowledged that these are key roles provided by those individuals in recovery. As service users find it difficult to navigate the health and social care systems, PMs appear to be vital to help signpost to local support, such as, benefits, housing and mental health services (Schinkel and Whyte, 2012; Barker and Maguire, 2017; Paterno et al., 2019). The research also highlighted that this practical support provided by PMs was instrumental in aiding individuals with social integration and community engagement, especially following their release from prison (Schinkel and Whyte, 2012; Roberts and Bell, 2013; Tober et al., 2013; Moyes et al., 2016). Published literature has argued that peer support roles' have historically been

a key element of the 'community re-enforcement' approach (Tracy and Wallace, 2016). Bagnall et al. (2015) identified a further extension of those roles which included providing education, training and advice around healthy choices and care to service users.

Service users are often overwhelmed by the experience of accessing substance misuse treatment, whether it is their first treatment episode, or they are re-presenting to services. Consequently, service users found it difficult to trust services and those who worked within them. The research has accentuated that alcohol and drug use can often cause social relationships to deteriorate or break down with friends and family members. Often, this can lead to the individual becoming isolated and stigmatised, thereby reducing their self-esteem and confidence (Roberts and Bell, 2013; Harrison et al., 2018). Furthermore, research has highlighted that PM roles can boost self-esteem and confidence in building service users through social networking and kinship (Roberts and Bell, 2013; Breedvelt et al., 2014; Bagnall et al., 2015; Parkman and Lloyd, 2015; Moyes et al., 2016; Tracy and Wallace, 2016; Barker and Maguire, 2017; Edwards et al., 2018; Harrison et al., 2018). In addition, the current review has found that PMs can be an emotional aid to service users to build trust, support challenging stigma, and foster relationships with professionals and services (Roberts and Bell, 2013; Parkman and Lloyd, 2015; Harrison et al., 2018). Harrison et al. (2018:10) argued that these emotions can result from conflicting goals between service users and professionals which may perpetuate a 'them and us' relationship. However, PMs can often be viewed as bridges between service users and professionals. Furthermore, Breedvelt et al. (2014) and Barker and Maguire (2017) also argued that PMs' roles were to foster relationships, establishing trust and provision of emotional support with the wider substance user community and the service providers to improve access to treatment. This thesis further explores these areas.

Significantly, while the review highlighted the tasks and responsibilities which may be commonly carried out by PMs, the PM role is not without its difficulties. These include

role conflict, role boundary issues, group integration and dynamics, organisational barriers, and lack of induction or training (Hind, 2011; Schinkel and Whyte, 2012; Tober et al., 2013; Roberts and Bell, 2013; Tracy and Wallace, 2016; Paterno, et al., 2019). As noted earlier, studies have identified that the PMs' role is not well defined and communicated, which has led to role conflict and boundary crossing, whereby there is a lack of clarity regarding who does what on the service team. (Tober et al., 2013; Tracy and Wallace, 2016; Dugdale et al., 2017). PMs have expressed that they feel disfranchised by staff, not valued within their role, or treated as part of the wider team (Schinkel and Whyte, 2012).

Mutual benefits experienced by PMs

It has been argued that there are mutual benefits to PM and service users which can be gained by providing emotional support (Hay et al., 2017). One of the central expectations of this role is that PMs are encouraged to share their previous lived experiences of using alcohol and drug services with current service users (Tober et al., 2013; Parkman and Lloyd, 2015; Moyes et al., 2016; Dugdale et al., 2016 and 2017). Sharing was found to have a dual function. On the one hand, sharing one's lived experiences provides kinship with those still in treatment. The contribution of PM to services has been viewed as a recovery orientated intervention[2] that provides symbols of hope and empowerment to others (Hind, 2011; Tober et al., 2013; Tracy and Wallace, 2016). Current literature argues that it also demonstrated to others that their experiences were not unique to any one individual, that others have experienced these struggles before, and that they have managed to progress in their recovery journey (Hind, 2011; Schinkel and Whyte, 2012; Tober et al., 2013; Roberts and Bell, 2013; Dugdale et al., 2016; Barker and Maguire, 2017; Edwards et al., 2018). This builds service users' confidence by providing living examples of role modelling and

[2] Recovery-oriented treatment support entails a range of non-structured interventions that complement structured treatment and consolidate the gains achieved, enhancing the service user's overall quality of life. These interventions include peer support and mutual aid, as well as practical assistance such as housing or employment support and referrals to services, such as smoking cessation (NTA, 2010,2012; HM Government, 2010,2012).

recovery (Hind, 2011; Schinkel and Whyte, 2012; Tober et al., 2013; Roberts and Bell, 2013; Dugdale et al., 2016, 2017; Barker and Maguire, 2017; Edwards et al., 2018).

On the other hand, sharing common or similar experiences of alcohol and drug use validated the PM's own experiences and informed their identity, their recovery journey, and their transition from service users to PMs (Tober et al., 2013; Moyes et al., 2016); which will be explored further in the findings and discussion chapters. Additionally, PMs, by providing support to others, enabled them to reflect on their recovery journey and gain affirmation of their transition in their roles.

In conclusion, while the published research provided some insight into the roles carried out by PMs, it was clear that further research was needed to establish what roles they are undertaking within drug and alcohol services. In addition, the literature tells us little about how PMs learn about their roles and what processes are in place within teams or organisations to facilitate the transitional process. This is considered in the next section.

The changing identity of PMs and their potential career pathways or progression

There were only six articles which captured the views of PMs on how they perceived themselves, or how they were perceived by others. Several research studies highlighted that PMs had a strong desire to want to 'give back' to the services that had previously supported them (Tober et al., 2013; Parkman and Lloyd, 2015; Bagnall et al., 2015; Dugdale et al., 2016; Tracy and Wallace, 2016; Harrison et al., 2018). These findings show that 'giving back' was a way for PMs to reconcile the guilt, shame and debts associated with their substance abuse. Several psychological theorists have identified that the concepts of guilt and shame are linked and cultivated from childhood as individuals become more aware of their actions and their bearing on others (Freud, 1923; Erikson, 1950; Pedder, 1982; Jacoby, 1994). Therefore, guilt and shame are fundamentally connected with an individual's sense of self and related emotions when

harm is caused to others. Other studies identified that being a PM created a shift in their self and social identity. These studies suggested that PMs experience an identity change from being a 'service user' or 'criminal' to a PM identity (Parkman and Lloyd, 2015). Parkman and Lloyd (2015:55) suggest that identity change was closely associated with 'the individual adopting a positive recovery identity'. Furthermore, some studies highlighted that peer mentoring was used as an opportunity to facilitate their development and as a way of 'normalisation', such as, having more structured days and working towards gaining employment (Tober et al., 2013; Parkman and Lloyd, 2015; Dugdale et al., 2016; Dugdale et al., 2017). Some studies also suggested that this helped PMs foster social integration with their community and society at large by having a sense of purpose and being constructive (Tober et al., 2013; Roberts and Bell, 2013; Bagnall et al., 2015; Parkman and Lloyd, 2015). Furthermore, Parkman and Lloyd (2015) identified that becoming a PM helped sustain their recovery by getting involved in new experiences outside of using alcohol and/or drugs.

Most of the literature reviewed did not capture how staff and the organisation viewed the PM's role. Several studies found that staff felt that supporting PMs was time-consuming, and there was some discord when PMs strayed into roles usually performed by professionals, causing role conflict and boundary uncertainty (Tober et al., 2013; Dugdale et al. 2017). Some research indicated that PMs were not effective at managing boundaries with service users (Tober et al., 2013; Parkman and Lloyd, 2015). However, Roberts and Bell (2013) and Bagnall et al. (2015) suggested that staff recognised the positive contributions that PMs made to treatment services, which was discussed above. Given the limited data available, it was important to explore how other staff, as well as PMs themselves, perceived the PM's role within the alcohol and drug teams. With regard to career development and progression, there were only two studies, Dugdale et al. (2016) and Chapman et al. (2018) which suggested that the PM role was a progression from being a service user. This was achieved through the consolidation of the individual's lived experiences, and further training was provided as part of this role. Chapman et al. (2018) argued that there was a need for supervision and training to be provided within the PM roles as a developmental support

to individuals who may have no previous work experience and no other support mechanisms. Equally, drug strategies (HM Government, 2010, 2017, and 2021) suggest that those in PM roles can develop their recovery capital by becoming recovery champions. The literature reviewed also found little research to illustrate at what stage in a service user's recovery they were able to become a PM, and whether abstinence was a prerequisite. Similarly, there was no clarity about whether PMs also needed to have stopped receiving care interventions.

Finally, the published literature on the issue of financial incentives or compensation for the PM's role is limited or vague. Barker and Maguire (2017) were the only article which made specific reference to PMs being paid but did not expand on what the payment consisted of.

2.6 Summary of literature review

There is clear evidence that the role of PMs and their presence within services across a range of health and social settings, such as education, sexual health services, harm reduction, and criminal justice, has increased in recent decades. However, within the alcohol and drug services, research has focussed heavily on drug services, and there remains a scarcity of literature on how PMs are embedded in alcohol services and alcohol treatment interventions. Similarly, who PMs are, and terms used to identify them remain unclear. It would be beneficial to have a better understanding of how lived experiences are valued and used within alcohol and drug services, and whether being abstinent or working toward abstinence is a prerequisite to entry into the PM role. In addition, the current research highlights the roles and responsibilities commonly carried out by PMs which include advice, support, and signposting to other services. It would be useful to understand whether PMs within alcohol and drug services perform other roles in addition to those identified above. Furthermore, we need a better understanding of how PMs perceive themselves, their sense of self and

identity, and their views on whether their roles offer opportunities for change and self-development. Lastly, further exploration may be useful to understand how organisations may be able to develop PMs as human and social resources and further facilitate the integration of PM into the organisation and the alcohol and drug sector. The areas discussed above highlight gaps in the current literature surrounding PMs in alcohol and drug services and have been used to inform this study's research questions, aims, objectives, and research design.

Chapter 3: Theoretical Framework

3.1 Introduction

This chapter describes the theoretical framework used throughout this dissertation to explore and explain the role of PMs in alcohol and drug services in England. The theoretical framework for this research was a product of an iterative process starting with my main focus on the role of the PM, who they are, and how they are perceived both by themselves and others. Consequently, the initial focus was on exploring the concepts of self, identity, and roles. Upon reflection and informed by the literature scoping review and preliminary data collected from participants, it became clear that the theoretical framework also needed to encompass meso and macro level factors to help explain the processes involved in adopting a PM role. Other emerging findings regarding how PMs transition into their roles highlighted the need to include concepts of socialisation, organisational socialisation, and culture, and the concept of liminality within the transition process, to strengthen the explanatory framework. Employing these concepts helped identify and analyse what factors may support or hinder a PM's progression in their role.

Social ecological theory provides the broadest framework for examining the role of PMs. This draws attention to the multiple factors at macro/ meso and micro levels that influence the PM role and how it plays out in practice. As noted in chapter one, I recognise the importance of the macro level but focus in this research on meso and micro level factors and on the interaction between those two levels. Second, I discuss identity theories and the concept of 'self', considering how the individual adopts the role of PM and how identity and the sense of self changes in the process. Third, as the process of adopting the identity and role of PM takes place within the context of the organisation where the individual works and is influenced by the rules, culture, and working practices of the organisation, organisational socialisation theory helps us to

understand how factors at this level impact the adoption and enactment of the PM role. Finally, I discuss how transition theory and the concept of 'liminality' were helpful in examining the changes that take place upon entering and progressing through the PM pathway.

3.2 Social Ecological Model

The Social Ecological Model, originally developed by Bronfenbrenner (1979), enables an understanding of how different layers of influence interact to shape an individual's behaviour, opportunities, and experiences. A social-ecological framework recognises that although individual (micro) level factors such as demographics and lifestyle are important, there are also influential external factors outside of a person's control. Within an individual's immediate environment, meso-level factors may include, for example, living conditions, organisational and working contexts, social relationships, and networks. Wider macro-level societal and environmental factors also have the potential to positively or negatively impact a person. Such factors include national and local policies, social norms and values, the provision of services, social rights, and welfare support. The social ecological model provides a lens through which to examine how complex sets of factors operating at macro, meso, and micro levels influence the PM role and the transitional pathways from service user to PM and, for some people, from PM to occupational pathways beyond the PM's organisation. Within this broad frame of understanding, my study focuses on the meso (organisational) and micro (individual) level factors and uses three key theoretical perspectives to explore perceptions of the PM role, identity theory, organisational socialisation, and transition theory.

3.3 The concepts of Self and Identity

Social and behavioural scientists use a variety of phrases such as self-awareness, self-motivation, and self-belief to understand the 'self' and the context in which it develops. However, Ashford et al. (2001:131) argued that 'the self is not a unitary concept but a complex system of different constructs that requires various forms of investigation and probably involves different networks'. In addition, the self-concept is an assemblage of attributes or qualities that an individual perceives about themselves. How individuals appraise these attributes and the significance they attach to these qualities may be heavily shaped by those in the individual's immediate surroundings -peers, family, loved ones, work colleagues- and by the wider society - environmental or societal values, norms, and beliefs (Bailey II, 2003; Swann Jr, 2005; McAdams and Cox, 2010). Therefore, a useful definition of self-concept is 'one's self-identity, a schema consisting of an organised collection of beliefs and feelings about oneself' (Baron and Byrne, 1997:152). Earlier scholars have also explored these concepts of self, such as those introduced by the Harvard psychologist, William James (1890) and further described by Mead (1934) as a good starting point. Mead (1934) describes the 'self' as how an individual interacts between two phases. Firstly, the 'I', the subject phase of 'self' denotes how one spontaneously reacts to others, circumstances, and life events. Crawford and Novak (2014:69) contend that this phase is 'unconditioned, or untrained and is never fully within our control'. Second, there is the 'Me', which according to Mead (1934), guides the 'I' as the object phase of self, which can be constrained because of one's self-reflection through one's role-taking in a given situation. According to Crawford and Novak (2014), role-taking is the act of assuming the role of another and viewing the world from their perspective, the perspective of a single individual or a larger group or society. Through this process, an individual can shape one's behaviour and social interaction by gauging others' expectations, as shown in Figure 3.3. This concept helps us understand how PMs negotiate their interactions and behaviours (consciously or unconsciously) as they carry out their role and engage in alcohol and drug services. For example, the PM's 'me' will be engaged, as they will take the role of staff with lived experiences to support other service users. At other times, they will engage the 'I' as they show initiative as

a PM to provide ad hoc advice to both staff and service users regarding substance misuse interventions.

Conversely, Mead (1934) contends that the controls that one places on whichever phase (I or Me) is more dominant should depend on the context. For instance, the 'I' phase of self can be positively dominant, where there is a need for creativity and challenging the norms. However, he argues that it is the 'I' that makes us both unique and human. Using this understanding of the 'self', one can begin to understand how an individual's behaviour can be shaped by specific environments and contexts such as the workplace. Equally, it offers an explanation how an individual's adopting either the 'I' or the 'me' self and how this might change over the course of someone's transitioning into a role, such as with a PM, where they may need to engage different parts of the self. It is useful to explore the concept of identity, especially from personal, social, and role perspectives.

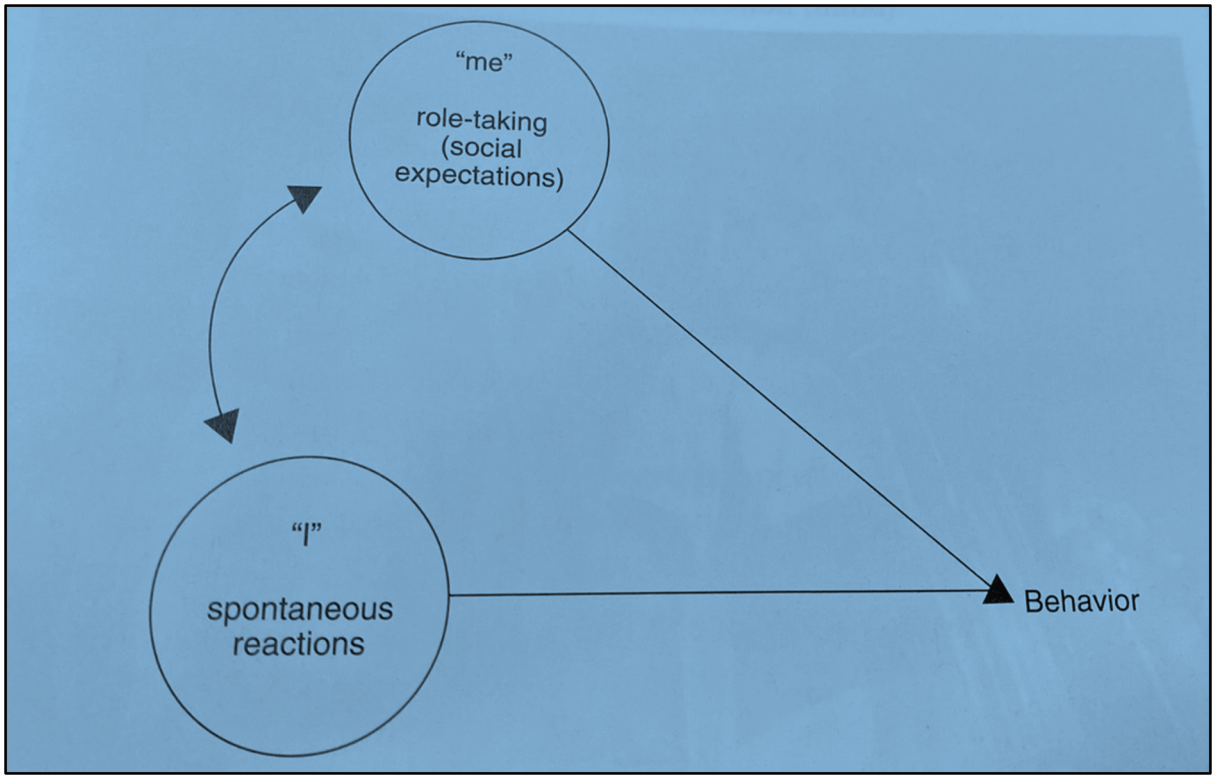

Figure 3.3 The Self and Social Behaviour (Sourced from Crawford and Novak, 2014: 232).

Personal

Scholars argue that an individual's sense of self or identity is shaped by a set of characteristics ordered by their significance (McCall and Simmons, 1966; Stryker, 1968; Chen et al., 2004; Oyserman et al., 2012). Consequently, when investigating identity, we investigated how an individual's personal, social, and cultural factors combine with their social context and how they fit within that group. Woodward (2003) also argues that each of us has a distinct sense of identity, which stems from recognising our differences from others. However, our interactions with others help us assess how we perceive ourselves and those we meet (Ashford et al., 2016). As described by Stets and Burke (2000), an individual's personal identity consists of the characteristics that distinguish them from others (Burke and Stets, 2009). These characteristics are influenced by a person's fundamental beliefs and values that shape their self-perception. One could argue that their uniqueness sets them apart from others (Hardy and Carlo, 2011; Stet and Carter, 2012). Personal identity is also intrinsically linked to how an individual perceives themselves and is dependent on one's sense of self, self-esteem, and self-worth (Tajfel and Turner, 1986; Hogg and Abrams, 1990; McAdams and Cox, 2010). Moreover, Trepte and Loy (2017) argued that a person's personal identity is intricately interconnected with the way their social and role identities are established, shaped, and preserved, as discussed below.

Social

According to Ecclestone (2007:122), 'identity is therefore constructed through complex interactions between different forms of capital (cultural, social, economic, and emotional), broader social and economic conditions, interactions and relationships in various contexts, and cognitive and psychological strategies'. Therefore, social identity refers to the qualities an individual attributes to themselves in a shared social role with others (Burke and Reitzes, 1981). Owens (2006) suggests that individuals

formulate and define their identities within a social context by utilising roles and institutions. According to Wetherall (2005), identity is also how the 'self' is portrayed in an ever-changing environment. Consequently, social identity assists individuals in comprehending their position within a group with which they identify, and which influences how they are treated (Hogg and Abrams 1988; Stets and Burke, 2000). Individuals can then choose to ascribe themselves to roles that inform their status. Similarly, a person's social identity is influenced by their adoption of the group's pervasive norms, values, and behaviour. A sense of belonging and the value placed on being a member of that group also shape their social identity, which is a good predictor of present and future behaviours (Jetten et al., 2014; Mawson et al., 2015).

As a PM, individuals begin to identify with other colleagues within the team by wanting to provide treatment and care to others for their alcohol and drug use and physical, mental, or social needs. Similarly, PMs may sometimes identify more strongly with the social identity of a service user when empathising with their substance misuse or as previous recipients of the services themselves.

Role

Role identity refers to the values and behaviours individuals adopt when taking on a particular role in their group or society (Stryker, 2002). According to Stets and Burke, (2000:225) 'persons acting in the context of social structure name one another and themselves in the sense of recognizing one another as occupants of roles'. Therefore, each individual tries to make sense of their identity, for instance, their role identity (being a father, a PM, a service user, an ex-service user), their social identity (what it means to be a male or female), or their personal identity (being a loving or caring or trustworthy person or a valued member of a team or service). Conversely, it is important that role identity not be confused with an individual's social identity. As discussed above, in social identity theory, an individual may identify with a group due to shared views, experiences, or values (Abrams, 1994). In contrast, possessing a

particular role identity involves fulfilling the role anticipated of them, typically via an ongoing process of discussions and collaboration with others (Burke 1980; Burke and Reitzes,1981; Stets and Burke, 2000). Role identity also brings into focus how individuals navigate and influence their micro social structures as part of adopting and undertaking a role within a group or organisation (Stets and Burke, 2000).

For instance, as a PM, they are expected to demonstrate behaviours which are similar to those of members of their alcohol and drug teams and to contribute to the safe delivery of care. As a PM, they will be required to adopt a new role which is different from their previous service user role. In some instances, this is sometimes difficult for individuals who have previously received treatment from that service due to self-esteem, confidence or lacking in work experience. In other instances, the PM role can come into conflict with how others perceive an individual who has moved into this new role – for instance, those who knew them as service users, such as previous key workers and other service users.

Therefore, understanding how an individual's social and personal identities are formed and altered is crucial to appreciating the impact that a role such as a PM may have on shaping these individuals' new identities. Notably, social identity is changeable and even more so during a period of transition or socialisation into a new role. The PM will be negotiating their newfound social status with their teams, among their peers, within the organisation, and in society at large. In many cases, the role of PMs can positively influence individuals. The concept of social and personal identity enabled me to better understand what impact, if any, the PM role may have on individuals who perform such roles and how they perceive themselves. The concept of self also has implications for the recovery pathways that an individual may choose. A strong sense of self may influence an individual to take ownership and be self-directed about how they engage with their treatment, their development and their future plans. This helped me to understand what motivates someone to undertake a PM role, as I will discuss in Chapter 5 (Findings chapter).

Having explored the importance of concepts of self and identity, it is now appropriate to explore how factors within the immediate organisation influence the adoption and enactment of the PM role. The next section discusses the concept of organisational socialisation as individuals adopt their PM roles.

3.4 Socialisation and Organisational socialisation

Socialisation is a relevant concept that can be used to comprehend how an individual can become acquainted with and transition into a new role or discipline. Sociologists, social psychologists, anthropologists, political scientists, and educationalists use the term 'socialisation' to describe the lifelong process of transmitting and disseminating norms, customs, values, and beliefs, thereby equipping an individual with the skills and knowledge required to participate in their society. This process occurs in a person's home, as well as in institutions, including schools, clubs, and workplaces. Baldwin (1911), who studied the concept of socialisation within developmental psychology since the 1900s, stated that as individuals, we often inherit, adopt, and enact the accumulated beliefs and values of groups and institutions and own them as our own which then shapes how an individual thinks, behaves, and identifies (Baldwin, 1911). Murray (1938) was one of the later theorists who examined the role of cultural norms and socialisation in relation to personality development. In addition, social psychology theorists such as Bandura (1977) and Tajfel (1981) have investigated socialisation in relation to social learning theory and social identity theory, respectively, in more recent years. While these are potentially relevant conceptual lenses that could have been used to investigate the role of PMs, this research focuses on organisational socialisation to help explain the findings and understand how those in PM roles underwent a socialisation process within the organisations where they worked.

According to scholars such as Van Maanen and Schein (1979: 211), the term organisational socialisation refers 'to the process an organisation uses to guide

individuals in desirable and acceptable workplace behaviours and attitudes, as well as those that are not'. Recent researchers such as Bauer and Erdogan (2011) also assert that organisational socialisation is a process that enables individuals to acquire knowledge and develop new skills that will allow them to be productive members of their organisation. Figure 3.4 shows a summary process model of socialisation below. The model comes from an earlier study on socialisation by Bauer and Erdogan (2011) which can be used to understand the processes which a PM might undergo as part of their socialisation into an organisation. Both the PMs and the organisation play an active role in integrating a new member into any team or organisation which could be through tools such as education, training, supervision, or aligning the policies and procedures to reflect all roles carried in an organisation.

Figure 3.4 below offers a diagrammatic representation of these onboarding methods, which support the socialisation process.

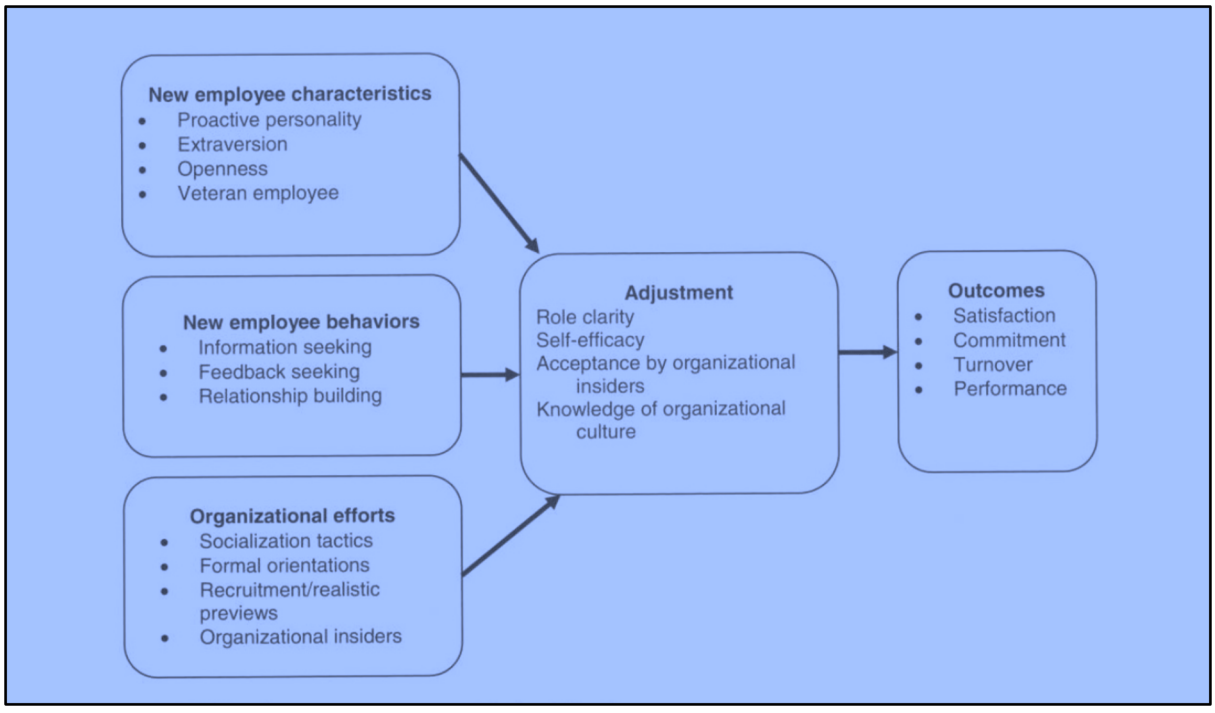

Figure 3.4 A model of the socialisation process Source: (Bauer and Erdogan, 2011:52).

Similarly, it is essential to recognise that the organisational socialisation process is not unidimensional and only partially focuses on meeting the organisation's needs. Rather, it also involves achieving the individual's goals for joining the organisation. Consequently, organisational socialisation consists of balancing the needs of both parties. The concept of organisational socialisation may aid in comprehending the factors that contribute to or present barriers to the progression of PMs during their transition from service users to PMs.

In addition, it is essential to note that the organisational socialisation process is not static but rather dynamic, evolving as an individual transition from being a newcomer to the organisation to being more integrated into the relevant team and the organisation as a whole. Thus, organisational socialisation is defined as the process by which a person becomes acquainted with the organisation and its role within it. Organisational socialisation is a fundamental process for PMs, as it is for any new member of an organisation. Scholars have identified three significant stages of organisational socialisation (Schein, 1971, 1974, 1980; Van Maanen and Schein, 1990; Bauer and Green, 1998; Falcione and Wilson, 1988; Louis, 1980, 1990). These three stages consist of (1) the Anticipatory Stage, (2) the Accommodation Stage, and (3) the Adaptation Stage and are discussed in succession in the following sections.

The Anticipatory stage

During the anticipatory stage, newcomers or individuals new to a role collect and evaluate information about their employers and begin to form expectations of their roles (Feldman, 1976a). During this phase, they prepare to integrate into the team and start performing their functions. For a smooth transition into the role, robust and thorough organisational processes that provide information about the organisation must be in place (Dailey, 2016). This stage is crucial for both the new employee and the organisation. It helps them maintain the organisation's norms, values, and culture

while enhancing the new employee's coping strategies and buy-in (Cable and Parson, 2001; Haski-Leventhal and Bargal, 2008).

The Accommodation stage

The next phase is known as the accommodation phase, during which individuals acquire knowledge and comprehension of their roles or employment. During this phase, individuals receive guidance through supervision, formalisation of organisational policies, and observation of others performing similar tasks. This phase is crucial for ensuring that individuals are adequately trained and equipped to fulfil their responsibilities and contribute to the organisation's success.

The Adaptation stage

The adaptation stage occurs when the individual no longer views themselves as a newcomer, but instead as a valued team or organisation member (Bauer and Green, 1998). Attaining this stage successfully is indicative of a successful socialisation process in which the individual has transformed from an outsider to an effective team member (Feldman, 1976b). Using the previously described stages in conjunction with the transitional theory discussed below, one can gain insight into how a PM can transition from an ‘outsider’ to a valuable member of the alcohol and drug services team.

In addition to the three stages of socialisation previously discussed, an understanding of organisational culture provides additional perspectives on the socialisation procedures essential for facilitating the transition of individuals into new positions. The concept of ‘organisational culture’ refers to the general nature of how work is accomplished and influenced by its leadership, values, and other corporate governance structures (Schein, 2010). Thus, an organisation's culture is composed

of both overt and often intangible principles that guide and affect how individuals or groups behave in line with their shared values and beliefs. Therefore, as discussed earlier, there is a close relationship between the concepts of self and socialisation. According to Berger and Luckmann (1966), an organisation's culture is a social phenomenon that helps to inform an individual's behaviours and interactions. Arguably, managers and leaders can use an organisation's culture to drive each socialisation stage to align with the values and attitudes that newcomers, such as PMs, should adopt or the values and beliefs that they hold as part of their personal identity. In many cases, newcomers to an organisation may be familiar with the workforce and may have previous life experiences, as is the case with some of the PMs studied. Thus, an employer may draw upon awareness of an individual's past employment history to support and inform them how they settle into their current role (Berger and Luckmann, 1966). The adaptation stage for an individual and settling into a new position is always challenging for individuals transitioning to a new environment. However, understanding an individual's prior work history can facilitate transition and create a smoother adaptation period for employees.

While an organisation or team can adhere to socialisation procedures in order to aid and cultivate a seamless transition within an individual's work environment, there are indicators of successful socialisation procedures, as suggested below.

Indicators of successful socialisation procedures

Several research studies indicate that various factors contribute to a successful socialisation process. Individuals who can demonstrate their alignment with respective organisational values, a better understanding of their role, successful completion of tasks, acquisition of job satisfaction, enhanced social integration, attachment to the organisation, and commitment to their work are examples of such indicators (Brett et al., 1990; Morrison, 1993a, 1993b; Bauer and Green, 1998; Wanberg and Kammeyer-Mueller, 2000; Cable and Parsons, 2001; Allen, 2006).

However, Kramer (2011) and Dailey (2016) argue that organisations and teams cannot have predefined stages and durations for organisational socialisation. Similarly, Haski-Leventhal and Bargal (2008) state that there is no concrete and established evidence that clearly contributes to factors and their roles in influencing the transition stage. Nonetheless, a few influences, such as acclimation to their supervisor, acculturation, job recognition, feeling involved, job competency, organisational goals or values, and role negotiation, may influence the process (Chao et al.,1994; Myers and Oetzel, 2003). Alternatively, Berger and Luckmann (1966) suggest that a person's socialisation into a new role may be influenced by their internalised values, attitudes, and social behaviour acquired during the primary socialisation stage.

The consideration of organisational socialisation and the factors that help or hinder successful socialisation into the PM role were, therefore, important in exploring the immediate structural influences on the PM. Having considered the organisational (meso) factors, I looked more closely at the transitional nature of the PM role using Schlossberg transition theory and the concept of liminality.

Schlossberg (1984) argues that change is an unavoidable aspect of life and that individuals must continuously adapt to such transformations, which may result from political, economic, social, or global factors, or even their own actions. Thus, individuals experience transitional phases throughout their lifetime. Schlossberg emphasises the need to comprehend both the transitional process and coping strategies that can assist individuals in adjusting more effectively. Thus, transition theory can potentially provide insights into the significant changes and alterations that individuals experience as a PM.

Given that substance use recovery necessitates change and transition (Mawson et al., 2015), Schlossberg's (1984) transitional theory framework directs our focus to the PM's role and its development, or lack thereof. Different transition theory models exist.

Benner's (1982) Stages of Development theory concentrates on an individual making the shift 'from novice to expert' using five stages of development, change, or transition namely – novice, advanced beginners, competent, proficient, and expert. The focus of this transitional theory is not on how to become a particular individual but on the process of gaining knowledge and skills. Another transition theory is Duchscher's (2001, 2008) Transition Stages and Transition Shock theory, in which, like Benner's theory, the emphasis is on building knowledge and skills over time through stages of doing (transition shock), being (transition crisis), and knowing (expert or competent). Finally, Schlossberg also highlighted a transitional theory of development – which was adopted for this research study. Schlossberg theory focuses on the changes to the individual's role, relationship, and perception, which is relevant to understanding how PMs adapt and change within their newfound role within the alcohol and drug team.

Schlossberg's different types of transitions

Schlossberg's (1984) transition theory framework defines a transition as any event or non-event that brings about a change in an individual's relationship, role, normal routine, or perceptions and assumptions. Additionally, Schlossberg's theory describes three different types of transitions:

1. Anticipated,
2. Unanticipated, and
3. Non-events.

The 4 'S' that Schlossberg (1984) defines as a framework for simple categorisation are provided below. This framework divides the transitions into three categories. The first transition is the 'anticipated' transition, in which changes occur as anticipated'. In these situations, individuals are well prepared and generally viewed favourably. One example is that of a service user completing their treatment journey and deciding to participate in a peer mentoring programme with their key worker's assistance. A

further illustration would be a shift in 'roles' or 'work status'. The second transition is related to 'unexpected transitions'. These occurrences are unplanned and unanticipated, such as relationship loss, relapse, and unexpected health conditions. The path to recovery is not linear, and increased stressors in the PM role may result in a relapse of substance misuse. This type of occurrence is not intended and may not result from an individual's actions but rather from personal, social, or organisational circumstances. The third and final transition identified by Schlossberg is a 'non-event', which occurs when an expected transition does not happen and the individual experiences a sense of loss or deflation. Although individuals are frequently encouraged to investigate the possibility of peer mentoring and may be provided with various developmental opportunities, it is not always guaranteed that they will transition into PM roles. Numerous factors that have aided or hindered the development of individuals are explored in the findings and discussion chapters that follow.

The 4'S' system of coping to support a transition.

Schlossberg (1984) identifies the factors that support an individual in coping with what she describes as the 4'S' systems which are also regarded as positive influences on the individual's transitions. They include:

(a) the situation,

(b) the self,

(c) support, and

(d) strategies

A person's understanding of a situation involves examining the transitional triggers, the amount of control they have over a situation, whether there has been a change in role, and the duration of a transition. An individual's perception of transition plays a significant role in determining their reaction to change and whether the event is viewed

as positive or negative. Second, an individual's self-awareness is essential for coping with the transition and for recognising their strengths and weaknesses. This transition requires an awareness of one's characteristics and psychological resources which are invariably connected to a person's sense of self and self-esteem. Third, it is essential to consider the type and level of support, as discussed previously in the context of socialisation. Support varies from individual to individual and from organisation to organisation. For instance, having intimate solid relationships with partners, family, and friends can positively affect one's transitional outcomes. Developing secure networks within their communities, such as mutual aid groups and institutions, or organisations, such as workplaces, is also helpful during the transition process. Lastly, assessing an individual's comprehension and capacity to adopt appropriate coping strategies to aid in the change transition is necessary. This strategy may involve altering the situation or the individual's perception of the problem, such as viewing the loss as an opportunity for change or ignoring or denying the issue. Significantly, it may depend on an individual's responses and actions to the transition-induced stress.

These four 'S' systems are relevant when applied to the role of PM. These theories have helped shape the research interview schedule and the analysis of the results concerning socialisation in a new environment and organisation. While the transition theory provides a valuable framework for examining the PM's individual developmental, organisational, and health transitions, one additional concept offers a more robust framework for comprehending the PM's transition. Throughout their recovery journey or chosen pathway, PMs experience changes and progression, but the transitions are complex. They can be fraught with uncertainty, which can be challenging for individuals experiencing them. Consequently, the concept of liminality can enhance our understanding of this transitional process and how individuals can navigate changes in their lives and circumstances.

3.6 Liminality and Occupational Transition as it relates to PMs

The concept of liminality has been beneficial for understanding an individual's experience of transition as part of the PM role. Liminality was conceptualised by Van Gennep (1960) as *a rite of passage* for an individual. Both Van Gennep (1960) and Turner (1967,1984) describe this phase as a liminal state in which individuals transition from one status to another. Van Gennep (1960) noted that there are three phases: separation, transition (liminality), incorporation (investiture). He argued that individuals would move through the pre-liminal, liminal, and post-liminal phases (Van Gennep, 1960:21). Therefore, it infers there is a 'before' and 'after' state and the liminal state is where the individual shifts from one state to another (Ashforth, 2001; Fiol, 2002; Beech, 2011). Turner (1967) also described the liminal state as a 'betwixt and between space'. Meyer et al. (2010) offer a simple but valuable example to explain this liminal stage more clearly. They stated that the liminal state could be likened to a phase when a child is going through puberty. Therefore, it can be argued that the individual is no longer seen as a child, nor can it be viewed as an adult at this point.

In the case of my study, it is an instrumental concept to understand individuals' experiences within an organisational context, as they transition from the status of service users to the role of PMs. Some studies have argued that the liminal stage within an organisational context can cause upheaval and disruption for individuals as a result of the fluidity and unstructured nature of the individual's position at the time (Turner, 1982; Czarniawska and Mazza, 2003; Beech, 2011; Hoyer and Steyaert, 2015; Bamber et al., 2017). Organisational literature on the effects of liminality and individual well-being has been mixed. For example, Galais and Moser (2009) described that individuals in a transitional role could experience poor well-being by feeling a lack of belonging to the organisation. Alternatively, they contended that individuals who have a strong organisational commitment might experience positive well-being by feeling valued and contributing to the organisation's objectives. Equally, it is suggested that the frequency, and the order of transitions could vary depending on a person's roles within the organisation (Ellis and Ybema, 2010; Beech, 2011). For

instance, Beech (2011) argued that someone who engages in a contractual or temporary work role may experience a more prolonged liminal state. This can be attributed to the fluctuation in their social identity because they do not belong to the organisation, but still engage in work and activities to achieve organisational objectives (Beech, 2011). Furthermore, Beech (2011) also states that an individual liminal state and the length of that liminal state may be influenced by the individual's perceptions which are linked to their work position and their well-being during the process of transition. Finally, the liminal state, the success of their transition, and the individual's identity are related to how easy it is for them to build relationships between parties not only on an individual-to-individual basis, but more broadly on an organisational or societal basis (Shotter, 2008).

3.7 Summary of the theoretical framework used

As mentioned earlier, the theoretical framework for this research was a product of an iterative process starting with my main focus on the role of the PM, who they are, and how they are perceived by themselves and others both within personal and organisational settings. Initially, I explored the concepts of self, identity, and roles. When it became clear that the theoretical framework also needed to encompass meso and macro level factors, I used Social Ecological theory and organisational socialisation to examine how factors at macro, meso and micro level interacted and impacted on the PM role. The need to understand the transition pathway from a service user to a PM led to the examination of transition theory and the concept of liminality. Employing these theories and concepts helped to highlight what factors that may support or hinder PM progression in their roles. This chapter has provided an overview of the theoretical framework and relevant concepts that have guided and partly emerged from the analysis of the data. Concepts of self, identity and role, socialisation, and, in particular, organisational socialisation and liminality within the transitional process, were employed in this research to understand how the individual influences and is influenced by the transition from service user to PM.

In the next chapter, I discuss the methodology and methods used in this research. The chapter explains why the study design was chosen, the research procedures and tools, and the methods used to analyse the data.

Chapter 4: Research Design and Methodology

4.1 Introduction

This chapter outlines the ontological and epistemological considerations of this research. It includes details of the design, approach, and analysis required to formulate the research questions and aims (Saunders et al., 2009; Crotty, 2020). I also discuss the critical methodological issues, such as ethical considerations and the criteria used to ensure a high-quality qualitative research study in line with my chosen research design (Guba and Lincoln,1981,1994), and my role as a researcher.

4.2 Research Questions

Before exploring the research design and methodology, it is beneficial to consider the research questions which guided the research. As stated in section 2.2, this research focused on individuals who had previously used alcohol at a dependent level and now worked within alcohol and drug services as PMs. The literature review informed the formulation of the research questions, as it provided an overview of what is already known, identified gaps in knowledge, and areas that this study could examine.

Research questions:

1. How are the roles of PMs in the delivery of alcohol and drug services defined and perceived by PMs themselves and by other workers in their organisations?

2. How is the role of PMs in the delivery of alcohol and drug services enacted by PMs themselves?

3. What key personal and organisational factors influence the transition from service user to PM?

4.3 Research Design

A research design provides a clear framework and process for the investigation (Sileyew, 2019). This study sought to analyse the roles of PMs in alcohol and drug services and assess PMs' own and others' perceptions of this role, thus requiring a design that would meet that aim. A qualitative research design proved to be highly beneficial for this study, as it helped to explore and understand the phenomena under consideration, providing 'an insight into the socio-cultural context of people's lives' (Hennink et al., 2020:41). This qualitative approach (explained in more detail in the section below) also granted access to a wide variety of rich and nuanced perspectives from participants and increasing the overall understanding of their individual circumstances (Miler, 1991; Saunders et al., 2009; Sileyew, 2019). Additionally, this process allowed for the incorporation of theories and concepts that emerged with the data accumulation; this iterative, collaborative approach (having a continuous dialogue with myself and applying the advice offered by my supervisors) was necessary to generate a quality research outcome. This research design process evolved along a continuous pathway, combining the three salient components of the research questions, methodology, and theories, as shown in Fig. 4.4.

4.4 Methodology

This research takes a social constructionist approach to understanding the experiences of individuals who have previously used alcohol and drug services and have transitioned into the role of PM. In essence, this research aims to explore how people construct an account of their personal recovery journey using available

narratives as they work towards a new identity. The ontological and epistemological considerations of this study are discussed below.

Ontological and Epistemological considerations

PMs within alcohol and drug services operate in environments that are not objective realities but social constructs. The roles they carry out, staff attitudes, and the organisation's culture within which they interact are everchanging. These realities are also informed and framed by the respective organisational drivers, for instance, organisational strategic goals and national policy drivers. Hence, this study attempts to understand who PMs are and what transitions they may experience in these complex organisational environments. Earlier research on PMs concentrated on the PM's recovery (Best and Lubman, 2012; Roberts and Bell, 2013), their recovery capital gained (Granfield and Cloud, 1999; Laudet and White, 2008), and changes in alcohol and drug policies implemented by successive governments (Stimson, 2007; Scottish Government, 2008; HM Government, 2010). In a departure from this, this research concentrated on the PM role and their development as a member of the alcohol and drug team, following their lived experiences of treatment for alcohol dependency. In addition, this research sought to examine which factors (individual and organisational) appear to facilitate development and those that may hinder growth and place limits on the progression of PMs. Thus, this study provides a holistic and in-depth exploration of the PM's transitions and developmental trajectories.

To explain this further, please see Figure 4.4 below, which shows the relationship between epistemology, theoretical/conceptual perspectives, methodology, and research methods (Gray, 2009).

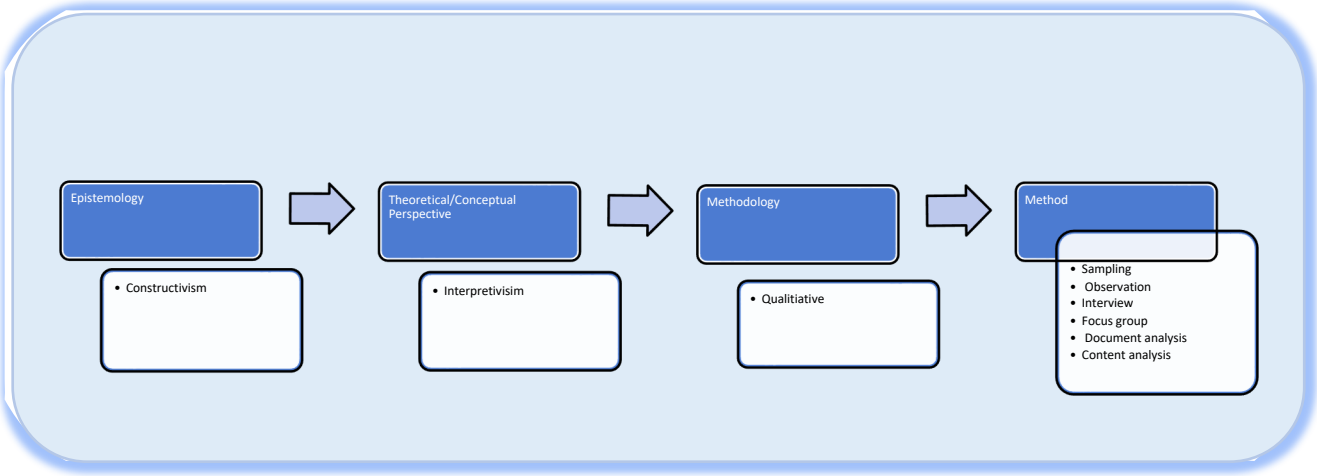

Figure 4.4 The relationship between epistemology, theoretical/conceptual perspectives, methodology and research methods (Source: adapted by author from Gray, 2009:56).

As a researcher, I wanted to understand the research participants' perspectives better. Therefore, it was essential to view the world through the participants' eyes to understand their contextualised human experiences and the meaning they ascribe to them (Schwandt,1994). This philosophical assumption is deeply rooted in constructionist ontology and interpretivist epistemology. As such, I adopted the constructionist view of reality and understanding of the world, which contends that people construct their own reality from their human backgrounds and experiences, and that their worlds are maintained by the actions they carry out (Cohen and Manion, 1994; Jaspahara, 2004; Gray, 2009; Creswell, 2003; Yanow and Schwartz-Shea, 2015).

Consequently, drawing upon a social constructionist orientation, it is evident that an individual's experience is co-created with other people, in which the precise meaning is likely to be dynamic and may differ between individuals (Goldkuhl, 2012; Moon and Blackman, 2014; Burrell and Morgan, 2017). This strongly endorsed my decision to adopt an interpretivist assumption using a range of perspectives and approaches to inform my investigations. This is further explored in the next section below.

Interpretivist Assumptions

Interpretivism is predicated on a life-world ontology and is based on a non-foundationalist orientation[3]. Essentially, this means that as a researcher, I am working on the premise that one's experiences are both theoretical and value-laden, and that exploring one's social world cannot be limited to the pursuit of an objective and detached truth (Guba and Lincoln, 2005; Amis and Silk, 2008; Leitch et al., 2010). Therefore, we all construct our own realities and beliefs as human beings through communication and observation of others. As a result, using this ontological assumption, I would argue that an individual's (PMs and staff working with them) beliefs and perceptions can lead to multiple truths regarding a situation or reality. Creswell (2003) and Yanow and Schwartz-Shea (2015) supported this viewpoint by claiming that interpretivist researchers discover reality through participants' perspectives, personal histories, and experiences. This ontological assumption has informed my research aims, particularly understanding how PMs with lived experiences of alcohol dependency make sense of their roles and how they define themselves. It has also influenced how I attempted to understand and interpret the perceptions held by the organisations (staff and management) that provided work-related experiences and the policies and procedures that framed the workplace environment in which PMs operated, namely the organisational culture.

On an epistemological level, using an interpretivist paradigm, it can be argued that an individual's knowledge of reality is a social construction that depends on their interactions, experiences, insights, and environments (Burrell and Morgan, 1979). As a researcher, I tried to capture the PMs' experiences in their current roles and what

[3] Non-foundationalist research is based on the argument that all knowledge is theory and value laden. That there is no possibility of discovering an absolute truth which is unbiased and is influenced by the context of research environment and the researcher's own input and construction of the truth, (Harrison et al., 2009). 'There are no hypotheses to be tested, proven, disproven, or retested, as there are no objective facts to uncover' (Amis and Silk, 2008:457).

processes or transformations may have occurred prior to this. I also wanted to learn how those who work directly or indirectly in an alcohol and drug service setting perceived PMs roles or their progression, for instance, from that of a service user to a PM. This would provide me with a wealth of information about my participants' perspectives on their work environments. Researchers who embrace an interpretivist paradigm frequently adopt a qualitative approach, relying on research tools that enable them to collect data that reveals feelings, emotions, and perceptions (Gray, 2009). I delve deeper into this in the following section.

A Qualitative Approach

In this research, a qualitative approach was adopted to gain a comprehensive understanding of the roles of PMs and other stakeholders in the drug and alcohol service sector. Using this approach, I was able to accomplish the goals I had set for this study through dialogue with research participants in their natural settings (Creswell, 2009). Using a nuanced understanding of the rich, contextual, and non-numerical data (Mason, 2002), I was able to attain the key objectives of this study: first, a rich and deep understanding of participants' experiences (Chase, 2008); second, the capacity to accurately interpret the participants' meanings, beliefs, attitudes, and motivators (Onwuegbuzie and Johnson, 2006; Polkinghorne, 2007; Denzin and Lincoln, 2008); and third, explore participants' reasons for thinking the way they did (Onwuegbuzie and Johnson, 2006; Denzin and Lincoln, 2008; Creswell, 2018). Achieving these goals required a methodological tool, such as semi-structured interviews (Janesick, 1994), that allowed for a detailed exploration of the topics. Furthermore, an exploratory approach was used to gain information about the participants, allowing for a critical understanding of their stories and experiences (Elliot, 2005; Liamputtong and Ezzy, 2005). This reflects the close synergy between interpretivism and the qualitative methods.

4.5 Methods

The choice of research methods reflects an epistemological stance rather than the 'mere application of a specific data-gathering technique' (Perren and Ram, 2004: 85). Taking this into account, and to assist me in answering my research questions, I employed a variety of commonly used research methods and tools which will be discussed in turn:

- A comprehensive literature review of the existing research on PMs is presented in Chapter 2.
- A service mapping exercise (SME) of London-based alcohol and drug services' websites.
- Semi-structured interviews were conducted (face to face and remotely) with both PMs and staff who worked in alcohol and drug services.
- Other data collection tools: participant observation was carried out with PMs and staff within the services.

Service Mapping Exercise

I conducted a Service Mapping Exercise (SME) to gain insight into the landscape of alcohol and drug services in this field, focusing on London-based alcohol and drug organisations' websites (see Appendix 2, Table 4.5[a]). Table 4.5(a) shows publicly available information on PMs from the four organisations involved in the study. In the first column, the table shows the name of the organisation (anonymised) and whether they were an NHS or non-NHS organisation; the second column highlights whether training was provided or not; the next column, whether the role was paid or not; and the last, included information shown on the respective organisation's website (not altered apart from anonymising any information which may identify the organisation directly).

I undertook a two-stage approach to the mapping exercise. First, I conducted an extensive search to determine the type and number of alcohol and drug services offered in London. Subsequently, a more thorough process was employed to explore which alcohol and drug services had PMs operating within their teams, and to gather more precise details.

In the initial phase, I meticulously compiled an inventory of alcohol and drug services overseen by Public Health England (PHE) and Clinical Commissioning Groups (CCG) throughout the London region, distinguishing between services managed by NHS and non-NHS organisations. Subsequently, I methodically examined the corresponding websites to acquire publicly available data concerning terminology utilised to recognise individuals with past experiences of alcohol or drug misuse, as illustrated in Chapter 2, the literature review. Using this information, I developed a comprehensive set of definitions and enumerations of tasks and functions routinely executed by PMs within these services. The data encompassed grey literature generated by the respective institutions concerning PM roles. This literature contained guidance for staff on the distinctions between staff and PM roles, whether the PM roles were paid or non-paid, the training packages for PMs, and the topics covered (where available). The SME information yielded a deeper understanding of the PM role's scope and facilitated comparisons with other positions within the alcohol and drug workforce (see Appendix 3, Table 4.5 [b] and Appendix 4, Table 4.5 [c]). Table 4.5[b] captures the grey literature collated from organisations which are used to inform staff of the different PM roles, their responsibilities, the employment check, PM's remunerations, potential training available to these roles, and the level of accessibility granted (IT and/or staff areas) to the PM role. Table 4.5 [c]) shows the list of participants who took part in the study, their roles, and the pseudonyms assigned to protect their identities.

Subsequently, through email, I contacted thirty-two services encompassing both NHS and non-NHS providers, as indicated in the service mapping document. An example of the email sent can be found in Appendix 8. In addition, reminder emails were sent to augment the response rate, resulting in another six services responding and providing additional information. The emails sought data on whether they were

commissioned to provide alcohol or drug interventions or both, whether they used PMs in their services, the presence of job descriptions and person specifications for PM roles, and whether they were potentially happy to share these documents.

Moreover, I compiled data on the training packages offered and topics covered within the PM training sessions. It is imperative to highlight that some services employed a generic email address for a cluster of services, while others relied on a centralised email address to manage all PM recruitment processes. Consequently, I was able to efficiently gather information pertinent to multiple services concurrently. Furthermore, one proactive organisation invited me to present my research proposal at their clinical and operational management meetings. This opportunity facilitated valuable interactions with committee members including senior managers, clinicians, practitioners, and PMs, paving the way for subsequent interviews to be scheduled.

Study sites: identification and access

Data from the SME was employed to pinpoint potential study locations. Consequently, it became increasingly evident that numerous services did not exclusively offer structured alcohol interventions, and similarly, not all service sites incorporated PMs within their team's service matrix. Upon initially scrutinising the SME data, I also discerned a heightened emphasis on drug interventions instead of alcohol, resulting in a significant reduction in accessing PMs possessing first-hand lived experience of alcohol services. This led to the identification of ten study sites suitable for accessing PMs who have personally encountered alcohol misuse.

I implemented various strategies to recruit participants from the list of the ten study sites. Primarily, the respective gatekeepers (service managers and the organisations research teams) accountable for the study locations were contacted via email. I briefly outlined the proposed research to maximise participation and attached a copy of my study's ethical approval from Middlesex University. Additionally, I extended the offer to meet with individuals, teams, and committees responsible for gatekeeping within the respective organisations. Subsequently, upon receiving responses from

gatekeepers, I promptly contacted them to ascertain whether they needed further information about my research to facilitate participant access. This strategy not only assuaged the concerns of the gatekeepers but also fostered trust by ensuring that all ethical considerations were considered to protect participants and organisations from potential harm. Furthermore, I leveraged my existing professional connections to secure access to other potential gatekeepers.

Finally, to bolster participant engagement, I contacted the Head of Public Health for England (London) for alcohol and drug services. I sought the opportunity to present my research proposal at one of their pan-London specialist psychiatrist forums. This crucial step allowed me to obtain strategic support from key decision makers within the identified London alcohol and drug services, enhancing the research's academic persuasiveness, fluency, and criticality.

Interviews with PMs and other stakeholders

Using the data identified in the literature review and the SME process described above, I identified gaps in the current literature and captured common themes to inform my research objectives. The next step was to create a rough draft of the semi-structured interview schedule which I created in collaboration with my academic supervisors.

The utilisation of semi-structured interviews proved to be fitting, as they aligned with the ontological and epistemological assumptions I embraced while also reinforcing the qualitative methodology. Furthermore, semi-structured interviews enabled the acquisition of empirical data regarding the social realm under scrutiny by prompting participants to discuss their lives (Glaser and Strauss, 1967; Miles and Huberman, 1994; Holstein and Gubrium, 2000). In addition, Kvale and Brinkmann (2009) contended that the development of qualitative interviewing conventionally integrates scientific techniques, the interviewer's abilities, and adherence to a prescribed set of interviewing guidelines. Therefore, interviews are among the most effective avenues for gathering authentic, personal accounts of participants' experiences (Rubin and

Rubin, 2012; Miller and Glassner, 2004). Furthermore, interviews typically involve face-to-face interactions between participants and researchers, which can lead to more nuanced data collection (Gubrium and Holstein, 2001).

Before March 2020, my interviews were conducted exclusively face-to-face[4]. However, this method was slow owing to logistical challenges, such as synchronising schedules and finding suitable interview locations. However, I favoured this technique, as it provided a more intimate and insightful understanding of the respondents' perspectives and surroundings. Furthermore, it allowed me to observe subtle details during the interviews, such as facial expressions, body language, and conversational nuances, including tone and intonation, which contributed to the contextualisation and depth of the data I deemed crucial for corroborating my subjective interpretation of the interview transcripts (Fontana and Frey, 2008). The semi-structured nature of this approach promoted a balance between a structured questioning process and conversational fluidity, which encouraged open, unhindered dialogue. Utilising open-ended questions enabled me to unravel the tasks undertaken by the PM and the factors that either facilitated or impeded their role. Concurrently, this strategy sheds light on the extraneous influences on their responsibilities, such as the availability or absence of support that could have assisted or obstructed their transition into the role. In addition, interviewing staff members offered them a platform to relay comprehensive accounts of their perceptions of PMs, supplying me with invaluable insights into their sentiments and opinions regarding their work-based relationships. Semi-structured interviews also furnished an ideal medium for delving into participants' emotions and perceptions about their current positions and prior work experiences (if any).

Moreover, I aimed to ascertain how their roles influenced their sense of identity, focusing on their transitional journey and potential societal reintegration, where applicable. Essentially, this data collection instrument empowered participants to

[4] All interviews conducted after March 2020 needed to be switched to online (Zoom/Skype) or telephone because of the COVID-19 restrictions at that time.

elaborate and share their individual trajectories and experiences more comprehensively (Wengraf, 2001; Rapley, 2012). Finally, a pilot phase, outlined below, was conducted to assess the practicality and suitability of the draft interview schedule.

Conducting a pilot of the initial draft of interview schedule

In August 2018, the first two interviews (consisting of a project manager and a staff member from a selected service) served as a pilot test for the interview schedules. On a procedural level, the pilot phase served to validate the feasibility, practicability, and suitability of the research design. In addition, the primary purpose of this procedure was to determine whether the interview questions were understandable to the participants and whether they generated sufficient and in-depth data to answer the research questions. In addition, it was essential that the applied research methodology was not rigid but somewhat flexible enough to identify emerging themes and provide clarity regarding previously gathered data (Denscombe, 2014). I determined that the first two interviews were of sufficient quality and were included in the study's findings. I also made several alterations to the initial interview schedule based on insights gleaned from the interviews. For example, some questions were reworded, and I altered the order of the questions to ensure a smoother transition between topics. In addition, it was advantageous to include additional prompts for me to gain a deeper understanding of the participants' roles and their perceptions of future growth.

After completing the pilot interviews, I conducted a total of 42 semi-structured interviews working across four different alcohol and drug organisations within the London area, with the last interview conducted in September 2020. Please see (Table 4.5[d]) below, which shows the number of staff interviewed and their designations. A more comprehensive list is provided in Appendix 4.

Table 4.5(d) The number of semi-structured interviews conducted and role designations

Designation or Job roles	Numbers interviewed
Senior Managers	3
Service Managers	2
PM Managers	6
Team leaders	7
PM Co-ordinators	3
PMs	18
Recovery Champions	3
Total	**42**

During the research, I conducted a total of ten face-to-face interviews, consisting of seven PMs and three staff members, up until February 2020. The primary reason for this slow progress was the time taken to obtain ethical consent from the various organisations, which is discussed in the 'challenges to data collection' section below. As a result of the global COVID-19 pandemic, the remaining 32 interviews were conducted remotely (Zoom or telephone), and two additional questions, accompanied by their respective prompts, were incorporated into the interview schedule from March 2020 onwards (see Table 4.5(e)). This adjustment aimed to address the environmental shifts that significantly impacted the PMs, staff members, and their organisations[5].

[5] All interviews conducted after March 2020 needed to be switched to online (Zoom/Skype) or telephone because of the COVID-19 restrictions.

Table 4.5(e) Questions and prompts added to the original semi-structured interview schedule for all participants

Additional Question 5a.	Can you describe whether the COVID-19 pandemic has had any positive or negative effects on the using of peer mentors or on you as a peer mentor/ volunteer in the service?
Additional Question 5b.	Can you give me any examples?
Additional Question 6	Have there been any adaptations which have been put in place as a result of this?

The PMs and staff members were assigned pseudonyms to maintain their confidentiality. Likewise, I provided all individuals mentioned in the interview transcripts or observational notes with coded alias. Given the small number of alcohol and drug providers based in the London area, no biographical information about the participants was included in this thesis to prevent easy recognition. Furthermore, during the data collection process, frequent communication with academic supervisors took place to address any questions or concerns related to ethical data collection practices.

Finally, to further minimise the risk of identification, demographic details such as age, gender, and ethnicity were not included in the participant list. However, I provided a list of participants (using pseudonyms), their designations, and the associated organisation where they held these positions (see Appendix 4, Table 4.5 (c)). Demographic data of the PM participants were gathered, encompassing aspects such as age, gender, and ethnicity. Analysis of the collected data revealed that 14 PMs were male, with an average age of 48 years and range of 34-67 years. The average age of the seven female PMs was slightly lower at 45 years, with ages ranging from 33 to 55 years. The data distinctly demonstrated a heightened presence of male PMs entering PM roles in contrast to their female counterparts. Within the male PM demographic, nine men were identified as White British or Caucasian, while two men

identified as British Asians and three men as Black or Caribbean British, respectively. Female PMs were predominantly identified as White British, accounting for five women, with the remaining two females identifying as Irish and British Asian respectively. Sixteen of twenty-one PM participants exclusively used alcohol and no other substances. The other five PM participants reported that they either used alcohol and drugs concomitantly or alcohol as part of a cross-addiction to their drug use. Equally, 15 of the PM participants disclosed that they had been in previous employment either prior to or during episodes of substance misuse and subsequently became a PM.

Among the staff across the four sites, eight were male and 13 were female. The average ages for both sexes were the same at 42 years old, with a slight difference in age ranges between male staff, ranging from to 31-52 years old, and female staff ranging from 33 to 59 years old. The ethnic composition of female staff included 11 people identifying as White British or Caucasian, one British Asian, and one Black British. Four male staff members identified as White British or Caucasian, followed by one male staff each who identified as Black British, Black African and British Asian.

Other data collection methods: participant observations

Participant Observations

At the inception of this research study, I considered various data collection techniques, including participant observations (PO), to facilitate data triangulation. Participant observation constitutes a data collection methodology wherein the researcher observes or actively participates in the event or phenomenon under examination (Creswell, 2003; Sileyew, 2019). PO is a robust instrument for data collection that can augment the validity of the gathered data by virtue of in-depth knowledge and rich insights attained from the direct observation of participants (Sileyew, 2019). Before the COVID-19 lockdown, I managed to conduct two brief PO sessions at two different service locations. Both sessions took place in the waiting areas of the respective services, where I observed three PMs (two PMs in one service and one in another)

performing their roles alongside the other staff members. This granted me the opportunity to observe the interactions between PMs and service users present at the time, as well as the rapport between PMs and their other work colleagues (staff members). My observations incorporated the participants' body language and the skills employed during these engagements. Immediately after the two PO sessions, I documented my reflections on the proceedings, an undertaking that would have been challenging and intrusive during the sessions themselves. In one of the PO sessions, I also had the opportunity to witness a PM's interaction with a staff member present, allowing me to gain valuable insights into participant behaviour within their natural context (Silverman, 1985 and 2013). Regrettably, the COVID-19 lockdown restrictions precluded the possibility of further PO sessions. Likewise, prevailing staff management protocols necessitated remote working, with PMs unable to access services due to social distancing and work-from-home measures becoming mandatory at the time.

4.6 Sampling of research participants

By the end of the research, I drew participants from four organisations across the London area. Three of these were national non-NHS (charity) providers and one NHS provider which used PMs as part of their service provision model. All three of the non-statutory alcohol and drug services also provided services outside of the London area and can be described as national alcohol and drug service providers. Participants were also drawn from services which provided both alcohol and drug services. As previously noted, none of the services exclusively provided alcohol only interventions in accordance with the commissioning agreements. Most of my research participants were gained through requests made via the service level gatekeepers in the respective organisations. The gatekeepers were mainly PMs managers and service managers of alcohol and drug teams within the organisations. To support the gatekeepers, I shared the given inclusion criteria that my participants needed to meet; for instance, PM participants needed to have received structured alcohol treatment interventions as a critical criterion. However, PM participants who had received structured

interventions for other substances along with alcohol (such as heroin, crack cocaine, benzodiazepine, and new psychoactive substances [NPS]) were also considered.

Due to the limited number of gatekeepers, I had to use a convenience sampling method and a 'snowballing technique' to gather more PM respondents. This sampling technique is used when participants are chosen based on their willingness to participate, accessibility, geographical proximity to the researcher, and if they meet the criteria of the study (Saumure and Given, 2008; Etikan et al., 2016). Using the snowballing technique, I encouraged the interviewees to recommend possible participants who could contribute to the research. This strategy worked well, and I was able to connect with more PMs and staff members. One of those contacts was a senior manager in charge of the regional policy development and implementation. Eventually, this approach allowed me to recruit five additional PMs for this study.

4.7 Interviews- Research procedures

All face-to-face interviews (n=8) [two participants were interviewed twice, first as part of the pilot interview and then as part of the regular interview schedule] were conducted in comfortable rooms at the service sites. The interview rooms were arranged in advance with the respective gatekeepers so that there would be minimal disruption, and the participants would feel comfortable sharing data in a safe and confidential environment. Before the start of each interview, the participants (PMs and staff) were read and given information about the research study, again using the participant's information sheet as a proforma to guide the information shared (please see Appendices 10 and 12). I also shared information with the gatekeepers and participants before the participants agreed to participate in the study. By sharing the proforma participant's information sheet again also allowed me to provide additional assurances about confidentiality and remind them that they were free to share as much or as little information as they felt comfortable in doing. I reminded all the participants that they could terminate the interview at any time, but none did so. At

this point in the data collection process consent forms were also completed and signed, reassuring the participants of their anonymity. I gave a pseudonym to each participant to support this further. In addition, all audio recordings, completed forms, and notes were stored securely in a locked case while being transported from the interview sites to a locked cabinet. All the participants volunteered their personal stories and expressed that they were comfortable and happy to do so.

The subsequent interviews took place via telephone (n=6) calls or Zoom(n=28) calls, conforming to COVID-19 guidelines and adhering to national social distancing and lockdown measures while employing the previously outlined procedures. These interviews ranged from 50 to 75 minutes in duration. All interviews were audio-recorded and transcribed verbatim throughout the data collection phase. In the transcription process, I incorporated minimal editing for comprehension and used capitalised text to indicate the participants' emphasis. Moreover, all transcripts were securely stored on a password-protected computer and One Drive, accessible solely to the researcher. Finally, this study adopted an iterative approach, enabling the exploration of emerging lines of enquiry as the study progressed (Payne and Payne, 2006). Please refer to the Consent form for all participants in Appendix 9 and the Interview schedules in Appendices 11 and 13 for PMs and staff, respectively.

4.8 Challenges of data collection

Despite taking the proactive data collection steps outlined above, I met several challenges as part of this research regarding access to PMs and staff. First, for non-NHS providers, I had to obtain ethical permission from each of the three organisations, which was a time-consuming and lengthy process. Due to this, I obtained ethical approval from the first two organisations in late 2018, which was later than planned. At the start of the data collection process, five different national organisations expressed an interest to be part of this research study. However, during the data collection period between 2018 and 2020, one organisation withdrew because it was

forced to close due to unsustainability from decreased alcohol and drug funding; this resulted in a loss of some potential research location sites. Furthermore, there were delays affecting data collection in three of the four remaining organisations. Two of these alcohol and drug providers merged, resulting in an organizational transformational process as the two organisations became one. Consequently, all research applications for ethical approval remained pending for nine months because of these internally driven transitional alterations. As a resulted, it meant that any ongoing research projects associated with these organisations were stopped during this time, causing delays in the progress of my data collection activities. Finally, the third of the four organisations in this study - a major national alcohol and drug services - started an overhaul of their research department processes at the end of 2019. This meant that all research applications ceased until after February 2020.

Furthermore, the COVID-19 pandemic and the concomitant requirement for social distancing made it impossible for me to meet with prospective gatekeepers and participants face-to-face. This approach presented a dualistic challenge regarding the speed at which my data collection transpired. First, it meant that the organisations redeployed staff into other roles and services. Second, the organisations primarily emphasised pandemic preparation and introduced new crisis work procedures. Consequently, it was more challenging to contact gatekeepers, and PMs were no longer allowed in services. Similarly, data collection exercises became more complicated, such as holding focus groups where participants faced technological challenges or needed more confidence to engage in online group calls. I decided that it was no longer possible to conduct focus groups, as originally planned. Finally, all these changes meant that I had to update my research ethics approval from Middlesex University to reflect on other non-face-to-face techniques. These issues have added to delays in collecting further data using telephone and Zoom calls.

Other challenges included outdated information on the service websites (e.g. number of PMs, which sites they operated in), and some PMs that turned out to have not yet completed induction and training, so they were not eligible to be interviewed. Even though gatekeepers were keen to get participants involved, in some instances, PMs

were reluctant to meet me. The reasons were mainly a lack of self-confidence to engage in research or because they felt they had nothing to contribute, as they had only recently become PMs. In all these instances, I duly respected the participants' choices. However, in other cases, a few PMs identified as possible participants had mainly lived experiences of opiates or cocaine use only, which did not meet the study's inclusion criteria. Similarly, I found that gatekeepers had several job roles in the two organisations. Therefore, I needed to contact them every week to keep momentum, for updates on any progress, and to remind them of my offer of support to get potential participants myself. Lastly, at the organisational level, I found that due to the uncertainty of protected alcohol and drug funding, shorter contracts awarded to service providers, and increased competition among providers, investing in research and development appeared to be a low organisational priority. As a result, I needed to make a more concerted effort to convince them that the proposed research was relevant, and that the findings could potentially benefit organisations wanting to implement PM roles more widely.

Upon reflection and evaluation, the qualitative methods employed were appropriate and instrumental in allowing me to achieve the purpose set out in the research questions, aims, and objectives. The interview type enabled me to gain comprehensive insight into the participants' perceptions (PMs and staff) of the PM's roles and how these individuals interact with their wider work environment. Equally, data from the participants' observation notes offered an additional context and viewpoint from the information communicated during the interviews. Finally, collectively, the various data types allowed me to reflect, triangulate, and process what I observed and to formulate my interpretation of the role of PMs.

4.9 Ethical considerations

Throughout the research process, I considered various ethical considerations into account. As outlined in the previous section on 'Interviews- research procedures', I

implemented measures to ensure that participants gave their informed consent and that I maintained as much transparency as possible throughout the study. Maintaining confidentiality of the collected data was deemed critical for both the participants and their organisations, and vulnerable participants were provided with reassurance to alleviate their concerns. To avoid any potential damage to participants' and organisations' reputations, I provided explicit guarantees to gatekeepers, managers, and senior leaders that the data collected would remain confidential and that I would not misrepresent their views. Several approaches were applied to address these ethical dilemmas, including using pseudonyms for all participants to protect their identities, triangulating data collected (see section on Triangulation below) by supplying individual participants with a copy of their transcript to check their own interview for accuracy what they had said, and generalising quotes and service literature to ensure that organisations were not easily identifiable.

In addition, from an ethical standpoint, I was acutely aware of my role as a researcher, including the assumptions and interpretations I made regarding the information shared by participants, my position within the interviewer-interviewee relationship, and the inherent power dynamics (Gray, 2009). Scholars in the field have addressed similar issues concerning power relationships in research and have emphasised the importance of researchers being mindful of these dynamics (Kondo, 1990; Bhavnani, 1993; Wilkinson and Kitzinger,1996; Denzin, 2008; Thapar-Bjorkert and Henry, 2004; Gray, 2009). In particular, Denzin (2008) contends that researchers often occupy a socially privileged position and are perceived as possessing power in the form of knowledge during the interview process. Bhavnani (1993) argues that the dynamic and vacillating nature of power in the research relationship is dependent on the range of identities adopted and the assumed power during interviews. Therefore, caution must be exercised when clearly demarcating power based on a one-sided and hierarchical relationship, as highlighted by Devotta et al. (2016). Additionally, it is strongly recommended that researchers be mindful of their potential blind spots, particularly in contexts in which participants share their lived experiences (Devotta et al., 2016). Power dynamics underscores the importance of researchers having a good understanding of the subject area. Finally, according to Tracy (2010), being self-reflective is paramount as a researcher, as conducting rigorous and unbiased

research requires researchers to recognise and critically reflect on their own social identities, perspectives, motives, and partiality which can impact and shape the research process. Further, see section 4.10 – Credibility and Conformability below.

Therefore, it was crucial to maintain objectivity in my interpretation of the data and to try to understand and capture the participants' interpretations of events rather than my own interpretation of their reality (Cutcliffe and McKenna, 1999). As a result, by addressing these issues, I have demonstrated validity and 'truth value' in my findings and conclusions. However, it is also essential to appreciate that total trustworthiness cannot be achieved (Lincoln and Guba, 1985). Instead, it is up to the researcher to provide a persuasive argument using the research findings.

4.10 Strategies used to improve quality and rigour

Qualitative research has been criticised for generating subjective impressions and therefore lacking in objectivity and scientific rigour. Researchers should employ the following criteria to dispel these claims: credibility, transferability, dependability, confirmability, and triangulation (Skrtic, 1985; Guba and Lincoln, 1994, 2005; Patton 1999; Carter et al., 2014; Gray 2009). In the following as, I will demonstrate how I have attempted to ensure that this research met these criteria.

Credibility and Confirmability

Credibility is associated with activities that ensure confidence and trustworthiness and can be ascribed to the researcher's findings and conclusions. As a researcher, credibility was significant to me in ensuring that this research had future applicability and relevance in the alcohol and drug sector. Therefore, at several stages of the data collection and analysis process, I consulted with my supervisors and research

participants to ensure that the findings accurately represented what was recorded. In addition, I wanted to ensure that the interpretation of the data was not biased by my own interpretation but instead that objectivity was maintained.

In some cases, the findings and conclusions were affirmed, or additional comments were offered to ensure that they represented a more complete and nuanced reflection of what was discussed. However, in others, data analysis allowed for a range of different perspectives to be captured and allowed the identification of new contributions to knowledge. This was a particularly significant part of my methodological approach, given that in qualitative research, there is an epistemological belief which purports that there is no singular truth and that the understanding of one's social world is based on one's interaction with others. Lincoln (1995) spoke about the researcher's awareness of their subjectivity in understanding what is being said, recorded, and subsequently interpreted, as discussed in the ethical consideration section (4.9). In addition, Lincoln described the researcher's self-awareness of their own emotional and psychological state before, during, and after the data collection process. This allowed me to reflect on my understanding of how others felt as they shared their experiences with me, and how I interpreted this.

Transferability

Lincoln and Guba (1985) argued that the transferability of research shows that it can be applied to other situations or contexts. Research transferability can be enhanced by providing readers with information on how the data were collected, the research sample used, and the findings derived from the research. Lewis (2003) asserts that this is based on the 'thick description' introduced by Geertz (1993, 2008), in which the researcher should provide details of the original observations and comments made. It is then up to the reader to judge whether the findings are applicable in different situations or contexts. These details have been provided above, and the associated documentation has been collated as part of the service mapping exercise in Appendix 2 and 3. While this research focused on those with lived experiences of alcohol misuse and now in recovery, literature on recovery capital and on transition from

service users to PM indicates that the findings from this study may be applied in other sectors such as mental health and other substance misuse settings. Similarly, the research demonstrated how organisational socialisation processes and understanding of liminality might help inform PMs to gain work-related transferable skills as well as to further personal recovery. Again, it may be argued that these concepts can be applied to recovery pathways in other areas.

Dependability and an iterative approach

Research must present a clear audit trail of how the researcher collected and analysed the data. Lincoln and Guba (1985) suggest that creating an audit trail promotes dependability and confirmability. As part of the finding's chapter, I have provided coded quotations from the transcripts which evidenced the themes discussed. This helps the reader assess the degree to which my own interpretation of what was said accurately reflected what the participants had communicated and how well their voices were reflected in the themes.

Another approach that supports the quality of the research method is the iterative approach performed as part of this research process. As a researcher, I was able to collate, transcribe, and analyse the data collected simultaneously. I then used the information analysed to inform new lines of enquiry from the proceeding participants. This helped me to gain further data on themes as they developed in the data collection phase. Similarly, throughout the analysis phase of the study, I used codes and re-code procedures on my data. I went back and recoded a section of the data after coding it, and then analysed the results. This ensured that a more uniform approach was adopted when analysing the emergent themes. Triangulation also helps support the dependability approach I employed which is discussed below.

Triangulation

Triangulation in qualitative research uses a combination of methods and sources to gain a more holistic understanding of the social situation under examination (Patton, 1999; Carter et al., 2014). As part of this research, data was collected using the different methods and sources described above to support rounded and different perspectives on the role of PM. Polit and Beck (2012) described this method as triangulation, in which several different methods were used to examine the same phenomenon to reduce potential bias from using only a single method. Figure 4.10 shows how different methods are used to triangulate and support the credibility of the findings and conclusions. As suggested by Lincoln and Guba (1985) information collected using different methods and sources helped me gain a more comprehensive understanding of the personal, socio-economic, and political circumstances in which the PM operated. Furthermore, to provide a more comprehensive and rich understanding of the phenomenon of PMs, I collected data from a diverse group of individuals using data source triangulation. Data source triangulation uses data collected from different types of individuals and locations to obtain multiple perspectives on the same phenomenon to confirm the findings, as described by Denzin (2012). As a result, I included interviews with staff from four different organisations and seniority and PMs at different stages of their PM role; again, from the four organisations. I also used the information from the service mapping exercise collected (shown in Appendices 2 and 3) on the PM roles and the assistance offered by the organisation–for example, training and supervision–to identify synergy in what has been offered and the reality of the PM's experiences. It also helped me gain a more comprehensive and robust understanding of their personal experiences and the variables that helped shape their experiences (Russell et al., 2005). The collated data also helped me confirm or tease out differences from my findings, allowing me to formulate a more holistic and well-rounded conclusion on the roles and experiences of PMs. The triangulation of the research findings was further supported by maintaining a reflexive journal of the research processes undertaken, my participants' observation sessions, and reflection on the study as a whole. Carter et al. (2014) advocate that this helps support the triangulation of the findings and conclusion and support the validity of the research conducted.

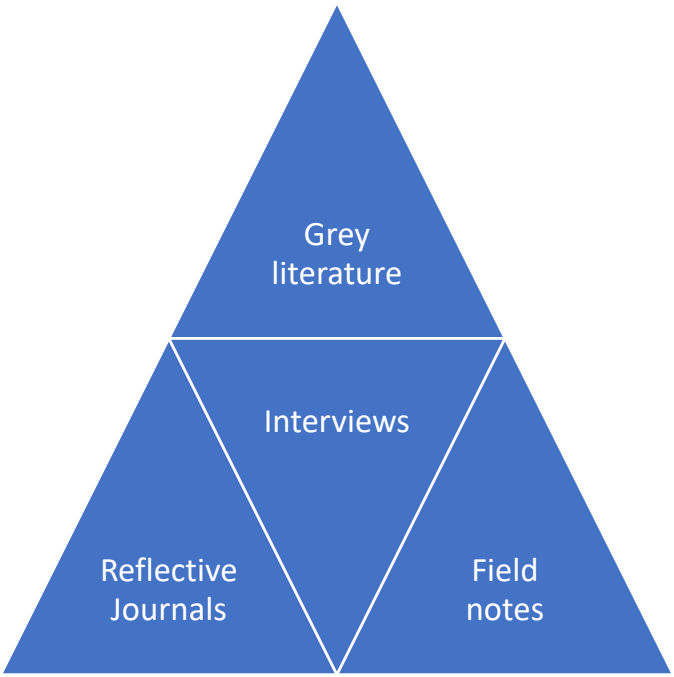

Figure 4.10 Method of triangulation (Source: compiled by the author)

4.11 How the data analysis was conducted.

Analysing qualitative data requires a researcher to employ an intuitive and dynamic approach to grasp the meaning of the collected data (Basit, 2003). The primary purpose of the analysis was to identify the categories and themes, scrutinise the relationships in the data, and deduce any assumptions the participants might have regarding the world they exist in, both at work and personal levels (McCracken, 1988). The inductive analysis process requires the researcher to extract meanings and themes originating from the collected data (Patton, 1990). Bogdan and Biklen (1982: 145) defined this process as 'working with data, organising it, breaking it into manageable units, synthesising it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others'. Therefore,

the thematic analysis approach fosters systematically categorising the data collected. It is a qualitative analytical method for identifying, analysing, and reporting patterns (themes) within data (Braun and Clarke, 2006). According to Boyatzis (1998:7), thematic analysis involves 'encoding qualitative information through manifest and/or latent categorisations'. Equally, this initial phase allowed me to familiarise myself with the facts, recognise important concepts, and focus my reading on collecting literature to better understand and support my findings and discussions (Kvale, 2012). Overall, this process is essential in qualitative research as it allows researchers to identify emerging themes and patterns that require attention when drawing conclusions.

Rationale for data analysis approach

Although computer-assisted data analysis is growing in popularity, it is not universally accepted (Atherton and Elsmore, 2007; Cypress, 2019). There are both advantages and disadvantages to utilising Qualitative Data Analysis Software (QDAS). When compared to traditional data management and processing procedures, software programmes can save the researchers a substantial amount of time on manual operations, such as frequent copying, pasting, and filing (St John and Johnson, 2000; Cypress, 2019). According to Silverman (2013), the most time-consuming part of data processing is the data management technique, which researchers would be better off investing in analyses and concept formulations. Due to the difficulties with data collection outlined in section 4.8, and the gradual acquisition of data to be analysed, I would not have profited from rapid data processing. I was able to include the initial phase of the data analysis in the transcription of all audio recordings and PO notes. These recordings were transcribed quickly after each data collection session, allowing me to observe emerging themes and trends and gain knowledge during the data collection phase (Stake, 1995).

Another advantage posited is that data analysis software can potentially increase flexibility as it does not hinder the limits of codes, or the size of the data collected. It is argued that this technology enhances the extent to which a study can be conducted thoroughly and comprehensively (St John and Johnson, 2000). Consequently,

Silverman (2013) asserted that such meticulousness can substantially enhance the validity and rigour, as it offers a clear audit trail demonstrating the careful examination of data. Conversely, coding text 'line-by-line' helped me develop descriptive themes and analytical themes (Boyatzis, 1998; Daly et al. 2007; Guest et al., 2012). Through this reductionist approach, I could organise, describe and interpret the data set in rich detail (Braun and Clarke, 2006). In addition, St John and Jonson (2000) argued that software programs can significantly reduce a researcher's connection to the collected data. This approach can lead to the lack of humanistic factors and sterility in the final product. To ensure the accuracy and significance of their findings and the integrity of qualitative research, researchers must maintain their connections to the data and its accompanying context. This highlights the importance of exercising caution while utilising software programmes for data analysis, as well as the need for researchers to be cognisant of the potential repercussions of such tools. In addition, I wanted to understand the language and context of the phrases employed. As a researcher, I connected and analysed the participants' body language, inflection, and inferred meaning through manual data analysis. However, it is conceivable that incorporating technology into qualitative research will lead to the loss of word meanings conveyed by intonation and body language (Seidel, 1991; St John and Jonson, 2000). Similarly, limiting the researcher's usage of qualitative data analysis software (QDAS) to a few programmes may result in the researcher becoming infatuated with the software's possibilities, leading to distraction from interpreting what the data is trying to say (St John and Jonson, 2000). In addition, St John and Jonson (2000:396) argue that if ‘all qualitative research were to be conducted using QDAS, or even worse, using a limited number of software packages, then the results of research would be at risk of becoming homogenous, predetermined, and limited’. Lastly, there is a pitfall that researchers can conflate the use of qualitative data analysis software as a research method rather than a tool to analyse the data (MacMillan and Koenig, 2004; Cypress, 2019). By weighing the advantages and disadvantages, I opted to use manual analysis approaches.

Data analysis approach adopted

For researchers to conduct comprehensive and rigorous thematic analysis, it is crucial to employ a critical and systematic approach. In this regard, a combination of Mason's (2002) processes, delineated in Table 4.11), and Braun and Clarke's (2006) six-step framework were utilised to ensure that each data analysis phase was carried out logically and rigorously. These steps ultimately yielded significant and meaningful findings. Even so, Maguire and Delahunt (2017) postulated that thematic analysis allows for flexibility and an iterative process, providing a framework that is not linear, but still results in robust and reliable outcomes.

Table 4.11 Systematic data analysis approach (Source: Mason, 2002:109**)**

'Literal' reading	Index topics of substance in the text. This may include the actual sequences and style of the interview.
'Interpretive' reading	'A version of what you think the data mean or represent, or what you think you can infer from them' (Mason, 2002:109). To capture what participants thought or actions taken, any similarities or conflicts in perceptions.
'Reflexive' Reading:	'Locate you as part of the data you have generated and will seek to explore your role in the process of generation and interpretation of data' (Mason, 2002:109).

Familiarisation with the data (Step 1)

For my initial reading, the first stage was to become familiar with each interview in its entirety. At this stage, I read the transcript multiple times in full, taking general notes, and recording my initial opinion of what was being said. Mason (2002) referred to this as 'literal' reading, in which the word document transcript is converted into columns to aid data analysis. To assist with this, I extracted the research data. I entered it into an Excel spreadsheet with headings, such as participant name, designation, organisation, quotations, main themes, sub-themes, and comments or early thoughts.

Next, I entered the transcribed data into one column. Another column contained a predetermined code or was left blank to allow for additional codes. Next, a column was used to record comments or observations about emerging ideas, thoughts, or lines that required closer scrutiny. Finally, I searched participant observations for information about PMs sharing knowledge and experiences, participant interactions, and my role in this process. This procedure entailed breaking down the data into smaller, more manageable parts and assigning a starting code or label (Dye et al., 2000).

Generate initial codes (Step 2)

In the second phase, I began to organise the data in a logical and systematic manner, using codes to divide the data into small relevant parts. This step expanded on the previously described first familiarisation phase with the data collected during the transcription phase. As part of this manual approach to coding in qualitative data analysis, I utilised highlighters and pen on the physical copy of the transcript and the Excel sheet to highlight selected text with codes, evaluating the text for relevant terms and usages.

Likewise, collecting and classifying pertinent data connected to the research aims and highlighting novel and intriguing findings was essential. As indicated earlier, I employed an inductive analysis strategy with a line-by-line coding approach (Boyatzis, 1998; Daly et al., 2007; Guest et al., 2012), beginning with broad predetermined codes and establishing and revising the codes as I proceeded through the data analysis process. As Bree and Gallagher (2016) explained, using Microsoft Excel, I could also encode and identify codes. Furthermore, during the data collection and analysis process, I addressed my preliminary thoughts and reflections with my supervisors who were able to provide constructive, supportive, and critical guidance as experts in this study area.

Search for themes (Step 3)

In the third step, as part of the 'Interpretive' stage, I primarily focused on data from interviews relating to the participants' perceptions of their duties and those they were

not permitted to perform as PM. Furthermore, I was interested in determining the degree of support they received while performing their PM's role, how their peers evaluated them, and how they interacted with colleagues. Recovery workers and other health care professionals, for example, the PM's superiors, and the transformation or transition they observed in themselves as a result. Maguire and Delahunt (2017:3356) describe identifying themes – as 'a theme is a pattern that captures something significant or interesting about the data and/or research question'. It is a complicated and challenging procedure, but different themes emerge because of the iterative strategy of reading and re-reading the data (Patton, 1990).

During this reflective stage, the codes were then classified into mostly descriptive themes (Mason, 2002). There were various motivators for becoming a PM, for example, 'being able to give back' – a theme 'Motivation of PM roles' was designed to collect all the relevant codes. According to (Dey, 1993:112), 'categorising is thus a critical aspect in the process of analysis'. It ultimately came down to making essential decisions based on what the data told me, deciding what was important, and what the data meant (Patton, 1990). Furthermore, to define categories, we must be 'attentive and tentative; attentive to the data and tentative in our conceptualisations of them' (Dey, 1993:102).

Review themes (Step 4)

I took considerable care in finding and organising the main themes and sub-themes persuasively and logically, as part of the process of re-examining the themes found in Phase 3. This iterative approach required cross-checking the data associated with the themes to ensure that they supported one another, fitted as part of a single participant's interview, and were consistent throughout the interviews. I also ensured that each theme was unique. Equally, on some occasions, I needed to change them so that they were differentiated from one another, for instance, where they had erroneously or insufficiently captured the information, the interviewee had intended to deliver. In other situations, I combined the two topics to create a new, bigger, and more inclusive theme.

Define themes (Step 5) and Write up (Step 6)

Step five encompassed a conclusive review of themes and sub-themes (see Appendix 5 - Mind map of PM role), with the primary objective of definitively discerning the fundamental crux that the theme intended to elucidate while outlining the relationships among the sub-themes and central themes (Braun and Clarke, 2006). I conducted the final data analysis to identify confirming and contradicting examples of themes and data collected, and to establish the relationship between the data obtained and the literature reviewed. Several themes were identified and will be discussed in Chapters 5, 6 and 7. Finally, the sixth step consisted of commencing the thesis writing process, which employed these themes as headings in the findings chapter.

4.12 Summary of methodology and method

In this chapter, I have discussed the rationale for choosing the methodological approach and techniques used in this study and how they were best suited to answering the research questions regarding the roles of PM, how they perceive themselves, and how others who work with them perceive the role of PM. Both the methodological approach and the methods employed allowed me to conduct an in-depth exploration of participants' feelings, thoughts, and perceptions. Tools such as participant observations, whilst they were limited, gave me a first-hand glimpse into the participant's world and an opportunity to observe their behaviours, reactions, and the reactions of others they encountered. Interviews were conducted using sampling techniques (both convenience and snowballing), which attempted to offer the best chance of securing the representation of the group being studied. Ethical considerations were duly observed and considered to ensure that the participants were treated fairly and respect for their contributions was acknowledged and given. Furthermore, a description and rationale for the data analysis process were provided to show how the findings were arrived at.

Chapters 5, 6 and 7, I reported and explore the findings of this study.

Introduction to Chapters 5, 6 and 7

The next three chapters report the findings from the data collected across the four alcohol and drug organisations where PM roles were identified. Even though most substance misuse providers are commissioned to provide both alcohol and drug treatment interventions, the focus of this study is on alcohol intervention and those who are involved in delivering it. The chapters capture the attitudes and perceptions of staff from a variety of job roles and seniority levels who work alongside PMs.

All four organisations considered the role of PM to be a critical part of their service care provision. It was also evident that these roles were becoming increasingly popular in alcohol and drug services, as discussed in the introduction chapter. These roles are essentially taken up by those who were once a service user either within the same organisation or in another alcohol and drug treatment service. The data revealed how these roles appear to be a transitory stage for the individual, as one part of the consolidation of their recovery capital on their recovery journeys. Of the four organisations participating in the research, three were national charity alcohol and drug providers which had been commissioned by the respective local authorities in which the service existed. The fourth organisation was a NHS provider who provided services covering only one London borough.

I interviewed 42 participants of which twenty-one were PMs with lived experiences and twenty-one were staff of varying degrees of seniority (frontline staff to directors of organisations). Excerpts from participants' responses were included to provide credence and context for my findings, to make their voices heard, and to better illuminate emergent themes. In some of the excerpts, I underlined the text in which participants placed great emphasis on the message they wanted to convey.

Chapter 5 discusses the concept of 'peer mentor', how it is defined, and how it is shaped by the people who take on the role and the organisations they work for. This chapter covers four main themes:

1. The first highlights the variable definitions and terminology used to describe and 'label' the PM role.
2. The second theme describes the range of tasks carried out by PMs, what support and guidance were available to them, and the perceived advantages and challenges encountered in carrying out such a role.
3. The motivations for becoming a PM are reported in theme three.
4. The fourth theme looks at organisational socialisation and how organisational policies and practices impact on and shape the PM role.

Chapter 6 discusses the pathways and stages undertaken to become a PM, looking at the enablers and barriers to adopting such a role. Four major aspects of the pathways that emerged from the data are considered:

1. The stages towards becoming a PM
2. The recruitment process for PMs,
3. The enablers to PM pathways, and
4. The barriers to the PM's pathway.

Chapter 7 considers what impact, if any, becoming a PM had on an individual's identity and sense of self. The chapter covers:

1. Impact of the PM role on identity through improving self-esteem
2. Improvement in self-awareness through the PM role
3. The importance of having a shared identity with service users
4. The fluidity of, and shifts in, identity through the PM pathway
5. Reintegrating into society and regaining or developing an occupational identity

Chapter 5: Defining and shaping the PM role

5.0 Introduction

This chapter explores the findings from the data collected across the four alcohol and drug organisations in which PM roles were identified. All four organisations considered the role of PM to be a crucial part of their care interventions offered by the service. Therefore, this chapter presents the findings on how the PM role is defined and how it is shaped by the organisations within which PMs are employed. Four key themes emerged from the data:

1. The first highlights the variable definitions and terminology used to describe and 'label' the PM role'.
2. The second theme describes the range of tasks carried out by PMs, what support and guidance were available to them, and the perceived advantages and challenges encountered in carrying out such a role.
3. The motivations for becoming a PM are reported in theme three.
4. The fourth theme looks at organisational socialisation and how organisational policies and practices impact on and shape the PM role.

5.1 Theme 1: What defines a PM

A varied range of terminology used to describe PMs

As discussed in Chapter 2, in the current published research, the definition of PMs and the roles that they carry out were either vague or there was little research available to clearly capture or describe these roles.

This research found that there were various terms used to identify or label individuals who carried out peer mentoring roles within the four organisations studied. However, across the different organisations, there were three commonly used terms to describe individuals who had previously used alcohol or drug services. They included 'peer mentors', 'volunteers', and 'recovery champions'; with the latter term only being used in one of the four organisations taking part in the study. Furthermore, there were subtle differences in the way that these terms were used and what meaning was attached to these roles across the different organisations, as illustrated in Appendices 2 and 3 and further supported during the interviews. Across three of the organisations (A, B, and D), the term 'peer mentors' appears to be used to describe those who may be in the initial stages of their recovery journey and who may be close to the end of or have recently been discharged from alcohol-structured treatment. For example:

> *In [the name of organisation], we have both… we use peer mentors, and we use volunteers and there's a distinction between what the two are within our organisation at least' … 'In terms of peer mentors, they are very much people who are just coming out of recovery or still in our recovery support programme. They are very much there to support the service and helping other service users with their own recovery, Sophie (Team Manager: Organisation D).*

The fourth organisation (C) used the term 'volunteer' instead to describe the same individuals described as 'peer mentors' in the other three organisations.

> *Volunteers are generally a step on from that [PM]. So, once someone has been completely discharged from [the name of organisation] treatment, they can then become a volunteer, but you can also have volunteers who didn't go through a recovery journey as well, Sophie (Team Manager: Organisation D).*

In some organisations, the term ‘volunteers’ was also used to describe individuals who have progressed in their recovery and were suitable to make the transition from the PM role to a volunteer role. However, these individuals were not allowed to share their lived experiences once they had progressed to volunteer positions. Another key finding of this study was that volunteers who had progressed from PMs were not allowed to continue working in a service or team where they were once service users. There were several reasons for this finding. First, it was felt that owing to data protection, ex-service users should not be allowed access to those with whom they were once service users. Data protection meant that PMs were not granted access to service user records to uphold and protect the confidential information of other service users. Second, the staff also argued that it was beneficial for the volunteer to have a 'fresh start’, which would help address stigma and stereotypes that may potentially be associated with having been an ex-service user.

Notably, for all organisations, the term ‘volunteers’ was also synonymously used to describe individuals who had no lived experience background of alcohol misuse. These individuals were often new to the organisation and were willing to offer their time and expertise for no financial consideration. Typically, these volunteers sought to develop further knowledge or offered services such as counselling to obtain practical skills within the alcohol and drug sector.

The range of terminology presented some dilemmas for staff and PMs at times. It was significant to note that the term 'volunteer' became conflated with the term PM at times.

> *How would you define a peer mentor or a volunteer? (Researcher).*
>
> *If I'm really honest with you, I [would] really struggle with what's the difference between a volunteer and a peer mentor, Tracey (Team leader: Organisation B).*

Tracey illustrated the confusion surrounding the various terminologies used to describe PM roles. Reflecting on the ones used in her organisation, she commented

that both terms: ‘peer mentor’ and ‘volunteer’, were used interchangeably to describe the same group of individuals who may carry out similar roles.

Lastly, the term ‘recovery champion’ was found in only one organisation (Organisation A) – also seen in Appendix 2 – service mapping exercise, and staff used it to describe individuals who had progressed from either a PM or volunteer role. It was a paid role but restricted to a limited number of hours per week to avoid affecting the individual’s social welfare benefits. It is worth highlighting that not all staff members were au fait with the various terminologies used.

Although the terminology for PMs varies, two fundamental characteristics commonly defined them in research. First, they were individuals who had lived experiences of alcohol misuse. Second, they must have attained a certain level of abstinence from alcohol use. These will be explored further in the subsequent analysis.

Two common denominators of PMs

Across all four organisations in this study, it was imperative that PMs had lived experiences of using alcohol at a dependent or harmful level that required some form of structured treatment in the past. All PMs and staff interviewed reported this and confirmed that it was a defining characteristic of the role.

> *So, I was a service user first in a service and then they asked me to go on a peer support programme… and then I became a PM in one of the locations. Jean (peer mentor: Organisation D).*

> *They are former service users before they become a peer mentor.’ Paul (PM Manager: Organisation A).*

PMs interviewed also explained that being able to use their lived experiences was vital to understanding and supporting others in their recovery, as they were able to empathise and relate to service users within alcohol and drug services. This will be explored further in section 5.2.

As alluded to above, the second defining characteristic of a PM was that individuals needed to demonstrate a level of abstinence from alcohol use. The level of abstinence varied across the four organisations. In some organisations, it was acceptable for PMs to be still using alcohol, but their usage needed to be at a controlled level which did not affect their ability to carry out their roles or attend training. However, all participants across the four organisations indicated that PMs were expected to be alcohol-free by a mutually agreed period in time once they commenced their PM role.

> *Was there a period of time that you needed to be abstinent to start the [PM] role? Was this a particular criterion that you had to meet? (Researcher)*

> *At that time [I started the PM role], I was not abstinent, but it was a set goals from day one, ... but accepted that I was trying to get alcohol consumption under control anyway. Josh (peer mentor: Organisation A).*

> *I suppose certain people and certain organisations use different times[frames]. I do believe that it should be far more than three months, even more than six months, Tracey (Team leader: Organisation B).*

Both the PM and the staff members above, who were from different organisations, concurred that PMs needed to demonstrate a period of stability and some level of abstinence from alcohol use before being placed on the peer mentoring training programme. In most instances, PM training was a precursor to an individual commencing their role as a PM. The reasons offered by interviewees were that individuals needed to adopt certain responsibilities and expected behaviour as part of

the role of the PM. Furthermore, staff and management argued that maintaining abstinence offered PMs the best opportunity to progress with their recovery, given the demands of the role, and the associated stress transition into the role can impose. However, it was evident from the data that what was defined as 'level of stability' and abstinence varied from service to service and organisation to organisation. Notably, Tracey, a Team leader, also questioned whether the three-month period was too short to adequately consolidate someone's recovery sufficiently to be able to assume other roles and responsibilities as a PM. She explained that the initial stages of post-treatment were a crucial time for individuals to reflect on their recovery journey, and some level of abstinence offered them time and space to do so. Furthermore, she also described that the pressure to take on new roles and the potential associated risks of relapse were high for those ill-prepared for the stresses of a 'work' environment, combined with the pressures of being accountable to both other service users and towards alcohol and drug services carrying out their PM role.

5.2. Theme 2: Tasks carried out by PMs

This section highlights some additional tasks that are commonly performed by PMs. This is not an exhaustive list, but examines the four tasks which were frequently referenced in the data:

- provision of administrative and emotional support,
- provision of advice and signposting,
- buddy and befriending system,
- PMs as translator of local intelligence.

Each of these will be addressed in turn in the next section.

Provision of administrative and emotional support

PMs described that they were allocated tasks which gently introduced them into the work environment before progressing to more complex ones. Some of these were administrative tasks such as photocopying, supporting service users to 'check- in' for their appointments, and completing initial referral forms into the services. PMs and staff stated that these low-level tasks were not only important for the smooth running of the services, but they also helped the PMs develop their confidence and improve their communication skills.

> *So firstly… it was a drop-in service; we will just meet and greet people. Sometimes, … we will complete an initial referral form and ask them how much they were drinking and a bit about their history, Debbie (peer mentor: Organisation C).*

Completion of the referral forms described by Debbie was the initial, low-level task of information gathering which may provide a more comprehensive assessment process at a later stage. This is an important first stage for any service user accessing alcohol treatment services. Within alcohol and drug services, there are many routes of accessing treatment, but all involve the completion of an initial referral form. This basic information collation exercise is commonly used by service providers as a screening tool which helps prioritise care interventions. It is also used to evaluate whether the referral meets the service's criteria and what interventions should follow. PMs and staff described that service users being greeted by a fellow service user quickly built a trust relationship between the service and service users.

Other PMs and staff described other functions, such as facilitation or co-facilitation of group interventions, and provision of emotional support. Participants described how PMs were able to use their lived experiences to relate to, and connect to, other service users in a way that someone with no lived experiences could not. This process was

not unique to Debbie's organisation, and other PMs and staff confirmed similar tasks carried out by PMs within their teams or organisations.

> *I would facilitate groups; one is the pre-detox groups on Mondays with [name of staff]. He (member of staff) asks me specifically to come into that because I've been through rehab and everything. Beth (peer mentor: Organisation D).*

> *Would you ever lead one [group]? (Researcher).*
>
> *I ... [hesitation] unofficially! Yes, I have... Maybe a member of staff who doesn't know what the hell's going on and they say ... Ronald, can you help out there..., Ronald (peer mentor: Organisation D).*

PMs commented that carrying out these tasks was mutually beneficial to themselves and the organisation. They reported that it was a helpful process to gain new skills and develop their confidence by conducting the groups as co-facilitators and eventually running them on their own. Beth, quoted above, described how she was able to use her experiences of having previously attended similar psycho-social groups herself and this helped to create meaningful engagement for the service users who are currently in treatment. Both Beth and Ronald also identified that, at times, because of their lived experiences, they felt more knowledgeable than staff members. They noted that they were seen by both service users and staff as experts when compared to some staff members in particular areas of treatment. These comments were interesting, as they highlighted a reversal of roles between PMs, who were once service users and were now akin to a staff member. Similarly, PMs were also viewed as experts, rather than staff members, when describing elements of treatment pathways, owing to their experience in using these pathways themselves.

While the PM roles provided positive benefits for PMs, participants identified a number of drawbacks. Some PMs highlighted that their tasks and roles played by them were not always clear or evident to the staff.

I mean, I was told off one day, just for helping someone fill out a form... I know, I'm sure it was [name of staff member] who came down and said: you shouldn't be doing that! one of the office staff should be doing that'... I thought, hang on, that's what we were told that we were here for... to help people that did not understand, Ronald (peer mentor: Organisation D).

In sum, PMs reported that some staff members needed clarification about what roles and responsibilities PMs were allowed to perform. Additionally, they described receiving conflicting directions from one staff member to another. They also said that sometimes the tasks and responsibilities discussed in the peer mentoring training either conflicted with what they were asked to do, or the role of PMs did not appear to be communicated to staff in the services, which had led to the PM's frustration and feeling marginalised.

Provision of advice and signposting

PMs described how, as part of their role, they provided advice and reassurance to new or existing service users, their carers, friends, and family members.

I would go through what groups we have and suggest what groups I think that they might want to go on… If somebody was still dependently drinking, they can only attend certain groups, Debbie (peer mentor: Organisation C).

Debbie described how she was able to use her lived experiences and awareness of what had worked for her in the past to support others who were at the start of their alcohol recovery journey. PMs also described roles such as signposting and providing advice on how to access particular (health and social care) services which they had accessed in the past and which they had learned how to navigate.

You mentioned, you know, you helped others in terms of form-filling and signposting them and things like that? (Researcher).

I am quite good around the benefits and [the name of the benefits office]. I know who to point them [the service user and staff] to. It started out with people that I knew in the groups. Now, they [service users and staff] will go 'oh, he knows', ask him. Because I have had to do it myself when I had to go through my own medicals; I know how to cut through the red tape, John (peer mentor: Organisation D).

John described how he was able to draw on his lived experiences to support both service users and staff. As a result, he explained how he managed to use the expertise he had learned from navigating the benefits systems to help others. It was clear that the staff felt that they had specific knowledge and skills which they lacked. He was also able to support service users when the staff did not have time. Like John, other PMs also highlighted how they could use past experiences and initiatives to create new support structures for service users. These were different from the traditional structured treatment interventions, such as psychosocial key working sessions. For example, Beth explained how she and other PMs used a social media platform to provide additional support to service users and their peers.

We've got a WhatsApp group going now ... that gives the most support outside of the service. The number of times they (service users) have said oh thanks for your advice that I wouldn't have thought of that. The What's app group was set up by the PMs and the service users, Beth (peer mentor: Organisation D).

Through this communication tool, they were able to increase their access to support and offer service users and PMs a chance to share their experiences. PMs and staff recognised that it was a valuable resource, especially as individuals were able to identify with each other due to their shared experiences. The research data showed

that social media platforms were used in all of the organisations. In each of these organisations, their use was sanctioned by the organisations and monitored under their governance systems to ensure that those using it were well supported and were not vulnerable as a result. Equally, participants highlighted this method as a valuable means of keeping in touch to reduce isolation and obtain additional support, especially during the COVID-19 lockdown periods.

However, the PMs highlighted the drawbacks of providing this type of support intervention to others.

> *It's been a heavy session [referring to the what's app group on one night], Beth (peer mentor: Organisation D).*

Beth spoke about having heavy sessions of giving advice and, at times, people wanting more support during WhatsApp group sessions. Other PMs also described the potential associated risks of relapse from providing support to others during their own recovery. PMs such as Beth and Ronald described how several PMs had fatally relapsed because of the pressures of their PM role. They highlighted the need for self-awareness as a protective factor**,** as described below.

> *We have to be very careful about the negative side of helping people ... with especially our own mental health... There has been six [deaths] since I have been here, all through alcohol since I have been here, not drugs... oh no, one for drugs! Ronald (peer mentor: Organisation D).*

> *I mean, we have as well lost a few, Beth (peer mentor: Organisation D).*

Buddy and befriending system

In three of the organisations, PMs provided a buddying service for service users as part of their roles.

> *It kind of grew to it becoming sort of chaperone … So, if somebody needs to go to the doctor, coz they might suffer with real anxiety... or to go to the job centre from PIP [personal independence payment] assessment… we will facilitate that, Debbie (peer mentor: Organisation C).*

Debbie, like other participants, described that as part of the PMs 'buddying' role, PMs would accompany those in treatment to access vital physical and mental health support. These included, for example, attending GP appointments to either register with a GP service or attend a much-needed physical health appointment. Other PMs mentioned that they had helped service users access mental health support, where appropriate. For example, in two organisations, the PMs interviewed spoke about escorting service users to Tier 4 services (detox for alcohol or drug use followed by rehabilitation placements). Furthermore, the PMs asserted that the buddying system expanded to form a buddying relationship with service users. They highlighted service users' scepticism regarding treatment providers and other authority figures. In addition, they explained that such views reflected their own sentiments when accessing alcohol services in the past. Moreover, the PMs elaborated on how service users viewed them as individuals possessing comparable life experiences. As a result, service users found it easier to build trust with PMs. In addition, PMs thought that they possessed the ability to empathise with and understand what service users were undergoing, given their own past experiences.

> *I think, most enjoyable [part of the PM role] is about helping someone [service user] out… just being there and they know… that I'm there if they wanted to chat or whatever…, Raj (peer mentor: Organisation C).*

Yes… they have told us to do that … to make things comfortable... For a new service user who have come in... When you say that you used to be a service user too, … Their whole-body language changes…, Ronald (peer mentor: Organisation D).

PMs as translator of local intelligence

Although PMs may have come from an alcohol dependency past, within their roles, they were required to work across both alcohol and drug interventions, given that many service users may not present with only one substance misuse issue. Additionally, because PMs mainly live in their work areas, they can tap into informal community groups (current substance misusers and others not in treatment). PMs described gathering information from mutual aid groups in the areas, such as the latest trend in substances used locally, and any adverse events, such as deaths or potential deaths, which they could provide as local intelligence to the services.

So that's the bit for me where I think we needed to have some of that [PMs] voice. Some of the underground stuff. Staff who are not local [to the area] have no awareness about what drugs might be quite dangerous… batches of stuff where they [service users] might be using. But they've [PMs] got access to those connections. … Quite often, some of the real information that we may get two or three days later on, in drugs alert… and then is too late! Somebody [service users] have already passed [died]. Yeah…they [PMs] may be able to tell us that. And while we can't factually say yet, we can say to service users, 'be mindful. We've had reports… we have heard. So that's where it worked for me, Peter (peer mentor: Organisation D).

In addition, for some key workers who were new to the substance misuse field, PMs served as a vital information resource, as they could gather the latest jargon used by

service users regarding their substance misuse. This knowledge kept the staff members abreast of substance misuse trends but also helped inform interventions such as key working sessions and conducting assessments with service users. Both PMs and staff highlighted that this also helped build rapport between staff and service users by using the language to which the service user could relate. Similarly, this currency of information made their intervention more plausible and built confidence and trust among the service user population.

To conclude, this theme has described the wide range of tasks undertaken by PMs and noted that these differ across organisations. The section also indicated that, even within the agencies providing peer mentoring support, there is not always agreement – or awareness – of the tasks expected of PMs. The next theme provides some insight into respondents' perceptions of their motivations for taking up the PM role.

5.3 Theme 3: Motivational factors to becoming a PM

Several factors emerged from the research as important motivations for wanting to become a PM. These included:

- the opportunity the role afforded to sustain and progress their own recovery,
- the flexibility of the role which allowed them time for their own recovery,
- the positive effects of exposure to alcohol problems which served as a reminder,
- job satisfaction and the chance to acquire new skills, and
- a sense of altruism and guilt – an impetus to 'give back'.

Sustaining and progressing self-recovery

Some PM described gaining insight into their own self about their ability and resilience, but also of their limitations. PMs were able to acknowledge and identify what their triggers were and what could potentially impact their recovery. Some PMs reflected on how they had learnt when to say 'no' in an attempt of self-preservation. This represented a shift to their previous self, which demonstrated increased self-awareness while also supporting their self-identity and the opportunity to realise their potential.

PMs described that their role gave them a sense of progression and helped them sustain their own recovery by creating structure to their day without alcohol.

> *Getting your life back to normal… To know you got to be somewhere at 10 o'clock. On these days of the week [you need to be in the service]; you get back into a routine, John (peer mentor: Organisation D).*

> *For some of our guys just getting here and having breakfast before they get into their day, and it is a lot for them. But to hear their joy and to hear them say, I feel great, I feel <u>alive</u> today. Peter (PM manager: Organisation D).*

Both John and Peter described how the PM role provided a sense of purpose and routine and also supported their mental stability. They explained that PMs would normally comment on how having a focus for their day, something to do, and a reason to get out of bed were important factors for PMs, like John and many others. Other PMs recounted when they were actively using alcohol; they often experienced episodes of lost days, feeling in a daze, and not having a clear purpose. Most of the participants referenced having structure to their day as crucial to maintaining their abstinence and subsequent recovery. Most PMs, having a structure to their day, not only signalled the start of their recovery journey, but equally a crucial element of their

continued recovery progress. PMs explained that boredom was a major trigger for their drinking habits. Therefore, PM roles support individuals in remaining focused, while being able to fill that void and counter the boredom of their days. Staff who support PMs also spoke about the need for ex-service users to have something to do and focus on as a positive factor in recovery, as John described. Structure to one's day may come in many forms. This may entail being able to turn up on time for an appointment on a specific day, being able to sustain focus over several hours, and feeling that they can be relied upon to carry out the task (as noted by Peter and John above).

PMs also described other benefits apart from having structure to their days; they described the connections and relationships they had developed with service users and staff in their PM role.

> *All of us think that they still just need to check-in once or twice a week with people that understands what it is like. You can be happy in your life, and you can be successful... your recovery can be going great but every now and again, I think there's always that need just to be with people that understands you, Sharon (peer mentor: Organisation B).*

PMs described how the role provided an opportunity to reflect on their journey of recovery, liaise with like-minded people, as Sharon has mentioned, as well as when one needed it. Equally, PMs reflected on their shared experiences of having a clear connection with others regarding their emotions regarding substance misuse. PMs referenced the rewards they obtained from their roles and speaking with the service users. This included not having to explain themselves because of a deeper mutual understanding of their struggles with substance misuse. Furthermore, the PM role also provided ample opportunities to receive positive re-enforcement from others on their recovery journey.

Flexible commitment and potential of relapse

PMs described wanting to be more active in services, but there was also a need for flexibility in their role and the level of commitment they could offer, especially during the early stages of recovery.

> *I suppose what I am hearing as well is that it [the PM role] allows you to provide some more structure to your day… Does it also give you that flexibility and of being in a safe environment where you can grow at your own pace? (Researcher).*

> *Definitely… it is about being flexible. On the benefits side of things as well as attending to my recovery. The thought of coming out of rehab … maybe taking a month or two after rehab to…then go into a full-time job … I know for me, that would have been too much pressure! … um I needed time. It [the PM role] is being introduced back into societies and it re-introduced me into society, Debbie (peer mentor: Organisation C).*

Debbie, like other PMs, discussed how the PM role allowed them the 'breathing space' to develop before she was ready for a permanent role. Staff and PMs described a balance between being able to benefit from the mental stimuli of work and exercising their judgement to have an input into others' care against the strains of being a full-time employee. Furthermore, PMs advocated the flexibility of working at their own individual pace, while having welfare support to return to employment was a great attraction to the PM role.

Most PMs reported that their ultimate aim was to get back into employment. Whether it was because of having structure to their day, enjoying employment for the first time, the need to return to that employability position again. Others were motivated by feelings of guilt and wanting to give back to society which they felt that they had

overused in the past through their alcohol and drug misuse. Furthermore, PMs and staff contended that PM roles, in most instances, offered a level of flexibility to continue to access other elements of their recovery, such as attending mutual aid groups and medical appointments, without feeling the strain of having to commit to a set number of hours every day. Debbie described this as a crucial element of the PM role, as indicated above, beneficial during the transition period between being a service user and becoming a full-time employee. She noted that,

> *I have seen… people come out of detox… they've had about a couple of weeks off work, and they go straight back into full-time work. Then relapse... they just become a revolving door[patient] and back into the service and then they feel even shittier about themselves because they failed ..., Debbie (peer mentor: Organisation C).*

Thus, the PM role offered them an opportunity to gently build up to the responsibilities of paid employment and the associated pressures that these roles could have on their recovery or relapse.

Positive reminder of their recovery

PMs also argued that the role of PM was providing 'positive re-exposure' to previous alcohol misuse experiences through sharing their experiences with others.

> *I had about 12 to 15 years of hard drinking. But it did take a lot away from my life… financially, family wise…It damaged a lot of people around me and myself…caused mental and physical health problems. I enjoy being able to talk about it … it helps me in my recovery. It makes me realise where I have come from and where I am now. … I say to people, you know 'I'm still an addict' … but as it has been the last six years [since my last drink]. All I've been doing is getting stronger and I'm still in a good strong place because of my role, Patrick (recovery champion: Organisation A).*

Patrick reflected on how speaking to service users as part of his PM role has helped him to reflect on his own experiences and recovery journey. He explained that the constant exposure to those who were actively using substances was a reminder of his own recovery journey and the pain associated with his past alcohol misuse which supported his determination not to return to those experiences or circumstances again. Others, like Patrick, also spoke of the material and emotional stability that their new identity as a PM had brought them. PMs also recognised that this role was a way to channel their energy in a more focused manner. The PMs commented on having newfound energy and motivation to be productive.

Job satisfaction and skills development

Financial rewards were not the main motivation for becoming PM. All the interviewed PMs were still receiving benefits. Only specific PM roles, namely, the recovery champions, received payments for their time. Three recovery champions interviewed stated that they were paid but were limited to how many hours they could work so as not to impact the welfare benefits, they received.

> *I wouldn't have been able to afford it. I wouldn't have been able to be paid for it [the PM role], because if someone is on benefits and I'm on PIP (personal income payments), Gemma (recovery champion: Organisation A).*

Most participants said that becoming a paid employee would have a detrimental effect on their benefits and provided several reasons for not wanting the PM role to be a paid role. PMs reported that they could claim various benefits to assist with their self-sufficiency. These include Housing benefits as well as either Employee Support Allowance (ESA) or Universal Credit. PMs, like Gemma quoted above, explained that taking a paid position would leave them financially disadvantaged compared to the benefits they would receive. PMs argued that the amount of money they would be

paid for the PM's position would be insufficient to cover their current financial obligations, such as travel, housing, and other living expenses.

Second, the PMs argued that their unpaid PM role supported them in developing trusted working relationships with non-staff members, particularly service users.

> *When I tell people that I am a PM and what it means [being an ex-service user], people [service users] don't see me as staff and they know that I don't get paid. So, they know I am not bullshitting them, so they tend to believe what I am saying, Tony (peer mentor: Organisation C).*

Tony, like other PMs, argued that being paid was not the primary motivator for them to embark on the PM role. Instead, they thought that being remunerated was more of a hindrance to the therapeutic relationship they sought to build with the service users. Many other PMs described maintaining a more neutral identity, which helped establish confidence and rapport with service users. They argued that building trust with service users was more effective because they communicated that their help was independent of the PM fulfilling contractual duties as paid employees. Mike argued that it complicated the relationships between PMs and the service provider.

> *I'm really happy not getting paid. I really enjoy what I do and the fact that there's no knots tied to it. When you got monetary values attached, your body and mind become attached to it, Mike (peer mentor: Organisation B).*

Mike highlighted that, as a PM, he felt more liberated to engage with the service. It offered him more flexibility in his responsibilities and commitments than he would have had in a paid position. Mike talked about the emotional stresses associated with being in previous employment. He described feeling restricted and under constant pressure to excel as a salaried employee. In an unpaid role, he could dictate the days and hours he worked which suited his continued recovery.

While not being paid to work as a PM can benefit the PM and service users, it can also often contribute to issues around setting boundaries and maintaining a professional identity, as discussed in section 5.4. On the other hand, PMs expressed their appreciation of the organisation's financial consideration in offering to meet their travel and lunch expenses. These financial considerations were also highlighted in the service mapping exercise captured in Appendix 3, the various incentives and contributions that the organisation was happy to offer as part of valuing the PM's role.

> *Do you get paid for this role? (Researcher).*
>
> *No, No! However, you can claim your [travel] fares and lunch money… I'm happy with that, Jack (peer mentor: Organisation B).*

The minimum payments, according to Jack, were seen as a symbol of goodwill. He described that although it was small, he appreciated the gesture and felt like a reward for their efforts without jeopardising their receipt of benefits. Jack further explained that he was also grateful to exchange his efforts as a PM for the opportunity to develop skills. Sandra also expounded how the organisations recognised that PMs, like staff, needed to be rewarded for their efforts and the time that they gave to service provision in different ways.

> *So, we gave all our staff money, [to pay for flu vaccine]. It was an <u>incentive</u> to staff. And then, we said that this would also count <u>for</u> our <u>PMs</u> also, Sandra (Senior Manager: Organisation A).*

Sharon gave an example of one of the reward schemes they offered to staff which was extended to PMs. She explained that the organisation provided free medical vouchers for vaccines to support the PM's well-being. Sandra also explained that the management team had carefully considered how these financial considerations could be made to individuals off the payroll. She also highlighted that her organisation was keen to ensure that not being on the payroll should not be a barrier. Instead, the gesture should promote equity and inclusivity, and communicate that PMs were valued by staff members. Furthermore, some PMs also acknowledged that they preferred to

engage in the PM role as altruistic acts, without payment, as another way of repaying society for the resources they had used. For example:

> *A friend that I was in recovery with said, well, why don't you just become a PM and volunteer and give back to your community. And I thought that would great … and I did damage my community through addiction, Gemma (recovery champion: Organisation A).*

> *I see it [being a PM] as giving back … I have taken so much in the past and I feel that this is just giving back to my debts, Tony (peer mentor: Organisation C).*

Like many other PMs interviewed, Gemma and Tony expressed regret and guilt for taking from their community, family, and society at large. However, PMs were keen to relate giving their time and sharing their knowledge to an act of atonement for the damage they felt they had inflicted on those close to them, their 'community' and society. Jack, a PM from Organisation B, also mentioned that he was aware of the current financial difficulties that alcohol and drug services faced. He felt guilty about receiving payments to help others, especially when he had used resources extensively in the past.

Others felt that the PM role offered the opportunity to put into practice elements of their recovery. PMs explained that offering their 'services' without conditions was a vital tenet of the 12-step programme. Notably, many PMs with a previous alcohol misuse background appeared to gravitate disproportionately towards AA programmes compared to those with previous drug misuse issues. Furthermore, altruism was closely linked to the development of recovery capital, as identified by some participants. PMs explained that they wanted to build on their recovery capital by changing their attitudes, creating new relationships, or reconnecting with old ones more positively.

Within the transition to the PM role, PMs described using the opportunity to consolidate the skills they either had before their alcohol dependency or the new knowledge and skills that they had accumulated as part of their recovery process.

> *For me, it [the PM role] is more seen as a part-time role because it does also allow me to focus on my early recovery. To make sure that I still have that time for myself. It is just a stepping-stone, but it is a serious, serious occupation, ... I am growing, Debbie (peer mentor: Organisation C).*

Participants highlighted that having been outside the work environment for some time, they felt that they had lost some of their work-related skills, such as their communication skills, workplace etiquette, and even feeling confident enough to engage and interact within these environments. PMs described how their role offered the chance to re-acquaint themselves with softer social skills or further enhance their skills in a new sector. For others, becoming a PM offered them the first opportunity to work in a team or office environment. Some of the interviewed PMs had polysubstance misuse, and alcohol dependency was one element of their involvement in treatment services during their formative years. As a result, they had been either not in employment, been on benefits due to being in substance misuse treatment or they had been serving several prison sentences. Therefore, PM roles offered the first work environment experience to these individuals.

In addition, participants argued that the PM role not only helped to develop a diversity of skills, but some organisations placed PMs in locations which offered developmental opportunities where the roles matched the individual's areas of interest or strengths and knowledge base. For instance, some PMs mentioned that they had previously worked in financial services, and those individuals were offered PM roles to compile information for strategic meetings for the organisation. In other instances, PMs described working in the private sector, so they were able to contribute to branding and service development.

Staff and PMs commented that, within the safe environment afforded by the PM role, they could tap into non-judgmental support to ask questions freely. As a result, it offered PMs a greater range of work-related learning without fear of failure. In addition, the PM role offered individuals a space to observe and reflect on the tasks performed, as they were counted in the staffing matrix. Lastly, PMs can learn from others by shadowing a range of staff and disciplines from a safe but inclusive position.

Altruism and guilt

As indicated by some of the comments above, the study identified the need to help others, including those in similar substance misuse situations to which PMs were once, as a decisive motivational factor in becoming a PM. It may be seen as part of the altruistic nature of human beings but also more deep-seated in the philosophy of mutual aid, such as SMART recovery[6], NA[7], CA[8] and particularly the AA-step 12 programme. Within the AA doctrine- providing 'Service' was about providing information and guidance to others who are less informed and to giving back to others. Many of the PMs interviewed appeared to have had some engagement with AA programmes and continued to use them as an important enabler of their recovery. Some, such as Tony, described the need for servitude as a part of their faith and beliefs.

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[6] SMART recovery is an evidence-based programme designed to help people manage and support their recovery from any type of addictive behaviour. SMART stands for Self-Management and Recovery Training.

[7] Narcotics Anonymous (NA) is a self-help group which was founded in America by like-minded narcotic addicted individuals who support each other to break the addiction. The self-help group aims to provide assistance and help for those with a drug addiction, it is a 12-step program which is modelled on the AA or alcoholics anonymous program.

[8] Cocaine Anonymous (CA) is a fellowship of men and women who share their experiences, strengths, and hopes in recovery from cocaine addiction. The members of Cocaine Anonymous groups work together to maintain their individual sobriety as well as to help one another to overcome the struggles that often arise whenever addiction is concerned.

I also see my roles in terms of my faith. I have given my life to God…spirituality playing a role in being a peer mentors. But, I have also signed up to be a sponsor as part of the (AA) fellowship and I wanted to do this for someone else, Tony (peer mentor: Organisation C).

Other PMs also strongly desired to give back to the community through information-sharing. PMs described feeling the need to help others and sharing their knowledge of their lived experiences as essential to their recovery. Sharon said she had a moral duty as a citizen to support others who were 'less fortunate' than her and the PM role helped her to achieve this desire. As described by Sharon,

Yeah, I have done a lot of voluntary work in my life. I just I think you do need people that give back and I think it plays a part in our society. I think people are quite ungrateful for what they have and being grateful for what you have and helping others less fortunate comes quite easily to me, Sharon (peer mentor: Organisation B)

The need to give back also appeared to be closely linked to the PM's core beliefs and values, and their need to show social responsibility towards others. Therefore, giving back was part of the civic duty, especially for PMs.

In addition, the feeling of guilt was enshrined in Step 5 (Integrity) of AA and included the admission of guilt and speaking to others about that guilt. For example, some PMs felt guilty of prolifically using services over many years. As a result, this guilt appears to have created a desire to want to repay their 'debts' not only on an individual level but also on a broader societal level, either within their communities, within the more general alcohol and drugs community and in some cases at a national level.

I have always had a conscience and always been compassionate, even when I was at my rock bottom, I wanted to look after others. But I also see people

struggling and I felt that I have always been a taker for all these years, and I wanted to give back and now it the time to give back, Tony (peer mentor: Organisation C).

In conclusion, there were several motivators for taking up a PM role; some were related to the individual's personal needs to sustain recovery, develop their skills and prepare for the next stages of social inclusion, be that in employment or other forms of self-development; other motivations stemmed from the desire to 'give back' and to help others experiencing similar problems to their own. Although some financial recompense for expenses was appreciated, financial rewards were not the main motivator to become a PM. As discussed in a subsequent chapter, the PM role provided a transitional pathway between alcohol and drug use (and treatment) and re-entry into post-recovery roles.

5.4 Theme 4: Shaping the PM role through occupational development and organisational socialisation.

Organisational policies and procedures, organisational norms and values, and the ways in which organisations inducted and supported PMs were important factors in shaping the PM's role. Both staff and PMs across all four organisations interviewed were keen to illustrate how these factors were instrumental in the PM's development and progression. Ways in which organisational socialisation processes facilitated the PM transition and their incorporation into the organisation, or presented barriers, were discussed by PMs, managers, and alcohol and drug workers. Their comments illustrate how different organisations have attempted to adjust to recent shifts in workforce composition towards including PMs more centrally in service provision.

How Organisational strategy and ethos informs the PM role

During interviews with staff and senior executives, they expounded on how they integrated their PM roles into their respective strategic five-year plans. And they also explained how they allocated resources to support the PM's recruitment and retention processes.

> *So, I think from a strategic point of view; they're absolutely key roles. We really see the high value in those roles. Having people with lived experience, Sandra (Senior Manager: Organisation A).*

Like Sandra above, other managers (in her organisation) shared data they had gathered from a recent virtual consultation with the Chief Executive Officer (CEO), PMs, volunteers, and other personnel. The event's primary purpose was to capture information informing the organisation's PM or volunteering offer, recognising PMs as a valued part of the workforce, both presently and in the next five years. Furthermore, at a planning day, participants (PMs, volunteers, managers, and other operational members from the executive team) were encouraged to share how they delivered the current PM programmes and opportunities for improvement. Similarly, participants commented on how the organisation's current policies and practices affected PM roles. Participants offered recommendations on how future practices, including communication strategies, could be developed to support better PM engagement with the organisation.

As mentioned in Chapter 4, three of the organisations involved in this research were charity organisations and one, an NHS provider. Staff interviewed from these charity organisations described more flattened organisational hierarchical structures compared to NHS providers. As a result, some authority and decision-making processes were more decentralised which facilitated more localised approaches to PM role implementation. However, in key areas such as policies, procedures and recruitment processes, all four organisations reported that they were a combination of core policies - centrally-development and informed decisions made by the executive's

leadership - and other procedures which were shaped and implemented locally has been discussed below.

Managers from other organisations were also keen to demonstrate their positive perceptions of the PM roles, both at the frontline and at a strategic level. For example, Marie, a senior manager from Organisation D, highlighted how the organisation's leadership was 'passionate' about having PMs as part of their workforce. Marie, like other staff members from different organisations, described how there was 'buy-in' and support from the top of the organisational chain of command.

> *We do invest, and I sort of see especially from the senior level we're very passionate. CEO as well is very passionate about sort of volunteers and PMs and supporting them, Marie (Senior manager: Organisation D).*

Participants noted that there is a close relationship between the structure and culture of an organisation and how these are aligned to ensure successful workforce development, especially when integrating new staff members. An organisation's management structure can offer valuable insights into its members' attitudes, personalities, and behavioural codes. One of the service managers, Claire, explained how her organisation created an inclusive organisation to incorporate those with lived experiences.

> *So, it was certainly a <u>big</u> area of that part of the service. We also have a service user involvement lead, who is now a <u>staff</u> member who leads on that area of the services and links in <u>nationally</u>, Claire (Service Manager: Organisation A).*

Participants from all the organisations that participated in the study highlighted that they had actively promoted having service users and ex-service user representation at a senior management level, as well as on the frontline. This inclusivity

demonstrated a commitment to the organisation's ethos and values of PM roles as a positive transitionary role.

Leslie, a senior manager in Organisation B, spoke about how her organisation had changed its existing policies to encompass PMs and staff with lived experiences. This approach demonstrated a more inclusive tactic that supported cohesion and reduced discrimination within the staff of that organisation. Leslie explained that having worked at a strategic level, she was aware that the senior management team valued the PM's role in service delivery and development and as part of business continuity by winning future business. However, she acknowledged that there was sometimes a discrepancy between what happened at the board level and what happened at the front line.

> *I went to the board of trustees and the executive team, and I said, this is the position we're in that actually. It is not okay. It does not match our mission, vision values as an organisation and how we work with PMs and staff who have been ex-users, Leslie (Senior Manager: Organisation B).*

However, she also highlighted how the organisation's culture was instrumental in shaping the behaviours of the board of trustees to ensure that management issued timely directives to address policy deficiencies that were at odds with the organisation's ethos and values or its culture. Similarly, Leslie also advocated that local managers were able to exercise their autonomy and creativity in how they worked with PMs.

> *… what I thought at first was we need some sort of relapse policy for staff and PMs. But then through our consultations, actually, we don't need a new policy. We needed to adapt the policies you've already got. … In terms of Human Resources (HR) processes and processes of change in terms of policies, we have got like wellbeing policy, Leslie (Senior Manager: Organisation B).*

Similarly, the data have shown how organisations have attempted to endorse an inclusive and supportive culture of the PMs' role and transition. Julie told us:

> *We're really keen on for a long time [for PMs to get involved]. He [PM] contributed to developing the interview questions and was a big part of our interview panel for the recruitment of our last two recovery practitioners. The [name of the organisation] usually have a panel of interviewers and he was a third panel member, Julie (Service Manager: Organisation D).*

Julie described how they had involved PMs in interviewing new staff members. She also explained how this was a two-prong approach. First, PM can develop employability skills and improve self-confidence. Second, the organisation or service benefited from the knowledge and skills the PMs acquired as part of their lived experience and the emotional intelligence they brought to the interviewing process. Julie, like other staff, stated that the promotion of the PM's role supported the transition of PMs within their recovery journey.

However, while there was evidence that PMs were considered when developing policies and protocols, as in Leslie's organisation, these were not universally applied. (see section 5.4., on barriers to the pathway). In most organisations and services, recovery-focused interventions were the primary raison d'être. However, some staff also highlighted that organisational culture, practices, and attitudes can sometimes conflict. For instance, Paul, a PM manager, described how some key workers sometimes struggled to accept PMs as colleagues. Despite championing the recovery-oriented practice and supporting the PM to continue to build on their recovery capital, some staff expressed caution and scepticism about PMs' ability to maintain their abstinence or boundaries with other service users.

Socialisation Stages

Most PMs had been previous service users of the organisations. Therefore, they would have been acquainted with some staff members and most service hubs within the respective organisations. However, PMs may not necessarily have been formally introduced to the staff, made aware of the hierarchy and organisational relationships between staff, or were orientated to their new 'work' environment. Nor would they have been familiar with the policies and procedures which help inform their behaviour and how they carry out their roles and responsibilities.

Three stages of organisational socialisation were identified from participants' comments – an 'anticipatory' stage, an 'accommodation' stage, and an 'adaptation' stage. The next sections explore how these were applied by the organisations in this study to support PMs in the transition process from service users to PMs.

The anticipatory stage

At this stage, PMs are preparing themselves to join the organisation's service delivery staff. PMs who are nearing the end of their treatment journey or have shown an interest in pursuing PM roles or have demonstrated traits which will be a good match to the PM roles are encouraged to apply. All the organisations involved in the study have dedicated staff working in the capacity of (Education, Training and Employment (ETE) or PM coordinators or managers. Their primary role is to identify potential PMs and to make them aware of these opportunities. In addition, key workers and managers of alcohol and drug services also played an active role in encouraging service users or those who had left treatment to apply for PM roles. For example, Sue was approached by a PM manager:

> *I was due to leave [discharge from treatment] the service in the end of May or June and as the [PM manager] said, 'Are you interested in becoming a PM? Sue (peer mentor: Organisation A).*

Marvin describes a more formal approach:

> *Well with this of the PM manager for the service ... [the name of the member of staff], she would do the recruitment. So, she would advertise the posts … exactly the same way as recruiting the staff member, Marvin (PM manager: Organisation A).*

As previously mentioned in the Chapter 4, section 4.5., all the organisations in this study had a dedicated section of their website on which they actively advertised how PMs can access this opportunity to join the organisation. Organisation D's website stated:

> *The organisation has a robust PM recruitment process. Accredited training is offered to successful applicant as part of their introduction. Applicants can get further information from any member of our team within our services. Organisation D website*[9]*.*

The website entry described how the vacancy for PMs was advertised across the organisation. The webpage also described the roles involved, the support that the organisation provides to the potential candidates, and who they would be working with. This organisational approach keen to attract PMs into these roles were not unique to organisation D but across all four organisations as seen in Appendix 2 and in greater details illustrated in Appendix 3.

Furthermore, Marvin, a PM manager from Organisation A, similar to PM managers and staff from the other three organisations, also described how this process is translated into practice by frontline staff and management.

[9] This information was taken from Organisation D website which was captured as part of the Service Mapping Exercise described in Chapter 4.

The [PM] post is identified, then it's advertised on the website and then people apply for it. They will complete an application ... then there's the values-based interviews, Marvin (PM manager: Organisation A).

Marvin highlighted that most organisations used a multi-layer approach with the anticipatory socialisation stage to attract PM to these roles. As previously described, PM roles form part of these organisations' core values and ethos. They recognised the importance of this entry stage as part of the socialisation process.

The accommodation stage

At this stage of the organisational socialisation process, PMs are introduced to the organisation to learn how it is structured, managed, and where they will fit into it. In all the organisations, both PMs and staff spoke of the provision of PM training prior to the PM commencing their roles. Jane described how she had undergone the same 'onboarding' exercise as did any newcomer or member of staff to an organisation.

I completed the actual PM training they provide here … then you have to wait to get your DBS, Jane (peer mentor: Organisation D).

All PMs interviewed reported that they followed the same process of completing their DBS, attending induction programmes, and accessing mandatory and specialist trainings. In some instances, they had the opportunity to shadow other peers or work colleagues, such as key workers and managers.

The adaptation stage

At this stage, the PM became active and, in some areas, independent members of the team. This occurred once the initial stages of uncertainty were over, and the newcomers became much clearer about their own roles and their positions in the organisation. Kath and Jean both explained how they moved between stages, from

being new staff members with regular supervision and support to taking on additional tasks and responsibilities.

> *This is done in such a way that the PM takes on more responsibility at task gradually, and their needs are discussed and agreed regularly within their supervisor. PMs carry out a range of support based on the local needs of service. Kath (PM Manager: Organisation D).*

> *I get to do all different types of things on different projects… I get to work on business development project, I get to work on my own project, designing some research, I get to write literature review which gets published! Jean (PM: Organisation D).*

At this stage of the socialisation process, PMs became more aware of the norms of the organisation. Consequently, PMs became more comfortable and effective members of the alcohol and drug teams. Jean explained how her confidence and proficiency had improved which enabled her to be delegated more responsibilities. She stated that being given more responsibilities represented a very rewarding progression in her PM role and a positive impact on her recovery journey. These adjustment processes were generally well documented, and it provided support for greater organisational commitment towards achieving job satisfaction for individuals in the work environment.

Through these socialisation processes, PMs were able to acquire attributes that were synonymous with staff within the alcohol and drug services. These attributes included occupational behaviours, appreciation of role boundaries, skills, knowledge, and experience. These will be explored in the following sections.

Enacting occupational behaviours and setting role boundaries

PMs explained that an essential part of their role was conforming to occupational norms and behaviours appropriate to the organisational and social environments. These included being courteous, non-judgmental, and not using obscene language, behaviours which would not discredit themselves, or the organisation. As Sue said:

> *I had one service user who I just I wanted to say, oh just piss off, but I didn't do it. But I keep cool and just be helpful. It is an expectation because at the end of the day, it is all about what I am, a PM, Sue (peer mentor: Organisation A).*

Sue highlighted that within her role as a staff member of the alcohol and drug team, she understood the need to be courteous and non-judgmental; she recognised the expectation to behave in accordance with the organisation's norms and values. Other PMs, drawing on their prior work experience, also mentioned their ability to adjust their language to align with the occupational expectations of their new roles. Specifically, they spoke about how they had adapted their language, for example not using phrases such as 'fuck head', 'fuck up', or 'off his/her head' (that they might have used with their alcohol misuse friends) to be more sensitive when interacting with colleagues within alcohol and drug services. Sue also alluded to using other language to describe either their own experiences or those of their 'intoxicated' or 'service user dependent on alcohol' in the service settings to demonstrate the different approaches she took.

Service manager Claire also explained the importance of work-related behaviours in the role of PM and occupational conflict that those new to the role experience.

> *We delivered bespoke training package as well because what we found that people perhaps struggled [with professional behaviours]. Sometimes, some of the PMs who came through had never worked before. You know, certain*

behaviours that might be expected in a working environment. Then, they also produced a booklet for new PMs and new people coming in, so they all had it when I first come in, Claire (Service Manager: Organisation A).

Claire asserted that her organisation supported individuals in their PM roles by providing relevant training to address apparent knowledge and skill gaps. These gaps were frequent among individuals who had never worked in this capacity and required guidance in learning and culturally integrating these new approaches and behaviours. She also pointed out that as part of their new roles, PMs may often encounter others they previously used substances with, and clarifying the organisation's expectations of those in the PM role was crucial. Data collected as part of the service-mapping exercise captured in Appendix 3 also showed how Organisation B recognised this knowledge gap among the PMs. As a result, they included specific training around professional behaviours and boundaries as part of their training suite to PM.

Most of the PMs interviewed argued that their roles allowed them to develop and practice work-related boundaries. They described how they could apply these work-related boundaries within the workplace environment and felt that they prepared them for future employment opportunities.

I was just told to be very careful about boundaries. To be careful about what I say especially in terms of, admitting to anything that was potentially a kind of criminal act or anything, Gary (peer mentor: Organisation D).

Gary discussed how he, like other PMs, had learned to understand how to adapt his behaviours and to determine what information he could communicate about his past lived experiences and with whom it would be appropriate to share that knowledge. He explained that he felt that being part of the alcohol and drug service and exercising boundaries was about the type of information one shared in the work environment and recognising when it is appropriate to share that information.

It was pointed out that work-related boundaries are also related to the relationships that one develops with others.

> *I think sometimes, it's kind of hard… I have to be professional when I'm in the office and I have to know boundaries. I have to know when I've overstepped my boundaries or if a service user has, Gemma (recovery champion: Organisation A).*

Gemma asserted that they had to negotiate relationships with former service users while maintaining their occupational boundaries as part of their new identities and roles, owing to the training they had received in their PM roles and support and learning from others. Most PMs recognised the importance of maintaining work-related boundaries to be effective in their current roles and to help them grow in their future. Gemma clarified this point when she stated that she was acutely aware of her struggles. She sometimes found it challenging to maintain a professional attitude as a PM while maintaining a 'sociable' and 'approachable' behaviour with her ex-peers. Thus, according to Gemma and other staff members, work-related behaviour was not always straightforward, and negotiating limits and appropriate behaviours were sometimes tricky to maintain.

Notably, the study found that PMs with previous alcohol dependency issues were unique to those who had polysubstance misuse, as they were more likely to have had previous experience of full-time or regular employment. Most PMs who had used alcohol misuse alone reported that they found it easier to re-learn previous occupational behaviours and work culture compared to those who had a history of drug misuse.

Another PM, Tony, also described how he executed his responsibilities within his PM role. He highlighted how he maintained and explained boundaries with individuals who had previously been their peers as service users. He explained how he shifted his behaviour to guarantee that the service he provided was equitable to all service users while maintaining his occupational boundaries.

So sometimes when people come to the service at [name of one service sites], they will be like … can you help me to get in? I would say that I am not here because I know you from my past. I am not going to get you to jump the queue. You have to do like everybody else and put in the hard work or I don't want to cheat someone else who were in front of you, Tony (peer mentor: Organisation C).

Tony explained that he was not prejudiced against those he knew through previous service user interactions. While he believed that these relationships remained valuable to him, he asserted that they were distinct from the interactions he was now expected to have with service users seeking treatment.

5.5 Conclusion

This chapter has discussed how the terminology used to indicate people with lived experience working in service delivery is variable, but all PMs share a number of common characteristics. In particular, they have lived experience and have been abstinent from alcohol (drug) use for a required period of time, which may differ between organisations. The chapter reflects participants' views and experiences and the individual-level factors which influence who takes on the role and why, as well as the socialisation process which goes on within organisations to recruit and retain people in these positions. The chapter has indicated both the benefits of the PM system to the individual and to organisations, as well as some of the problems that may arise in developing this relatively new aspect of the workforce. The next chapter examines the pathways to becoming a PM and the transitional nature of this process.

Chapter 6: Pathways to becoming a PM: a transitional process

6.0 Introduction

Adopting the role of PM is one of the many routes that individuals with a history of alcohol misuse could take as part of their recovery. This chapter examines the concept of a developmental pathway, the PM's progression into, though, and sometimes out of the PM role within alcohol and drug services. I have focused on four major themes that emerged from the data collected during this research. They are:

1. The stages towards becoming a PM
2. The recruitment process for PMs,
3. The enablers to PM pathways, and
4. The barriers to the PM's pathway.

6.1 Theme 1: Stages towards becoming a PM

Both the PMs and staff described different pathways for PM roles. Fig 6.1 shows the basic pathways of the route towards becoming a PM.

A PM's recovery pathways would normally begin at the point where they accessed services during a period of active and dependent drinking as a service user. For many service users, alcohol detoxification, either through a private/public residential detox or in a community setting, is the first stage in their treatment/recovery journey. For many service users, the length of time they remain in this stage will depend on their motivation to address their alcohol use, comorbidity factors such as physical and mental health, and the use of personal or publicly commissioned services. A small

minority of service users may be in a financial position to fund their treatment privately. However, in most cases, access to inpatient placements is funded by the respective local authorities in the catchment area, which is costly and the funding for these placements varies among local authorities.

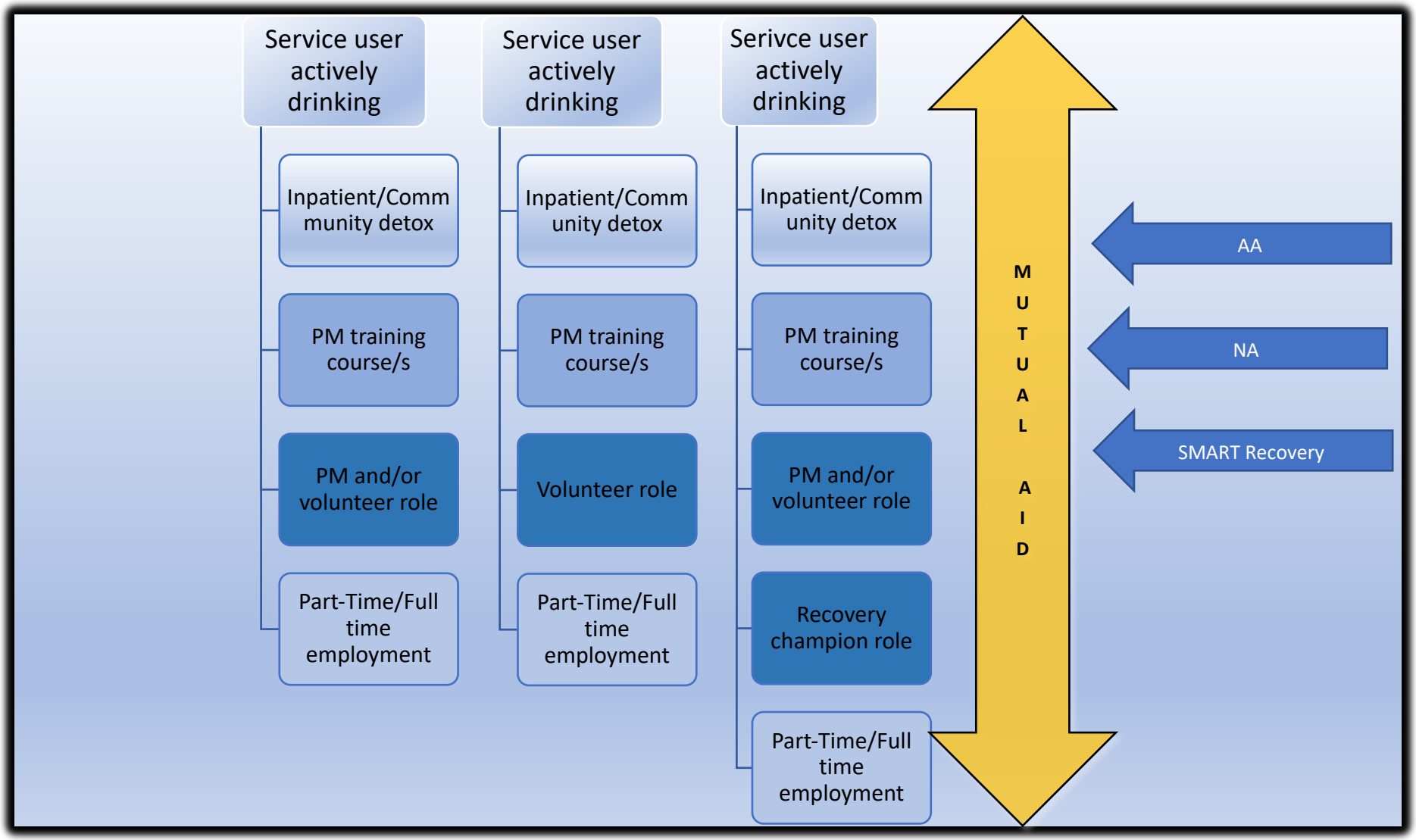

Figure 6.1 Pathways- Routes to becoming a PM (Source: compiled by the author)

Finally, there was a small cohort of service users who were detoxed in the community setting with the support of their allocated alcohol key workers using a safe self-reduction plan that did not require pharmacological intervention.

Sue and Jack highlighted a combination of three detoxification options (privately funded residential detox, publicly funded residential detox, and publicly funded community detox) that are available as part of an individual's alcohol treatment journey and are related to the first stage of the recovery pathways:

> *I was luckily enough that I had savings to fund myself and go into detox, Sue (peer mentor: Organisation A).*

> *When I first had a detox, I went into [name of detox centre] in London. On my last occasion, I completed my detox in the community. ... After my detox, I went into the aftercare day programme and we started to look at the real financial constraints, if we don't get a lid on our drinking and/or if we do relapse. They explained the chances of the funding being available, the next time we need a recovery [detox] … was going to be even slimmer, Jack (peer mentor: Organisation B).*

Significantly, Jack highlighted the growing economic pressures surrounding funding for detox on alcohol and drug services and the increasing economic pressures affecting detoxification and treatment interventions faced by alcohol and drug services. Interestingly, as Amanda explained, services and treatment programmes are also educating and involving service users and PMs in the realities of financial pressure and availability of treatment options.

> *In Dorset, … there wasn't much [rehabs centres]. However, I know that more rehabs and detoxes … are closing and they [staff] want you to have more*

commitment to your recovery before this[detox] is explored, Amanda (peer mentor: Organisation C).

Amanda also described funding disparities across the country as well as the closure of these treatment centres as a result of funding cuts in this part of the healthcare system.

Following the detoxification stage, some service users may choose to invest more time in their recovery by accessing further rehabilitation interventions. Some participants described accessing a 12-week inpatient rehabilitation programme offered by a variety of Tier-four treatment providers or signing up to community-based relapse prevention aftercare packages offered by the alcohol and drug treatment facility to which they are attached.

I wanted to go into rehab and I just kind of went with it...After, I came from rehab where I was for three months, and I lived in the aftercare service for another three months. After this, I think I just started peer mentoring on weekends, *Steven (recovery champion: Organisation A).*

Steven emphasised how he felt that he needed to consolidate his recovery further by using both the inpatient rehabilitation programme and then accessing further aftercare support due to his mental health and housing needs at the time. He also stated that these interventions provided the foundation for his recovery journey.

Furthermore, becoming a PM appears to be the next step in a service user's recovery journey. As shown in Figure 6.1, the three simple but non exhaustive routes are not mutually exclusive. It is worth highlighting that the data revealed that the pathway to the PM role is not a linear one. Rather, it was contingent on several of the factors mentioned previously, such as the availability of funding and other medical and social factors which might have had a bearing on meeting the eligibility criteria for accessing

certain treatment interventions. In Steven's case, the stability of his mental health state and well-being was a significant influential factor in accessing Tier-four interventions. Numerous PMs stated that poor mental health, such as depression, auditory hallucinations, and bipolar affective disorders, were contributory factors to their initial alcohol misuse. Similarly, based on the data collected for this study, there appear to be differences in the pathways from organisation to organisation. For instance, the pathway pursued may be dependent on the organisation's interpretation of what defines a PM. In certain organisations, for example, the PM was someone in the final stages of their treatment pathway with the organisation, while with another organisation, individuals will only commence a PM role once they have been formally discharged from a structured treatment programme and are no longer considered to be a user of that service.

As shown in Figure 6.1., the experience of mutual aid groups was an important element in the recovery and PM pathways. All PM participants interviewed for this study said that they had accessed a variety of mutual aid support groups in the community, including AA, NA, and SMART recovery groups, prior to, during, or well after their treatment episode for alcohol misuse had concluded.

The data gathered indicate a strong connection between access to mutual aid and the PM's recovery journey, as described in section 5.3, the motivation for becoming a PM. Furthermore, these findings appear to corroborate what the National Treatment Agency (NTA) has identified as a critical component of recovery orientated treatment for service users. The NTA states that recovery support is a component of the treatment intervention and should be included in the treatment episode of a service user. This national agenda can also be identified as an external factor which enables the PM's pathway into this role. This is discussed further in section 6.3.

PMs identified mutual aid support as a major factor in their pathway to becoming a PM. For instance, Gemma and Amanda commented,

I want to be able to still help people maybe in addiction, but I still do that anyway in my 12-step fellowship when I sponsored people [during this role as a peer mentor, Gemma (recovery champion: Organisation A).

My journey to get here [being a PM] was through AA initially but obviously when I came to London, other things - mutual aid support - was also on offer… AA aren't for everybody and lots of other methods and support like SMART groups and maybe just returning to the [the name of service] or whatever was possible, Amanda (peer mentor: Organisation C).

As Amanda and Gemma described, accessing mutual aid interventions provided the starting point for their recovery, and it also supported their decision to become PM. Equally, they also highlighted that ongoing mutual aid support helped them sustain their recovery by continuing to meet others with similar lived experiences of alcohol. Gemma particularly stated that her 'fellowship' enabled her to continue carrying out her tasks as a PM. She commented that she was able to give back, which was part of her personal identity. Amanda described learning about other types of mutual aid that were available by becoming a PM, adding that her peer mentoring training was enlightening and offered individual choices. Many PMs described how having access to mutual aid was pivotal and continued throughout their recovery journey. However, the findings also suggested that mutual aid support can cause conflicts for PMs.

My recovery is more A.A. and I use A.A. for what I need; however, I do have this conflict. I personally, I don't feel too comfortable sitting in an AA group with other people that I'm trying to help, Debbie (peer mentor: Organisation C).

Debbie explained that she felt limited in the way she could express her own support needs and vulnerability. Debbie discussed how she needed to be able to divorce or separate her own recovery needs when she attended mutual aid groups in her community where service users were also present. This issue is explored further in

section 8.5 as it relates to the various liminal states that the PM experiences in their PM role.

The next section discusses recruitment, the first step in becoming a PM. This was followed by an examination of the enablers and barriers which influence progression along the PM pathway.

6.2 Recruitment process for PMs

As mentioned previously, all the PM participants interviewed described having received structured treatment from the respective alcohol and drug services to which they were now attached as PM. From the collected data, a referral or application process appears to be undertaken as part of an internal recruitment process. This signified the progression and/or transitionary point from being a service user to becoming a PM. It was also evident that there were various approaches ranging from informal to a more formal recruitment process. These application approaches also appeared to be different from PM to PM, from service to service, and from organisation to organisation. Whilst the terms referral or application appeared to be used by staff and PMs alike, it is a loose terminology used mainly in this context to describe the initial process of recruitment in all services. The different referrals or application processes are discussed below.

Referral/Application by word of mouth (Planting the seeds)

In some instances, the referral/application process was performed by word of mouth by key workers when working with service users.

While I was doing the day programme, I was asked 'how do you feel about co-facilitating in the SMART recovery groups. So, I said, Yeah, I don't mind. After a couple of months of co-facilitating, the facilitator said, have you ever thought about doing the SMART facilitators course? I said 'Well, considering that, this is what I've mapped out for my future and wanting to give something back, yeah! I think that it [peer mentoring] all kind of happened very organically and it just presented itself, Jack (peer mentor: Organisation B).

Honestly, it was more my key worker, just letting me know, Hey, here's an option [to be a PM], think about it! George (peer mentor: Organisation C).

Jack and George both described a very informal process of being made aware of the opportunity to become a PM, which culminated in their appointment to the roles following a PM training course. In Jack's case, he was also still receiving psychosocial interventions at the time, such as attending psychosocial groups. Despite this, he has been sober for several years. During his interview, Jack described himself as being emotionally attached to the service and taking his recovery journey much slower compared to other PMs interviewed. This may have been a contributory factor explaining why he did not consider the role prior to being asked.

PMs who were approached informally described this transitional process as almost osmotic in nature. They felt that their needs had changed, and that they had outgrown the level of support they required as service users. Having developed their own coping and other recovery skills, they were now receptive to developmental opportunities, for which PM roles appeared to be an ideal and logical next step in their recovery journey.

For George, while the referral process was done on an informal manner, it involved an application or referral form. It appeared comparatively more structured compared to Jack. George was encouraged through a structured treatment intervention, namely

his psycho-social interventions during a key working session with his key worker at the time.

It could be argued that while these referral processes were not like the conventional formal applications to a job role, the relaxed approach may be more favourable to service users. The informality of this approach may make it less intimidating and rigid, and those lacking confidence and direction may be more receptive to these recruitment approaches. The manager at Organisation A explained,

> *What we found was that it was quite important to give them a sense of direction. When they've been in the process of being abstinent for a while and they are showing interest with being involved with the organisation, we offer them the opportunity to come on-board as a peer mentor, May (Team manager: Organisation A).*

May commented that during key working sessions with service users, key workers may identify the goals or aspirations held by service users. Staff may advise them on different options to help them progress in their recovery. One of these may be to become a PM. Thus, one could argue that becoming a PM may be seen as a by-product of the therapeutic relationship which has developed between key workers and service users. May described 'planting the seeds' of becoming a PM with service users in order to introduce them to the next stage of their recovery pathway.

Application to PM roles also occurred through the PM's own initiative. Debbie indicated that she had always worked prior to her alcohol misuse. However, she felt that she needed a gap or break between being a service user and being employed full-time. In Debbie's case, she was proactive in seeking other opportunities, and she had made enquiries about the role of PM on her own initiative.

So, I went into detox and rehab through [the name of the service] … and once I got my shit together should I say [laugh]... I met with a paid member of staff and this person she was with …let's call her, Michelle… she was a peer mentor. So, I inquired what does [a PM] mean …what do they do and how did you get into it… so then, after I was told, I filled out this application and I did, Debbie (peer mentor: Organisation C).

A similar experience was reported by Jane.

I spoke to my key worker one day; it was about eight months into my recovery… that I am really interested now [in the PM role]. I said to her, now that I'm stable… I feel I've got some skills and qualities that I might want to actually be looking to explore this field further... maybe eventually look into it in a paid capacity. So, she said … are you aware there's a few mentoring programmes going, I'll put you forward, and she actually spoke to one of the [PM] programme facilitators and they thought I would be ideal; that's, how I got on, Jane (peer mentor: Organisation D).

In both cases, the PMs had prior experience of being employed, and they appeared to be self-motivated to return to the working environment. They both expressed levels of self-determination and viewed the PM role as an opportunity to develop employability skills. Having knowledge of previous recruitment processes informed their approach to seeking information and trying to access further development opportunities, enabling them to adopt an active rather than a passive approach.

Referrals via the Employment Training and Employment (ETE) co-ordinator or PM manager approaching service users during or after structured treatment.

Both Sharon and Sue described a very different organisational approach to recruiting PMs compared to Debbie or Jane above.

…as my recovery was going very well, I just thought if I could help one person in anyway get through this, I wanted to do that. So [the name of the PM coordinator] approached me and said, would you be interested and I said, yes very much as I felt passionately about it so, Sharon (peer mentor: Organisation B).

So, I was a service user, and I was doing groups and never missed a week. So, they knew that I was reliable, and I was serious about my recovery. So, [the PM manager] said, why don't you take a peer mentor course, Sue (peer mentor: Organisation A).

Sharon and Sue were from different organisations but described a similar recruitment process. Both organisations invested in dedicated staff members to support the PM's pathways and recruitment. These roles were called ETE coordinators or PM managers, and in some organisations, there was a team of these individuals who covered services across a geographical area. The main task of these individuals was to concentrate on supporting service users who were at a stable point in their recovery, to explore the next step following discharge from structured treatment. Marvin and Kath, both PM managers in two different organisations, illustrate these roles more clearly in their comments below.

The volunteer coordinator/manager for the service [the name of the member of staff], she would do the recruitment of PMs. She would advertise the posts and then all the posts are advertised in exactly the same way as recruiting a staff member…Then there are the interviews which is a combination of value-based and competency-based interviews; then there's the training package, which is set up for the PMs, Marvin (peer mentor manager: Organisation A).

So, my prime function is to support the peer mentors and volunteers as a PM manager/ coordinator. So, we try to help them find roles within the services or

outside of the services where they were once a service user and along with providing ongoing training. We are responsible for the recruitment process and we [deal] with all that side and the applications process as well, Kath (PM Manager: Organisation D).

Marvin and Kath described how they actively liaised with key workers to share information about peer mentoring training and PMs placement opportunities and to explore work-related options within other agencies. These individuals or teams would also act as the first point of contact for staff when supporting service users in transitioning into PM roles. Other elements of the role include educating key workers about the PMs recruitment process and how to be a central point of support to help guide and support PMs once appointed. Furthermore, they both said they were responsible for the recruitment process, such as the application forms, interviews, and induction training, as part of the peer mentoring programme. Paul, a PM manager, also described similar support functions, but he added methods he used to encourage individuals into the PM roles.

At the aftercare services, I'll leave my contact details and I'll say to them, if you're interested in the peer mentoring, let your key worker know and they'll make a referral... or fill out an application form with you. Another obvious route to advertise the PM role is on our organisation's website…I also check-in with the key workers from time to time and ask if they had any service users who have completed [their treatment] and they are not doing much else with them, Paul (PM Manager: Organisation A).

Paul noted that it was vital to remind staff to continue to think about the peer mentoring options and to offer ex-service users other avenues to occupy their time, which invariably supported their recovery. Like those working in other organisations, Paul described using several ways to publicise peer mentoring opportunities, such as on the organisation's website, tapping into aftercare services, and regularly checking in with key workers. However, Paul also described a more outward approach to

publicising PM roles, which differed from the method adopted by other organisations or services. For example, he reported connecting with existing groups in his local area and working in partnership with other agencies to publicise the PM role and its benefits to others.

> *There are groups in the borough, and I will pop into them from time to time and give a bit of a talk about what peer mentoring is, what training is involved and what the prospects are and the benefits of doing it and so on, Paul (PM Manager: Organisation A).*

Notably, Marvin, Kath and Paul were participants from different organisations with a dedicated role to support and encourage the development of PM roles and transition into these roles. However, they described slightly different recruitment processes for getting service users into the PM roles. Furthermore, these individuals were also responsible for supporting generic recovery/key workers who worked with service users to access PM roles. In addition, Paul also described a more creative and broader-reaching approach employed to advertise and raise awareness of the PM roles within the community setting. Lastly, an interview with a senior manager from Organisation C described the advantages of having dedicated staff for PMs. Their primary roles were to support the development of the PMs as new but valuable members of their workforce. However, this work with PMs was still only in the implementation stage.

> *In an ideal world, the vision would be that we would… sort of, 'grow our own'. Where we've got people who would become PMs for us, we have to invest in them as they have invested their time in us and hopefully, they would want to work for us. I think that this will create a good, positive culture because they like the organisation and can see the skills that they have acquired. They will also have a shared vision with the projects that we are doing. I hope that we will be able to lead the field of PM/volunteers in the next three years or more, Marie (Senior manager: Organisation D).*

Furthermore, Marie argued that investing in PMs could lead to retaining these individuals by engendering a shared vision and organisational culture. She also explained her dream of being a flagship in peer mentoring programmes in substance misuse.

The following two sections focus on the factors that were enablers or barriers to the PM's pathway process. I will attempt to explore these factors at an individual level (front-line staff/ managers/ service users), at the organisation level (management, resources, and financial or institutional structures) and with external influencers (broader health and social policies).

6.3 Theme 3: Enablers of the PM pathways

The study revealed several essential factors that enabled PMs to progress successfully along the PM recovery pathways. First, at an individual level, PM coordinators/managers and key workers advocated for a supportive environment for PMs as they undergo the PM pathway process. By providing mechanisms such as supervision sessions, shadowing opportunities, training, feedback, and recognition of their work, PMs can feel supported and better positioned to grow at their own pace and in their own time. However, it is crucial to note that fostering an enabling and supportive environment alone is not enough. Staff must also consider the broader context of the policy environment.

Supervision sessions for PMs

Supervision with line managers and other types of supervisory contacts was one form of support provided to the PMs. Marvin, one of the PM managers in Organisation A,

explained that the frequency of supervision provided matched the level of competency and stage in the PM's recovery. First, he explained that there were official supervision sessions booked, which occurred on a planned and regular basis. Then, he also described the ad-hoc supervision he provided based on each PM's developmental needs.

> *Their [PMs] supervision was done twice a month now. That's their official supervision. But it depends on the strength of the peer mentor, and it depends on where they are in their recovery. I've got one at the moment who's fairly new and I have a meeting with her sometimes twice a week, Marvin (PM manager: Organisation A).*

Peter, a PM manager from another organisation, also said that supervision sessions were a staple part of a PM's developmental toolkit provided by the organisation.

> *They all receive supervision. Normally, when, we've got peer mentors, we will have supervision with them once a month but mainly, I will do it on a fortnightly basis. We will set goals and objectives and do a bit of 'human nursing, Peter (PM manager: Organisation D).*

Peter, like Marvin, commented that PMs often needed supervision sessions more than once a month to support them. He described how he structured these sessions to concentrate on identifying developmental needs, providing protected time to listen to, and offering feedback to the PMs. The interview with another manager, Chris, highlighted other modes of communication deployed to ensure that supervisory support occurred. He explained that being approachable and engendering a reassuring culture in which PMs could raise concerns, whether in a one-to-one session or as part of a group.

Yeah, they also get one to one support. The support might be supervision, but we also can support them over the phone. We've also got our own peer mentor WhatsApp group as well. We also have a chat, and they know they could talk to me anytime, Chris (PM Manager: Organisation C).

All the PM managers from various organisations unanimously believed that supervision with PMs was an indispensable factor in their role and promotional advancement. They asserted that supervision is paramount, mainly during the introductory phase of a PM joining an organisation. Additionally, Marvin, Peter, and Chris revealed that PM support came in varied forms, and some supervision sessions are one-to-one and pre-planned face-to-face meetings. Nevertheless, there was the flexibility to add more supervision and support sessions to PMs on an ad hoc basis, if needed. All managers agreed that PMs should receive, at least, monthly supervision. However, the number and type of supervision provided depend on the level of support the PMs require at different stages of their PM roles. Thus, managers and staff tasked with PMs use the same support structures and techniques as they would with paid staff members. PM coordinators and managers also argued that supervision and support sessions provided an opportunity to clarify roles and role boundaries, and how they may be able to address any work-related issues. In some of these sessions, they focused on discussing what changes PMs can make in their practice, whether through positive or negative observations made during the day or week by their line managers. It also helped the PM to clarify any techniques that may have helped them develop their practices. Like any new staff member, PMs are often uncertain about how an intervention or procedure works, or how it may fit into other interventions.

Even with the data presented above, inconsistencies in supervision were evident, as they varied from manager to manager and from service to service. This observation leads one to deduce that these variations may be due to the supervisor's comprehension of the PM's needs and experience in dealing with the roles of this nature. Marvin underscored this lack of consistency and a dissimilar approach when compared to his own practice and other staff members who work with PMs.

Let's put it this way... if a peer mentor is under my supervision, they will get more supervision and they'll get more training with me than they would, say if they were under somebody in a different part of our service. I believe that these guys with the right supervision and the right nurturing and the right training would make them outstanding drug and alcohol workers, Marvin (PM manager: Organisation A).

Shadowing opportunities for PMs

As mentioned above, shadowing opportunities were another support intervention provided to PMs at the individual and organisational levels. Both PMs and staff reported that allowing PMs to shadow other team members, including other more established PMs, benefited PMs' progression. Shadowing allowed PMs to observe first-hand how interventions were carried out in practice and how governance, policies, and procedures for that organisation or sector informed them. For some PMs interviewed, this was the first opportunity to observe the interventions they received themselves and delivered to others. Watching them through the lens of a caregiver rather than a care recipient allowed PMs to reflect on the purpose and significance of the intervention.

They will shadow various staff and teams to get an experience of what the whole organisation does. They will continue to shadow the key workers and then these workers may start to relinquish some responsibility over to them. PMs would not necessarily hold a caseload of service users. However, the key worker whom they are shadowing may allow them to work with low-risk service users, May (Team manager: Organisation A).

May described how she had used shadowing to allow the PM to observe others at work, for instance, to see how a key worker's roles and responsibilities may differ from a nurse or doctor in the same team. This form of support also created a nurturing

environment for PMs to have opportunities to ask questions without feeling judged. Shadowing also supported the organisation in developing PMs as part of the potential workforce while managing the risks that may arise when inexperienced PMs work with vulnerable individuals, such as service users. Tracey, a team leader in Organisation B, also highlighted how shadowing was an effective learning tool for any new team member.

> *We do encourage people to shadow other members of staff… anyone who comes into the service, whether it's a student nurse or a social worker and our peer mentors. I really believe that in order for them to proceed effectively, it is a form of induction for them. It also says to that the person, whoever it is, peer mentor or volunteer, that they're valued. Through shadowing, the team gets to know where they're at and what skills they have, and I think it works in a more fluid way, Tracey (Team Leader: Organisation B).*

Tracey likened shadowing to a form of induction that offered the team a chance to get to know a new team member. She also drew comparisons between individuals who were at an early stage of their development, such as student nurses, and those with a PM. Student nurses' placements were vital to building competent practitioners, and in the same way, staff could apply shadowing opportunities for PMs.

Organisation made an array of training opportunities available to PMs

PMs and staff emphasised that all PMs received a wide range of training, including the initial peer mentoring training, which covered topics like safeguarding and managing boundaries and information governance. For example, PM Jane, spoke about the initial training offered to PMs before starting her role, which supported her in developing the skills needed to carry out the tasks required within her role as a PM.

They offer training to all PMs initially… We've got a [name of the course] course which is a level two employability skills course… which focuses on things like CV writing, about your strengths and weaknesses and your areas for development… it is very much more geared towards workplace... or future workplace inspiration, Jane (peer mentor, Organisation D).

Other PMs also reported being offered training to deliver group interventions such as SMART.

I went on courses like mental health and first aid training … We get extra training from [the name of the organisation], they have been put on their online training that they have for staff, Debbie (peer mentor: Organisation C).

Furthermore, across all four organisations involved in this study, Debbie, like other participants, reported that PMs could also access most of the training available to staff, whether online or face-to-face. A few PMs spoke highly about the training they received as a PM and how some training matched their own goals and aspirations, such as training on counselling. PMs argued that training helped them feel valued and created an inclusive culture. Equally, PMs also recognised that the role provided a unique opportunity to develop transferable skills and knowledge on a cost-neutral basis. In addition, they felt that the training they received would equip them for generic and key worker roles if they chose to enter the alcohol and drug field. As illustrated in the interviews with both providers and recipients of this support, training was identified as a crucial developmental component within the PM pathway.

Meaningful feedback and recognition

PMs expressed feelings valued for their contributions to the work environment. They claimed that receiving recognition for their work efforts from staff, the team, or the organisation were positive influencing factors in the PM pathway.

Yeah, I kinda got an award from the sheriff of [a London based borough] for being a PM and volunteering with the community for the past three years, Gemma (recovery champion: Organisation A).

I went to an external meeting [stakeholders meeting chaired by the commissioner] where I actually heard feedback about the peer mentors. I thought it was really good when we were being recognised in [the name of the London borough], Debbie (peer mentor: Organisation C).

During the interviews, it was clear from how Gemma and Debbie spoke about their experience as a PM that they felt motivated, appreciated, and empowered by what they had been doing as a PM. As a result, it encouraged Gemma to continue her PM role for a bit longer. Gemma, like others, also described how it was confidence-building to receive a tangible reward that reminded them of their self-worth and contributions. Another PM, Patrick, also spoke about receiving feedback from service users and staff, which he found helpful, as described below.

Absolutely, you know, I feel great from the feedback from service users and colleagues, like, you're natural with my clients. That's boosted my confidence massively, you know! Patrick (recovery champion: Organisation A).

Other PMs echoed the meaningful and respectful feedback received from the staff and service users. They also emphasised how the support from colleagues helped them develop and improve their confidence, competencies, and transition into their current and potential future roles.

Staff also described other external feedback they had received about the PMs efforts.

I have had a peer mentor who had an events management background. They helped to set up an art exhibition and the commissioner for that borough attended and wrote to us the following feedback, Such a genuinely transformative experience coming along to hear about the lives that [the name of the organisation] has impacted in such a positive way, Mira (Team Leader: Organisation C).

Mira, a staff member, highlighted several positive feedbacks they had received from commissioners, where PMs contributed to the success of several events. Mira said that the feedback was shared with the PMs and management to acknowledge how valuable the role was to service provision. For example, commissioners were required to monitor awarded contracts and provide feedback on their performance. Mira noted how recognition and feedback from commissioners provided reassurance that the work they had been doing with PMs motivated them to continue to support PMs' roles to be developed and improved as part of the broader community development and the positive modelling of PM's roles outside of the alcohol and drug setting. Many PMs and staff said that they would provide feedback to PMs in different forums, such as morning briefings, team meetings, and national events. Feedback was a means of giving non-monetary rewards which supported those who often suffered from low self-esteem and self-worth.

PMs also reported feeling valued when allowed to exercise autonomy and show initiative in their roles. Staff and managers also recognised this:

There's a lot of autonomy in the role and we often try to bring in people that we know will bring new ideas. I think [the name of the organisation] is an organisation, that give freedom to commission people to make decisions and go for it, and our PMs often bring to the table something that we've not thought of before, Robert (Team Leader: Organisation D).

At an organisational level, Robert, like all the other PM managers/coordinators across the four organisations, acknowledged the need to foster PM's autonomy and actively seek their input into the PM's development and their roles. Furthermore, they also vigorously championed the vital role of PMs in continuously shaping the service development. It demonstrated an organisational commitment to investing resources and staffing in roles such as ETE and PM coordinators/managers to ensure that the pathway for PMs is developed, supported, and sustained (as discussed in section 6.2).

External policy drivers

Interviewers mentioned external factors which supported entry into and through the PM's pathways. Some of these drivers included Alcohol and Drug strategies (Home Office, 2016 and 2017), Strang's report, *Recovery-Oriented Drug Treatment* (2011), and NTA (2008, 2010, 2012). In addition, they all referenced a strong emphasis on recovery and associated support mechanisms. Evidently, many organisations saw the development of PM roles as a way of responding to these drivers and policies. Similarly, the PM role was a good vehicle for organisations to translate these theoretical ideologies into practical applications, such as enabling individuals to live more fulfilling lives and focusing on recovery-oriented treatment rather than harm reduction.

Marvin succinctly explained the synergy between these drivers and the role of the PM.

> *I mean if you go back to the Drug strategy in 2010. This was a turning point for drug treatment for the country as far as I can recall. That's when the recovery... became something, Marvin (PM manager: Organisation A).*

In his interview, Marvin elucidated the multiple national drivers and policies that contributed to building a greater appreciation for the existing recovery communities, which were primarily concealed in mutual aid groups. Additionally, he underscored

the divergent government approaches that brought the role of PM and recovery communities to the forefront.

6.4 Theme 4: Barriers to the PM pathway

As much as an overwhelming number of factors supported the transition of service users into PM roles as part of the recovery pathway, the study also identified several barriers. I will address this in the next section. These were: the risk of relapse and burnout, the lack of support and training for staff working with PMs, short contracts and restrictive financial envelopes, the lack of robust human resources processes, and professional discrimination.

Risks of relapse and burn out as a PM

Participants identified PM relapse and burnout as counterproductive to progression.

> *We know people [PM] who struggle, and they lapse, and they relapse when they work with service users. It is important to give support to others, but I know that they [PMs] get too actively involved in their role, May (Team manager: Organisation A).*

May reported that the potential for relapse remained a barrier to PMs continuing in their role. PMs were keen to give back, but this can be detrimental to their health. She emphasised that balancing giving to others and protecting themselves in their recovery was essential. Gemma and Debbie, quoted below, captured this point clearly and the need to be self-aware of their limitations.

Sometimes the role can be <u>really</u> hard for me. Sometimes, I come home from work, and I have to nap. I have to sleep, and I have to do a little bit extra recovery work. For instance, I might have to go to an extra [mutual aid] meeting that day or whatever, just to kind of share some stuff, Gemma (recovery champion: Organisation A).

We have to look after our recovery as well. I am trying to encourage people but at the same time, I am trying to not to be triggered myself. It can be quite intense and full-on… so it can be emotionally quite draining at times as well, Debbie (peer mentor: Organisation C).

In their separate interviews, both Debbie and Gemma highlighted that the PM role could be intense and re-exposed them to memories of their previous chaotic existence when they were misusing alcohol. However, they appeared to have developed coping skills, including self-awareness and self-care promotion. In addition, another two PMs from the same organisation, who were interviewed together, highlighted that a lack of support from staff could exacerbate relapse. Ronald and Beth, from Organisation D discussed the point:

Beth: You are told, you'll have someone there to support you[on the peer mentoring course]. Ronald: There isn't, and I have never had one? Beth: <u>No</u>, not at all. Ronald: <u>Luckily</u>, … I get my <u>back-up</u> from them, who is from a different organisation entirely. <u>We have to be very</u> careful about the <u>negative side of</u> helping people with our own mental health and past substance misuse. (Ronald and Beth, peer mentors, Organisation D).

Ronald and Beth asserted that the support promised to them by the staff at the beginning of their PM was not delivered, which resulted in them both resorting to seeking additional help from external organisations. They argued that the external organisations' interventions solely facilitated their progression. In some cases, their PM colleagues who were not fortunate enough to receive the needed support relapsed and lost their lives. Julie and several managers echoed similar concerns, highlighting

that inadequately resourced or structured services could result in poor outcomes and relapse for PMs.

> *I have worked in services that had people who were peer mentors, but [they worked] in an unstructured way, and that felt awful, and it was unsafe. And it was not fair to people when they relapsed. There was a lot of shame and stigma around seeking help because they were working in the service that they needed help from, Julie (Service Manager: Organisation D).*

Marvin, a PM manager also supported Julie and Sandra (another senior manager in Organisation A) when he explained that a lack of appropriate organisational support structures could cause relapse. Similarly, he commented that PMs sometimes approach their PM roles like they have their substance misuse, being overzealous, and not appreciating the consequences of overdoing it. Sandra, who worked at a strategic level, also recognised that PM's roles are stressful and can potentially trigger a PM's relapse. Sandra spoke about the potential for the PM to be re-exposed to trauma which may precipitate their deterioration and compromise their progression along their PM pathway.

Provision of support for staff working with PMs

Most of the training offered focused on PM development and pathways. Training to staff on how they work with, and support PMs seemed to be either limited or non-existent in most organisations. Staff described feeling ill-equipped to provide the support that PMs needed.

> *There used to be one specific worker managing those peer mentors. It was a very structured programme which is paramount, and it went hand-in-hand with training. There isn't as much training. It's not as structured as it should be in my eyes. I can only go according to what I see, Tracey (Team Leader: Organisation B).*

What do you mean by it's not as structured? (Researcher).

I think that the people that are working here are doing many jobs. It's not just specific for just peer mentors. They're kind of having to put on more hats with no support, Tracey (Team Leader: Organisation B).

Tracey indicated that there were changes to the programme's structure for PMs. As a result, there were no longer dedicated staff members responsible for PMs and who could coordinate and manage the PMs and their transitions and progress. She described this as an oversight by management needing more dedicated, trained staff members to support PMs in their roles. Marie and May from two other organisations also felt that, combined with a lack of training, there is a need for other support mechanisms.

I think sometimes with the pressures on services. it is to acknowledge that if we are saying we need more peer mentors, everyone is going to supervise peer mentors. But it's also making sure the staff have the right training and skills needed, Marie (Senior manager: Organisation D).

On the negative side, I have seen in some teams that are super busy or workers that are super busy. They [peer mentors] can be a bit of an encumbrance having somebody to train and almost spoon feed through a role. It is only because of the demands of the job and the level of demands of [for caring] for service users. Some teams are like, we're too busy, we don't have enough staff to sit down and have them sit there. When they have sat with certain teams, they are not really being brought in and given training, May (Team manager: Organisation A).

Both May and Marie emphasised that staff sometimes feel ill-prepared to fully support PMs in their role. They referenced heavy workloads and a lack of training, contributing

to this lack of preparedness. This can lead to staff resentment towards PMs, potentially leading to an unfavourable environment that was not conducive to learning. This barrier to the PM pathways reflected not only how the services may be ill-equipped to support a PM's pathway, but also demonstrated a lack of strategic recognition and preparedness at an organisational level. This finding is rather paradoxical, as my interviews with Sandra and Marie, both senior management staff from different organisations, portrayed a different narrative.

> *Do you know how the [PM] role might fit into, for instance, the organization or within your services? (Researcher).*

> *I think from a strategic point of view, they [PMs] are absolutely key roles. We really see the high value in those roles… Having people that kind of live and breathe and came through the other end and have been really doing well on their recovery journey. To have those lived, that positive experience that change is possible! Sandra (Senior Manager: Organisation A).*

> *I think we do invest, and especially at the senior level, we are very passionate. CEO is also very passionate about peer mentors and volunteers and supporting them, Marie (Senior manager: Organisation D).*

Sandra and Marie were strong advocates and passionate about having more PMs in their organisations. They emphasised that the organisation recognised the value that the PM roles brought to the ethos and cultural values of the organisation, which the senior management team championed. However, the data suggested a disconnect between the organisational visions at a strategic level and the frontline level lower down the corporate hierarchy.

Short contracts and restrictive financial envelopes

As have been highlighted in Chapter 1, changes in national policies have contributed to pressure on alcohol and drug services. The participants interviewed attributed the cuts and shorter-length contracts to these strategic factors. They cited reduced funding and shorter length of contracts as barriers to the PM pathways.

> *What is happening now, a lot of that has changed due to funding. There isn't as much structure to the PM process. And there isn't as much training, Tracey (Team Leader: Organisation B).*

> *[There have been] contract cuts. We understand the cuts happen in austerity but … it's very hard for it to grow and develop into something that could become a peer mentor network that actually would really support service, Marie (Senior manager: Organisation D).*

> *I think as a ballpark figure, one peer mentor per hundred service users, would be good, but, you know, it depends on the length of the contract, you need a bit of leeway. So, depending on how long your contract is people can start and finish their peer mentoring, Julie (Service Manager: Organisation D).*

> *I think that we started off well in 2010, … making recovery possible, recovery visible in the community. I think nationally we're starting to veer from that now… mutual aid across the country and then noticing the same thing. People and the services are becoming more <u>treatment</u> focused and less <u>recovery- focused.</u> It seems to be going backward and I'm not sure whether this is the result of 10 years of <u>austerity</u> which has left services stripped financially. We can only deliver the bare essentials and recovery is being seen as a luxury. They know [the name of borough council], for example, are faced with a £17 million*

deficit…and that will come out of services. I am concerned that will affect the recovery arm of the service, Marvin (PM Manager: Organisation A).

Participants argued that these factors make investing in and implementing a peer mentoring scheme challenging, given the uncertainty and lack of resources. Some managers, such as Julie, highlighted that it is difficult, or that organisations are reluctant to invest in implementing PM schemes on shorter contracts. Like other managers, she emphasised that more than the contract timeframe may be needed to see the PM projects fully embedded in the service, and consequently, the service would reap fewer rewards. Marvin, a PM manager from a different organisation, concurred with this view on the impact of spending cuts on service delivery and how individuals' recovery is supported and sustained within both alcohol and drug services and the wider recovery communities.

Unclear and lack of robust human resources processes

The study demonstrated that the human resources (HR) process and departments were not geared towards supporting and managing PMs as an emerging part of the alcohol and drug workforce. Subsequently, there was a need for more recognition of the added support for those who had come from a lived experience background, compared to those who did not.

The thing is, I completed the actual peer mentor training … but then you have to wait to get your DBS which takes a while. My DBS came back in May, but I did not start my role until September. There was a quite time lapse between the time I finished the qualifications and when I'm actually began my role, Jane (peer mentor: Organisation D).

It was the way that it was kind of gone about that when we recruit in somebody with lived experiences, there wasn't any sort of like wellbeing plan or risk

assessment… We are kind of throwing them to the wolves a bit,' Leslie (Senior Manager: Organisation B).

Jane expressed her frustration and disillusion with the Human Resources (HR) process. She felt that her disclosure barring service (DBS), was much slower because of her previous alcohol use. There was also a sense that the PM's HR processes were seen as less of a priority than other staff recruitment processes. As a result, Jane expressed that she contemplated leaving the PM role at several points because of the time it took her to actively start her role.

At an organisational level and perhaps at a policy level, Jane described a lack of sensitivity towards those with lived experiences and failure to recognise the different supports and HR processes which need to be considered. Leslie felt that HR sometimes adopted a rigid and standardised approach to PMs. She commented that policies and those who work with them in the human resources field might need more experience in working with those with lived experience and PMs.

Staff prejudice towards PMs

Another barrier to PM pathways arose from staff perceptions and the need for greater standardisation of how service users progress to PM roles. As seen earlier, inconsistency in the criteria used to recruit PMs into the role has led to ambiguity in the role that PMs carry out and fear of erosion of occupational roles, which has given rise to personal prejudices from staff towards PMs. The following comments illustrate the concerns voiced by participants.

I mean, right here [in this team], it's all about the judgment of the person[staff]. I've seen it. I got one [PM] that I'm working with. He has been in prison, and he also still had that, 'them and us'[attitude], but there was something about him, I knew he could really do this; [become a PM]. At the time, he was one of

the service users that a lot of the staff were resistant against him [progressing into the PM role], Chris (PM Manager: Organisation C).

I think there were a lot of concerns at the time that I was not stable enough to be able to be doing the peer mentoring thing. I think the manager at the time actually said, no, and that is why I wasn't a peer mentor at the time. Then, I think they had a team meeting, and I was kind of discussed there, but the ETE practitioner basically said, 'I'm going to take a stand on this. I think you should do it!', Gary (peer mentor: Organisation D).

Both participants highlighted how staff perceptions and potential discrimination impacted the PM's pathway. Other participants shared the views expressed in the two examples above. The lack of a consistent approach to recruitment was perpetuated by the absence of clear criteria and a heavy reliance on key workers' opinions as a basis for decisions on which individuals progressed in the PM roles. Gary emphasised this point succinctly and showed how, without the intervention of the ETE coordinator/managers, he would not have moved into the PM role. Chris also identified how potential discrimination and past behaviours might influence the PM pathway to be either de-selected or delayed. At times, it was felt that the staff struggled to divorce the PM from the service user and their past alcohol-using behaviours.

Conversely, staff can be overly protective towards the service user's recovery or hesitant to view the service user as having the potential to develop skills within the PM pathway. However, staff perceptions were not always negative. As discussed in section 6.2, staff members were primarily interested in the service users' development and support them in achieving their recovery potential.

6.5 Conclusion

This chapter examined the pathways into becoming a PM and showed how a combination of individual factors, organisational processes and procedures, and external pressures on organisations facilitated or hindered the progression of PMs. The data highlighted the importance of support systems and inclusive policy approaches which, although promoted by all the organisations in the study, nevertheless sometimes fell short of the ideal. It also indicated a strong link between the PM experience and the recovery journey for individuals. Chapter 7, takes this up by discussing how the PM role helped individuals to develop and restore their sense of self and to shift from a service user identity to a new identity which allowed them to take up a wider range of social roles, including involvement in the workforce.

Chapter 7: Renewing and restoring identity

7.0 Introduction

This study demonstrated a strong relationship between the role of PM and positive changes in their self-esteem and self-awareness. In this chapter, I explore how the PM's role helped shape interviewees' sense of identity, facilitated shifts in their identity, and influenced how others perceived them. In particular, the discussion focuses on five themes:

1. Impact of the PM role on identity through improving self-esteem
2. Improvement in self-awareness through the PM role
3. The importance of having a shared identity with service users
4. The fluidity of, and shifts in, identity through the PM pathway
5. Reintegrating into society and regaining or developing an occupational identity

7.1 Theme 1: 'Removing the training wheels'- Improved self-esteem

The PMs described how their roles helped them improve their self-esteem. For example, Brandon explained how his role enabled him to cultivate a more positive self-image by building his confidence.

> *I feel like the role has given me confidence gradually to kind of, navigate within society and be able to have conversations with people. Just normal, general day to day conversations which I wasn't used to, Brandon (peer mentor: Organisation A).*

Brandon mentioned that his low self-esteem has contributed significantly to his substance misuse over the last two decades. As a result, he described self-medicating with alcohol to cope with his mental health issues. Brandon argued that his self-esteem grew as he became more competent in his PM role, and recalled how, in the past, his mental health had also made it difficult for him to engage with others. As with Brandon, an interview with one of the PM managers captured the transformative nature of the PM roles on an individual:

> *When you see people like [name of PM], that's where you see that picture of transformation. We have taken someone essentially from the street, someone who was disillusioned. And we've kind of, smoothed out their rough edges and given them exposure to a professional environment. That's where the greatest victories lie, and their retention in their role proves that, Hari (PM Manager: Organisation A).*

Brandon and Hari underscored the transformative process individuals experience through their PM roles. Hari maintained that these roles aid in cultivating new and refined identities that are more socially accepted within work settings. As such, individuals have evolved into more socially acceptable versions of themselves through the PM roles. Gary, for example, explained how the PM role had exposed him to an environment where he could apply the skills he had learned previously, which had a beneficial impact on his self-esteem.

> *With the [name of the department] peer mentoring, it's more about being able to apply skills that you have acquired elsewhere… I am really starting to love it… Yesterday, I actually made a pitch because the CEO came into the room while we were working, and he loved it, Gary (peer mentor: Organisation D).*

Gary mentioned his previous self-doubt and how the PM role allowed him to get real-time feedback from colleagues or other organisation members. He described how this has further helped him feel more confident and valued. This feedback has led to a transformation in his personal identity. Other interviewees reported similar experiences regarding the impact of adopting the role of PM. Jean used a compelling analogy to describe the PM role's effects on her personal and social identity.

> *It's like the training wheels on a bike, as a peer mentor, you got the training wheels on and as you progress, you remove those training [wheels]. It made me feel confident enough that I can do this. It's like someone who was holding your hands. These experiences, they all contributed to building my confidence to speak in front of people… I didn't think I was able to do that two years ago to an audience, Jean (peer mentor: Organisation D).*

Debbie made similar connections regarding how her confidence and self-esteem improved as a result of her PM role:

> *It was [the name of peer mentor manager] who during supervision, he [PM manager] would always just encourage me and he would say, you just need to step out of your comfort zone, you won't know until you try, Debbie (peer mentor: Organisation C).*

Both PMs, Jean and Debbie, expressed a lack of confidence in pursuing new work-related responsibilities because of their prior substance misuse. They stated that their experience as alcohol-dependent service users eroded their confidence and self-esteem, leaving them with self-doubt. They both emphasised how the PM roles enabled them to examine their emotions in a safe environment while regaining their confidence to engage in new activities. Like Gary, they described changes in their personal identities, most notably, in their self-beliefs. Additionally, they attributed

these shifts to the support provided by PM roles, such as supervision and opportunities to receive feedback.

Furthermore, Jean used the analogy of first learning to ride a bike and requiring the assistance of 'training wheels'. She compared these wheels with the numerous support mechanisms provided or embodied in the PM position. She discussed how these wheels helped her in confidence building during the transition from being a service user to becoming a more competent PM. She described how, as her confidence increased, she could continue her recovery journey at her own pace because of her acquired skills.

7.2 Theme 2: Creation or improvement of self-awareness amongst PMs

PMs emphasised that part of their role involved the experience of increasing or establishing self-awareness. Recognising personal strengths and attitudes towards oneself and others is integral to the PM role and can promote awareness of factors contributing to alcohol misuse. Working with other service users or alcohol and drug colleagues, PMs forged self-awareness and appreciation of the importance of ongoing self-reflection. Gary illustrated how his role facilitated his journey towards self-awareness and clarity of purpose, making him better equipped to navigate his future.

> *I've thought about becoming a recovery worker for a while. But the more time went on, the more I realised that I don't have the patience for it. It [patience] is something that I've had to grow within myself. And I've noticed that, the more I practice it, the more I try to cultivate those feelings of kindness and compassion and that capacity is growing, Gary (peer mentor: Organisation D).*

What some have said to me was that they found being a peer mentor was kind of like, a safe space to grow or to start to learn skills without being judged? (Researcher).

> *Yes, I think that this was definitely the case for me. Especially, because it's probably quite hard to picture this talking to me now, what I was like back then. I am very different. Being able to see people's attitudes change… historically, I'm quite a self-centred person, Gary (peer mentor: Organisation D).*

Gary discussed how his self-perception has changed because of his work as a PM and current service user. Gary described the insight he gained into his former behaviours, attitudes, and belief systems and compared this to his self as a user of alcohol services. He also discussed how his values and attitudes shifted because of the development of increased empathy and compassion for others. Gary asserted that he had become less self-absorbed due to his PM role. He noted that the PM role had instilled a sense of self-awareness that he had previously lacked.

Similarly, Gary stated that the role had allowed him to reflect on his own self-worth. As a result of this recognition of his strengths and potential abilities, he noted an increase in self-confidence. In addition, he acknowledged growing more self-aware through the reflective supervision process with his PM manager. This self-awareness also helped him gradually alter his coping mechanisms for mental health and alcohol misuse issues. Gary characterised his increased self-esteem and self-awareness as compelling evidence of his self-identity shift.

Other PMs, like Jean and Debbie, echoed the changes that the PM role helped them to foster. They commented that becoming self-aware of their own emotions and being able to regulate them was something they had learned in their PM roles and by working with others.

I know I have flourished and I've kind of gone off into other organisations also, Jean (peer mentor: Organisation D).

I don't have that aggressiveness anymore. I've lost my aggressiveness and I am calmer. I'm not in your face! I'm not f' ing and blinding [swearing] and doing things like that. I'm not that person today, Debbie (peer mentor: Organisation C).

For some PMs, the role helped to inform them about what they wanted to do after their PM role. For some, like Gary, it enabled them to realise that working as a recovery worker was not something they wanted to pursue. However, others, such as Debbie and Jean, felt that working in the alcohol and drug field was something they would strongly consider. Thus, the PM identity was seen by some individuals as a transition out of the alcohol and drug world, whether as a service user or as a PM, whereas for others, their identity remained linked to a transition pathway within the service organisations.

However, as discussed in the following chapter, throughout the transition process, PM identities tend to be fluid, shifting the context required between service users, friends, and work colleagues. The next section considers how this was experienced by PMs and service providers.

7.3 Theme 3: The importance of having a shared identity with service users

Participants described their identities in the context of their shared-lived experiences. Some PMs described having a shared identity with service users, which helped them develop their own sense of self-identity.

A peer mentor is about sharing their lived experiences with somebody else to say, look, I've been on the road to recovery and there is a bright side at the end of the tunnel. That is why it is called a peer mentoring role, because it is supposed to say, I am the same as you. … It is sort of trying to be a living example of what recovery, Kath (PM Manager: Organisation D).

Their disempowerment characterised this shared experience in the face of their alcohol misuse. Sue named this disempowerment the 'struggle of addiction' and the personification of the addiction itself as an evil or, in this case, a demon.

I understand how hard it is for this little voice saying in your head, Go on, you can just do this once and you really want one [a drink], and having to fight that demon all the time, Sue (peer mentor: Organisation A).

Another element of the PM's shared identity was the theme of hope which appeared to manifest very strongly within interviews. All participants expressed that the interaction with service users was a beacon of change and recovery. As Jean stated in the comment above, PMs were used as a symbol of hope that service users can relate to regarding their substance misuse and the ability to 'come out the other side'.

Developing trust was another essential factor in interactions with service users. Ronald and Beth, both PMs from Organisation D, emphasised the importance of their shared identities in establishing trust and therapeutic alliances with service users while performing their roles as PMs. All PM participants also described their unique position of influence gained due to their shared lived experiences with service users compared to their professional colleagues, who lacked these lived experiences.

Oh, Trust, that's a massive issue! Beth (peer mentor: Organisation D).

That's massive. They [service users] think it puts us in a better position, Ronald (peer mentor: Organisation D).

Other PMs referred to their shared experiences of alcohol use as a 'most powerful weapon' of a shared identity forged through lived experiences. Patrick, a recovery champion from organisation A, in this instance, used the term 'weapon' in a positive light in which his lived experience represented a source of strength to help re-enforce the therapeutic relationship between him and service users. Patrick also used weapons as metaphorical instruments to diffuse difficult situations.

From an organisational perspective, this shared identity that PMs have with service users was fostered to build hope, and it is a core part of the PM role. Managers argued that they have intentionally used these lived experiences and the recovery identities positively. This is captured in two quotes below.

All peer mentors are people with the lived experience of addiction, and they are now in recovery from addiction. Their very presence as a human being, and it is something that is designed to give hope. Rather than us trying to convince them [service users] of an outcome, if they can see one [it is better], Marvin (PM manager: Organisation A).

What it does, it is a belief, an inspiration, you know. If they [peer mentors] can do it, I can do it, Chris (PM Manager: Organisation C).

Marvin and Chris posited that PMs symbolise hope for service users undergoing treatment for alcohol dependency. This opinion is not unique to them, as other staff members in various organisations have supported this idea. PMs, who personally experienced struggles of alcohol dependency, inspired other service users to engage in and maintain their treatment. Furthermore, the PM roles have been found to

enhance recovery capital, which was pivotal for individuals in treatment to develop hope and sustain their sobriety.

7.4 Theme 4: Fluidity and shifts in PM's identity

The study participants described the PMs' identities as being in constant flux, rather than static. PMs' identities were fluid, as they constantly changed internally and externally regarding their perception of themselves, confidence level, and self-esteem. How others perceived them added to the shifting nature of their self-perceptions. The participants discussed these shifts in terms of their identities as colleagues, service users, and friends.

All the participants viewed PMs as colleagues or team members.

> *Sometimes, I would be asked to go into key working session with other colleagues if they've got service users that are a little bit difficult or aggressive, I will try to calm the situations by sharing my story, Patrick (recovery champion: Organisation A).*

> *They're considered part of the team, there is no distinction really. The only distinction is obviously we have to be careful in terms of their time, capacity but other than that they're a member of my team, Sophie (Team Manager: Organisation D).*

Both interviewees concurred that PMs were regarded as colleagues when working with service users. Patrick described his role as a supportive member of a team that collaborated with other paid staff members to provide therapeutic interventions. He explained how he exploited his lived experience and service user identity to develop trusting relationships with service users, while establishing boundaries and assisting

his colleagues within his occupational identity. Patrick demonstrated how he would use his fluid identity to negotiate positive therapeutic interactions with both service users and staff members. Conversely, some PMs described how they embraced their new identity and separated it from that of service users. However, they recognised how fluidity brought about the benefits of moving between these identities.

Similarly, Sophie concluded that PMs share their identities with other staff members. She maintained that the PM's identity was indistinguishable from that of the paid staff members she supervised. However, she acknowledged that differences were required in the workload and support offered to the PMs.

Gary discussed how becoming a PM transformed his identity from that of a service user to that of an ex-user. He explained that this depicted a significant shift from his previous identity, which dominated a significant portion of his life up to this point. He also recognised that his lived experiences were not entirely negative personality traits, and he used them to his advantage at times in his new role identity as a PM to identify with service users.

> *It also gives me a different identity, I'm not someone who uses alcohol anymore. That's part of the thing of peer mentoring. I'm someone who has recovered, Gary (peer mentor: Organisation D).*

Patrick succinctly captured the fluidity of his new identities when he described re-identifying as a service user and adjusting to their 'level' through sharing mutually lived experiences of alcohol use, feeling disempowered and disillusioned.

> *They could see I was like, down to earth and honest. I would sit with them and have a cigarette and share my story, I'll become one of them. So instead of being a member of staff and saying, wait there, we'll get your script in a minute, Patrick (recovery champion: Organisation A).*

Patrick explained that his story was about his experiences as an alcohol dependent, living a chaotic lifestyle, clashing with authority figures, and having a criminal record. Additionally, he expounded on his ability to create an identity relatable to service users, thereby lowering barriers and fostering a therapeutic, recovery-oriented relationship. Sharing identity will be discussed in greater detail below in section 7.3 'The importance of having a shared identity with service users.'

As a staff member, Clare reflected on Patrick's and Gary's identity transition and how PMs can use their previous service user identity to gain an advantage in their new roles. Her perspectives and perceptions represented the perspectives of other staff members at various levels of the organisations.

> *Do you think it is seen as a transitionary role for that person in terms of the identity. Moving from a service user identity to peer mentor's identity then to staff member identity? (Researcher).*

> *Definitely, definitely! I do feel quite strongly that the transition can be good for some people, but not for everyone. But for some people the jumps can be too much, it seems to pressurise them, Claire (Service Manager: Organisation A).*

Both staff and organisations used the PM's identity as former service users to represent how a recovery identity might look. Services utilise PMs as visible symbols of recovery and aspirational identity for current service users. Clare and numerous other staff members described how the PM's role crystallised the visual transformation that service users could achieve through support and accessibility to treatment. This transformation provided encouragement and hope for the recovery-oriented service model of alcohol and drug treatment.

Several research participants indicated that they felt conflicted but compelled to befriend service users despite their awareness that they had progressed in their recovery and had developed a new identity as a PM with occupational limitations. Acting as ‘a friend’ was emphasised by some PMs who said that they felt a kinship with the service users who come into service and to whom they provided support as part of their PM roles.

> *You tell people, I’m a former service user. They will then be like, you’re my mate, Jane (peer mentor: Organisation D).*

Sue expressed a view typical of others when she said she felt a sense of kinship with current service users because they had also used alcohol or drug treatment. Mutual trust, the ability to empathise with one another's difficulties, and the shared human qualities of compassion, empathy, and care all aided and bound their friendship.

> *That's my main goal as a peer mentor. It is just to let people know that I understand how they're feeling, I understand the struggles of addiction, Sue (peer mentor: Organisation A).*

The ‘friend’ role also influenced the fluidity of the PM identity, causing it to shift to that of a friend or recovery buddy. Beth repositioned herself as a friend and explained that altering her identity could alleviate the perception of a superior-inferior divide between herself and service users.

> *I don't see myself as being <u>above them. I am one of them</u>. I started <u>where all of them have started</u>. There is the friendship between us, Beth (peer mentor: Organisation D).*

According to another PM, Jane, one of the essential purposes of the PM's role was to personify recovery. PMs were expected to serve as visual symbols of recovery, and they were actively encouraged to share their lived experiences with service users. However, while not intentional, PMs sometimes encouraged a 'friend' identity amongst service users. Despite this, Jane expressed conflicting emotions regarding identification during her interview. However, she argued that she identified more with her occupational and staff positions than with her PM role as a friend or ex-service user.

Overall, participants agreed that the PM's identity was fluid and continuously changing. PMs appeared to switch from one identity to another rather than moving in a linear manner. For example, they seemed to oscillate between being a service user, friend, or staff member, depending on the situation they found themselves at the time.

7.5 Theme 5: Reintegrating into society and regaining or developing an occupational identity

According to PMs, the PM roles provide a good vehicle for most individuals to restore or adopt an occupational identity. As Sharon commented:

> *Since I got my treatment, I had like an epiphany moment, and I want to now work in the [alcohol and drug] services. So, I'm trying to get different qualifications and different certificates, Sharon (peer mentor: Organisation B).*

Many PMs were eager to highlight that they had previously worked before their treatment episodes. They were now preparing to regain the confidence and skills necessary to recover their associated work identity. Sharon explained how the PM role had been instrumental in reclaiming some of that identity. She argued that,

through the opportunity to work with colleagues in alcohol and drug services, she revisited those skills. Other PMs, like Sharon, spoke about using the PM roles to use previous skills and gain further qualifications while adopting their new identity. For some, it meant using the safe space to practice some of the training they acquired as part of the role. For others, it was gaining skills in an entirely different industry.

> *At the end of the day, it's just being a peer mentor, but some people can let it go to their head. If you've not had much going on in your life for a while and then someone gives you a badge and, you know, they give you a role, and this person now thinks they're a staff member and they can do this and that, Gary (peer mentor: Organisation D).*

Some PMs referred to items, such as badges issued to them as symbolic and affirmation of their transition from service users to a new occupational identity. They regarded this as a tangible representation of what distinguished them from the service users. According to my field notes from the interview, Ronald seemed to place high significance on his badge and appeared to take pride in wearing his badge.

> *I've got this on [showing me a peer mentor badge], Ronald (peer mentor: Organisation D).*

Similarly, the PMs argued that their PM badge engendered a sense of belonging to alcohol and drug service staff. Belonging was a fundamental aspect of the PM's identity of feeling accepted, which was not unique to this occupational group. Arguably, possessing a PM badge was equivalent to wearing a uniform, as in groups such as the police or nurses.

Conversely, as discussed earlier, some PMs also felt a betrayal of their service user identity, trying to negotiate different selves and relationships with peers, service users, other work colleagues, and friends. Other PMs described their inner conflicts with

themselves as service users and with their PM roles. As a result, it helped inform their decisions to move away entirely from the alcohol and drug sector to try to divorce themselves from their past substance misuse. Some, like Jane, argued that while they might be happy to be defined by their recovery identity, increasingly, they felt the need to move beyond the PM roles. Some PMs said that they wanted to be more than just 'an addict' and working in addiction and wanted to explore other work opportunities within different sectors. PMs discussed the desire to re-integrate into society more broadly than through their role.

According to this research, all participants across all organisations agreed that the PM role assisted them in reintegrating into society and leading more active and productive lives. They claimed that their PM responsibilities enabled them to reconnect with society or enrich their recovery journey within the PM roles through the workplace, family, and community participation process.

> *Do you think that being a peer mentor has brought you back into society or has it gives you a new identity? (Researcher).*

> *Absolutely, yes, absolutely. I have lived in the cracks when I used to live that life [using alcohol]. I mean, I could say, absolutely, I feel 100% that what I do kind of makes me feel like it has given me my identity back. Absolutely, I love it [peer mentoring] and being part of society in the role that I am doing, Brandon (peer mentor: Organisation A).*

> *I would say in this work environment, I was able to start to dip my toes back into society as part of my own recovery program, which isn't community based, which is not 12 steps-based recovery, Jean (peer mentor: Organisation D).*

Like many other PMs, Brandon and Jean highlighted how their alcohol misuse caused them to withdraw from social life. During their alcohol dependence, they recounted

losing their self-confidence, their social network of friends, and their families. They also asserted that their drinking habits resulted in feelings of shame and guilt, which fostered or exacerbated self-loathing, and finally led to social isolation. Numerous other PMs have stated that peer mentoring promotes peer-to-peer knowledge transfer and social integration. PMs stressed the need for a positive sense of belonging to a community not defined by alcohol misuse, and that peer mentoring contributed to their social reintegration. In addition, the participants discussed how newfound social and community networks with new groups of friends, as well as their reconnection with a broader community which included family members, were enabled through peer mentoring.

From an organisational perspective, staff described how one of the outputs of peer mentoring was social integration at a personal, community, and societal level.

> *The model [peer mentoring] ... it is about, kind of really re-introducing people into society and re-integration really, Claire (Service Manager: Organisation A).*

Clare explained how the philosophy behind the peer mentoring schemes was to foster a positive work environment for individuals who had lived experiences with alcohol misuse. The PM roles were primarily concerned with re-integrating into society individuals who had never worked or were out of work for an extended period due to substance misuse. However, she also described the benefits of supporting individuals in building on their recovery capital, such as their personal development goals, reconnecting with family members, and using their lived experiences to decide what they wanted for their future aspirations.

7.6 Conclusion

As part of the PM role, individuals experience a transition and transformation into their identity. The restoration of self-esteem and self-awareness emerged as a core element of this transition. Similarly, it was evident that the PM's identity was fluid, and that they struggled to divorce their old service user's identity, which could be beneficial in some contexts, from their occupational PM identity.

Chapter 8: Discussion

8.1 Introduction

This thesis sets out to explore the role of peer mentors (PM), how these roles are defined and performed, and what status these individuals hold within alcohol and drug service settings. The thesis also examines the transitional factors that support or hinder an individual moving into such a role. The key research questions were:

1. How are the roles of PMs in the delivery of alcohol and drug services defined and perceived by PMs themselves and by other workers in their organisations?

2. How is the role of PMs in the delivery of alcohol and drug services enacted by PMs themselves?

3. What key personal and organisational factors influence the transition from service user to PM?

To answer the questions, I used a combination of qualitative methods, a service mapping exercise (SME), participant observations and semi-structure interviews. The data highlighted the lack of a standard definition of PM although it was possible to identify common attributes, including previous lived experiences of alcohol or drugs dependency and maintaining abstinence from substance use. Examination of the PM role from the perspectives of PM themselves and others who worked with them, supported the theoretical framework for the study in that a mix of individual and organisational factors and processes within the wider policy and workforce context influenced the nature and enactment of the PM role.

Since this thesis was completed, a new survey: Drug and Alcohol Treatment and Recovery Services, National Workforce Census was commissioned by HEE and conducted by NHS Benchmarking Network [NHSBN] (HEE, 2023). This survey highlights the increasing presence of PMs within alcohol and drug services, with PMs accounting for two percent of the national workforce. The different approach to treatment offered by people with lived experience is recognised in the report. Notably, it was reported that PM roles were more likely to be located in the voluntary sector and these roles accounted for seventeen percent of the workforce in that sector. It was also noted that they were unpaid roles. This survey provides valuable insights, but it should be interpreted with caution due to the limited sample size of only twenty-three organisations with a lived experiences recovery workforce. However, the survey reflected the findings of my study that PMs have become increasingly important in the delivery of alcohol and drug treatment.

In the sections below, the findings of my study will be critically examined within the context of the existing literature. The findings will be discussed under five key themes:

1. What is a PM? – defining the role

2. Pathways and Transitional processes experienced by PMs

3. Identity Transformation

4. The 'liminal space' experienced by individuals effecting the transition to PM

5. The role and importance of organisation socialisation for the emerging PM role

The final section of the chapter examines how COVID-19 had impacted on the role of the PM highlighted in the findings. A comprehensive summary of the chapter is provided, and the final section of the chapter draws out conclusions and the implications for policy and practice.

8.2 What is a peer mentor? Defining the role

Variation in terminology used in the alcohol and drug sector.

The study found that there were three primary terms used to describe the PM roles; these were PMs, volunteers, and recovery champions which aligns with the terms used in the literature (HM Government, 2010; NTA, 2012; Tracy et al., 2012; Tober et al., 2013; Breedvelt et al., 2014; Parkman and Lloyd, 2015; Tracy and Wallace, 2016, DHSC, 2021). The terminology used in the examined organisations varied in denoting a progression in role status and sometimes using terms interchangeably. In most organisations, PM referred to individuals in the early stages of their recovery journey - those who had recently completed or been discharged from structured treatment (White, 2009; Tober et al. 2013; Tracy and Wallace, 2016). Conversely, volunteers were often reserved for those who had advanced to the subsequent stages or had no history of substance misuse treatment but willingly offered their time (free of charge) to acquire additional sectorial skills or participate in altruistic efforts.

Some researchers argue that using different terms to describe similar roles can create role ambiguity and overlap without clear definitions, leading to role conflict and confusion within a team or service (Kram, 1988; Eby and Allen, 2002; Kemp and Henderson, 2012; Creamer et al., 2012; Brown et al., 2015; Baumgartner et al., 2019). However, a lack of a standard definition of a PM role can also offer opportunities to shape and challenge conventional perceptions, and address discrimination and stigma associated with ex-service users in the workplace (Turner, 1990; Currie et al., 2009; Gillard et al., 2015). Scholar such as Gates and Akabas (2007) and Oh et al. (2023) suggested that such discrepancies could hinder someone's ability to integrate effectively and job satisfaction. In organisations such as Organisation A and B, where the PM roles were more well-established, having a clear and common understanding of the terminology used, positively impacted the PMs- helped them to form, confirm and progress their PM's identity. For staff- it offered definitive distinctions between them and the PM. While in the two organisations, the interchanging of terms used to

describe the role perpetuated a lack of demarcation and conflation of role clarity, how staff and the organisation could best assistance PMs to progress.

Importance of Lived Experiences

In this study, it was found that lived experiences is an essential and defining characteristic of the PM role. This finding is supported by previous research (White, 2009; Roberts and Bell, 2013; Tober et al., 2013; Breedvelt et al., 2014, Parkman and Llyod, 2015; Moyes et al., 2016; Barker and Maguire, 2017; Edwards et al., 2018). Although the use of lived experiences in providing service is not recent (Benoit et al., 2005; Hellman et al., 2016), it has become a valuable component of service provision and development in recent decades (Strang 2011; Reif et al., 2014; Edwards et al., 2018; DHSC, 2021). Contributions such as first-hand expertise, improving accessibility and symbol of hope emerged as valuable factors from this study. They are explored in further detail below.

Abstinence as a defining characteristic of a PM role

Abstinence from alcohol and drug use was a fundamental aspect of a PM's role. However, there seems to be ambiguity in defining abstinence, contingent on the underlying philosophy and context. According to NHS (2018), abstinence is when an individual has ceased alcohol consumption entirely, a belief shared by AA and affiliated mutual aid societies. In contrast, the literature suggests that abstinence is a stage where someone has recovered from substance misuse and maintains stability in substance use or abstains altogether (APA, 1994; Humphreys et al., 1995; Dawson, 1996; Grella et al.,1999; Cunningham et al., 2000; White, 2007; Dugdale, et al., 2016; Sells et al., 2020). The disparity in opinions was reflected in my research, where participants reported different interpretations of the concept of abstinence. For example, some organisations perceived the role of PMs as being in a transitional state of achieving ultimate stability (not necessarily having achieved complete abstinence

at the start). Other organisations mandated completely abstaining from all substance use as a pre-requisite for becoming a PM (Parkman and Lloyd, 2015). This varied approach often creates confusion among PMs aspiring to progress in their careers and it may be argued that it can hinder their mobility between organisations. Notably, across the four organisations, abstinence was more viewed as the end goal. Therefore, organisations stipulated that PMs must achieve abstinence at a pre-agreed time in the future in order to continue in their PM role (Klingemann et al., 2010; Witbrodt et al., 2015).

As argued by several PMs in various studies (Tober et al., 2013; Parkman and Lloyd, 2015; Dugdale et al., 2016), abstinence played a crucial role in their recovery and identity. For example, PMs stated that delivering their peer mentoring role involved providing various interventions, such as psychosocial interventions like group therapy, which made them more credible if they could demonstrate that they were free from substances. In addition, being a symbol of recovery and hope, as discussed below, helped the PM to be seen as a positive role model for others. Therefore, their abstinence made challenging others to change their substance misuse easier.

Building and sustaining relationships was another motivational factor for PMs who were abstinent. As found in other studies, some participants valued the relationships they had developed within an abstinence-based environment (White, 2009; Best and Lubman, 2012; Collins et al., 2016; Harrison et al., 2018). These included relationships with their other professional colleagues, such as nurses, doctors, alcohol and drug key workers and their fellow PMs. PMs ascribed the success and strength of their relationship with others to their sustained abstinence from alcohol and drugs. As mentioned in the section on lived experiences, PMs described using their abstinence as a commitment to rebuild fractious and broken relationships with family members.

The study found that while some PMs experienced a conflict between needing to be totally abstinent and preferring to be a moderate drinker, they were reconciled that

abstinence was their only option due to multiple previous relapses which was also supported in other research (Tober et al., 2013). Several participants also described being more reluctant to return to a life of chaos and uncertainty, which their alcohol use would bring. However, as found elsewhere in the literature, they valued the benefits gained from their abstinence and the consolidation of their recovery offered by this abstinence state (White, 2009; Parkman and Lloyd, 2015).

Key elements of the role of PMs

Apart from the two common denominator of lived experiences and abstinence, PMs contributed to the alcohol and drug services in many positive ways. These key elements of the role will be explored in turn.

Sharing knowledge and expertise from their own experiences

Several managers interviewed referred to PMs as 'experts' in their own right due to their experiential knowledge. PMs provided invaluable insights and viewpoints that could enhance treatment services and options (White, 2009; Ashford et al., 2021; DHSE, 2021). As found in other studies, PMs were able to share their first-hand personal experiences of using different treatment options and access to associated health and social services (Tober et al., 2013; Nixon, 2020; Jason et al., 2021). PMs explained that being aware of how to access the benefits system, knowledge of the documents to complete and benefits entitlement provided that unique edge which other colleagues in alcohol and drug services were not familiar with. Through the lens of PMs, they offered an alternative view, a view based on being service users before, during and after using alcohol services. Similarly, PMs have utilised their personal experiences to illustrate potential challenges in service delivery, related to improving service-user focus, aftercare innovation, collaboration with PMs, and service efficacy. By incorporating PMs' insights, services can identify previously unnoticed new solutions (Jason et al., 2021). Based on this, it can be inferred that the use of PMs' lived experiences in service delivery has been shown to contribute significantly to the development of effective and sustainable solutions. However, engendering a team-

based approach informed by PM's lived experiences is not without it challenges. As indicated in this study and described elsewhere, non-PM staff members, such as key workers - including recovery workers, nurses, and doctors - who possess professional expertise may often perceive the knowledge and skills gained by individuals with lived experiences as a threat (Frame et al., 2010; Sear et al., 2017). Given the limited published research on the topic, further studies could examine tensions between professional experts and PMs with the aim of finding ways to resolve the tension and improve team working.

Promoting accessibility and service engagement

Several participants described how they had turned their negative past experiences of alcohol misuse into a strength, by sharing their experiences with others during one-to-one sessions and meetings. They described how, by reflecting on their own lived experiences, they were more open to empathising with others' emotional and physical turmoil associated with alcohol misuse. By sharing their lived experiences with service users, PMs experienced an increased receptiveness, trust, and kinship from service users in comparison to how users related to other alcohol and drug services workers (NICE, 2008; Tober et al., 2013).

PMs accounts also revealed how creating therapeutic relationships with service users had helped to increase service users' access to treatment services. Service users are often overwhelmed by the experience of accessing and engaging with alcohol and drug treatment services, whether it is their 'first treatment episode' or 're-presentation to services'. Previous studies contended that service users often mistrust services due to stigma and conflicting goals between themselves and professionals; often referencing a 'them and us' attitude (Harrison et al., 2018:10). Service users have reported health professionals as being focussed on targets and policies rather than on their individual needs. Equally, service users described feeling stigmatised or discriminated by staff resulting in them feeling that staff were disinterested in their presenting needs (Fischer and Neale, 2008; Ti et al., 2012; Bottner et al., 2023).

Importantly, Black's report part 2, DHSC (2021) highlighted the importance of using those with lived experiences such as PMs to support training to other staff within alcohol and drugs services to address stigma and offer insight to those who have not come from a lived experience background. However, PMs explained that service users found they related best with those with lived experiences. Trust and positive relationships were more readily fostered through a mutual and unspoken connection, as found elsewhere in the literature (Horvath and Greenberg, 1989; Humphreys, 2003; Tober et al., 2013; Breedvelt et al., 2014; Barker and Maguire, 2017). Equally, ex-service users in PM roles can make use of this experiential knowledge to encourage and nurture service users and community engagement by being a conduit or bridge with hard-to-reach communities (Ti et al., 2012; Edwards et al., 2018).

PMs as champions of recovery and hope

Consistent with previous research (White, 2007 and 2009; Dugdale et al., 2016; Collinson and Best, 2019), both PMs and staff advocated that the PM's presence was associated with being a human symbol of hope, both physically and emotionally, and as an inspiration to others that recovery was possible. PMs can show service users how they have overcome their struggle with substance misuse and use their experiences to illustrate that their alcohol and drug misuse need not be a perpetuating cycle.

Consistent with the findings of (Tober et al.,2013), this research shows that there were reciprocal benefits to PMs and service users when PMs share their lived experiences. While having individuals with lived experiences in the services appears to be a positive factor for service users, PMs also described the benefits to themselves. Additionally, other benefits of lived experiences were confidence-building and self-esteem, as reported in sections 7.1. Several studies (Best et al., 2012; Tober et al., 2013; Dugdale et al., 2016; Barker and Maguire, 2017; Edwards et al., 2018) showed a direct relationship between individuals who use their lived experiences and a more positive self-identity because of improved confidence. This is discussed in section 8.6 below. Notably, PMs in this study found that using their lived experiences in their PM role helped strengthen their resilience to maintain their own recovery and recovery journey. PMs identified that sharing their experiences was a positive reminder of how far they

had come along their difficult treatment journey to recovery. In addition, this created a heightened awareness and determination not to return to that position in their life. Significantly, DHSC (2021) highlighted how individuals can use these PM roles to positively impact on their own individual recovery through helping others. However, this recommendation is not unique or new. For example, previous reports have indicated how ex-service users can help commissioners and service providers develop and improve services and care for current service users (PHE, 2016). Further examples were also evident in this study (see section 6.3) where that fledging partnership relationship between PMs, service providers and the commissioners. Therefore, whilst this is a positive recognition of the importance of PMs, the challenges remain for the commissioners and service providers - such as my study sites - to successfully implement these recommendations or directives into their frontline services. Arguably, DHSC (2021) recommendations, if adopted, will create the impetus for the changes needed through a concerted, focussed, and sustainable action plan for commissioners and service providers alike. Similarly, the feasibility of these recommendations to be translated into practice appeared to be much improved amongst third sector providers given their flatter organisation structure and more frequently than not, their localisation of decision-making processes.

8.3 Benefits to the PM as well as the alcohol and drug services

As noted above, there are reciprocal benefits attached to being a PM. It is a common finding that using their lived experiences provided individuals with an opportunity to 'give back' to others who they felt could make use of their experiences to avoid mistakes and circumvent some of the hurdles they had experienced themselves (Bagnall et al., 2015; Nixon, 2020). Whilst this may be perceived as an altruistic act by PMs, Edwards et al., (2018) contended that these acts are not solely selfless but may also be linked to personal development and preservation. This observation was confirmed in this study - PMs purported that giving back was also closely associated with doing something useful with their time and experiences and at the same time consolidating their communication skills which could be applied in other roles and life situations. In their systematic review of fifty-seven studies of PMs in prison settings,

Bagnall et al. (2015) similarly reported that giving back to others provided a sense of achievement through listening and offering educational information about prison services while offering their time to support and deliver such services.

There is substantial evidence in the literature, as well as in my study, that PMs show a strong altruistic urge and desire to 'give back' as part of their recovery when they share their lived experiences (Moo, 2008; Doukas and Cullen, 2010; Nixon, 2020; Rettie et al., 2021). Some PMs highlighted how providing support and giving back had contributed to a feeling of achievement and rewards, whilst others said that it had helped them to maintain their recovery. Several previous studies have also highlighted how this altruistic urge has supported well-being and continued recovery (Scott, 2011; Mourra et al., 2014; Watson, 2019). PMs described feeling guilty for the pains caused to family members and friends linked with the behaviours or things they had done during their active substance misuse use (Dearing et al., 2005). Fossum and Mason (1986) and Silverman (2019) argued that shame, guilt and substance dependency are intractably linked and indivisible. Through helping others, PMS associated this with doing something selfless that counteracted the guilt that they felt (Harrison et al., 2018). Similarly, PMs described how using their lived experiences to support others not only satisfied their need to meet their civil responsibility (Edwards et al., 2018) but assuaged the guilt (Tracy and Wallace, 2016) they perceive from the overuse of health and social care resources over the years as described in section 5.3. Alternatively, there are potential negative consequences such as risk of relapse (see section 8.4 below) associated with giving back, shame and guilt (Tracy and Wallace, 2016; Harrison et al., 2018).

8.4 Pathways and Transitional processes experienced by PMs

This study identified various paths a PM could follow during their development and recovery journey into their PM role. As stated in the introduction, a clear definition of the term 'pathway' needs to be provided in current published research. However, this study revealed different pathways that could be adopted to progress in the PM role

and beyond. Current research concentrates on the treatment procedures carried out with people with alcohol dependence during their treatment episodes (NTA, 2010, 2012; NICE, 2011 updated in 2019 [Clinical guideline [CG115]; NICE, 2021). This represented in Figure 8.4(a) below. There is limited literature that explores the recovery journey and transition pathways of individuals after their alcohol treatment episodes (NTA, 2010, 2012).

Variations of the PM's Pathways

In this study, participants identified three transitional pathway processes utilised by PMs across the four alcohol and drug organisations (Figure 8.4(b) below). First, the development of recovery capital (Duffy and Baldwin, 2013; Kowalski, 2020) was crucial in their transition and progression success. According to Best and Laudet (2010:2), recovery capital is 'the sum of resources necessary to initiate and sustain recovery from substance misuse,' represented through four domains – social, physical, human, and cultural recovery (Best and Laudet, 2010). Using any of the three pathways, PMs could develop all four elements of their recovery capital to successfully sustain their recovery and social integration into the wider community (Best and Laudet, 2010; Duffy and Baldwin, 2013; Kowalski, 2020). The PM pathways, in particular, proved helpful for developing the 'human' aspects, such as educational attainment, problem-solving skills, and achieving goals, as well as the 'physical' factors, such as securing housing and increasing income potential. This study highlights the importance of developing pathways to support PMs' recovery and integration into society fully. It is important to highlight that despite some PMs saying that the ultimate goal of their pathway was to achieve employment, others were contented to achieve the position of PM or volunteer or recovery champion.

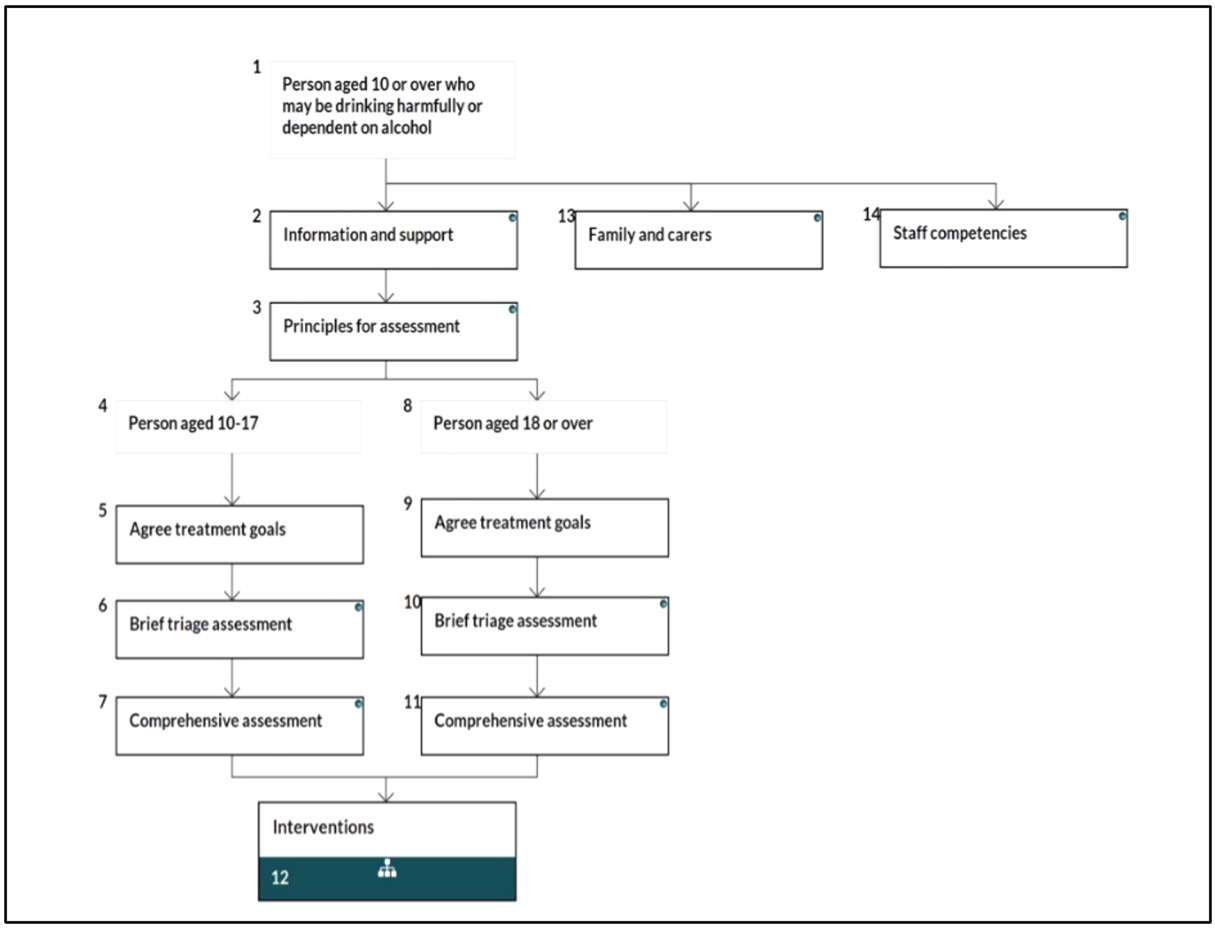

Figure 8.4(a) An Alcohol-use disorder pathway during a treatment episode. Source: (NICE, 2021 online:https://pathways.nice.org.uk/pathways/alcohol-use-disorders)

In previous research, it has been argued that PM pathways may lead to the 'over engagement' of PMs with treatment services or recovery communities, or not exploring other life experiences, and potentially becoming stuck (Parkman and Lloyd, 2015:52). However, this study's findings challenge Parkman and Lloyd's assertion that individuals may become over-reliant on services. Instead, each phase of the pathways represents not only a transition and progression for the PM but also a foundation for their recovery journey. As Kinsman et al. (2010) recognised, transparent and informed recovery mapping was crucial. The following section examines the enablers and obstacles to PM's transition along these pathways as stated by participants.

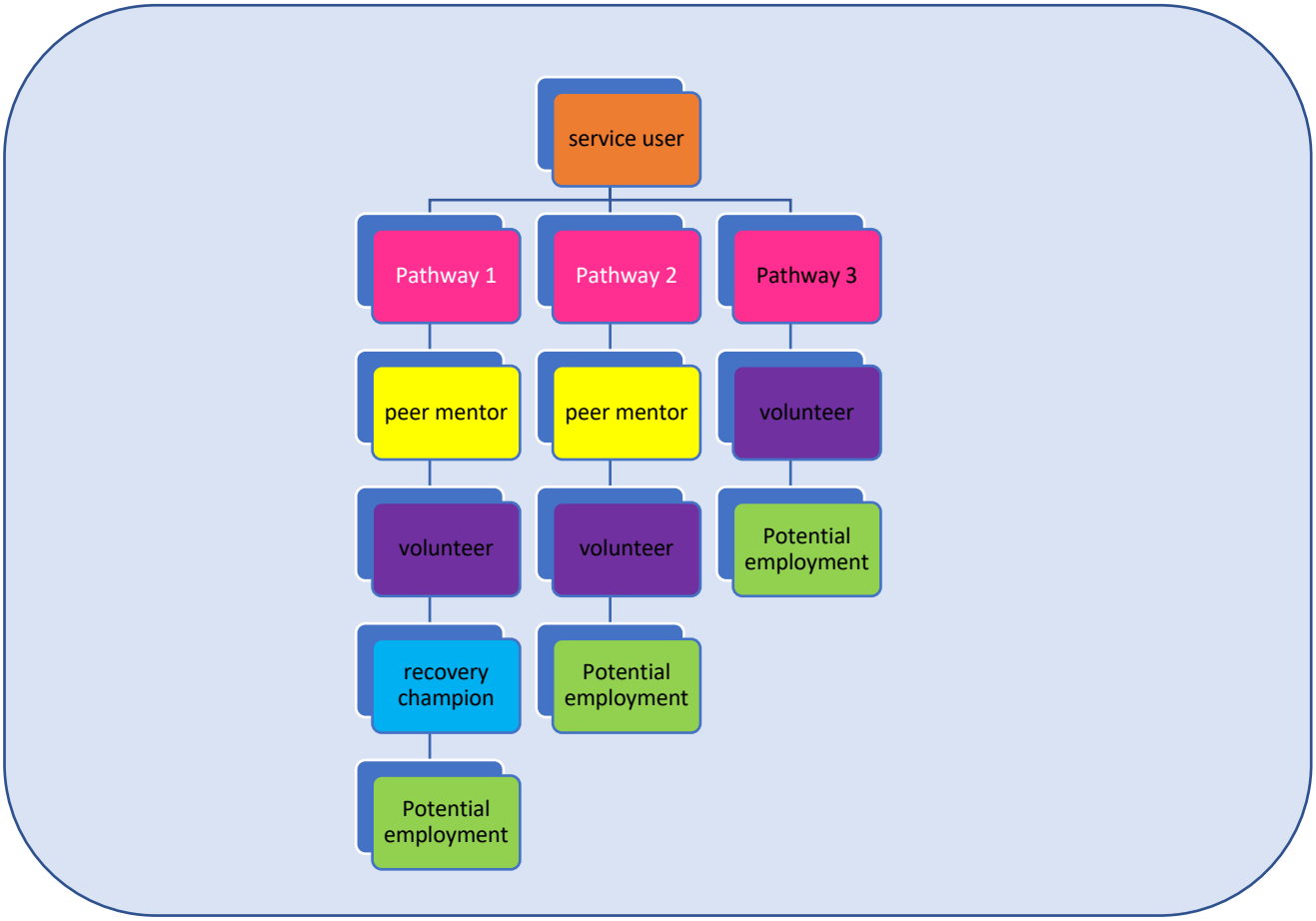

Figure 8.4(b) Three Different PM's Pathways in alcohol and drug services in London (Source: Compiled by the author).

Enablers of PM Pathway

PMs found having a supportive environment, being recognised for their contributions, inclusive policies and national drivers supported their movement in a positive manner. These will be explored in turn below.

Supportive and Developmental Environment

At an individual level, participants reported that supportive peers such as other PMs, staff and the organisation at large enabled them to progress along their PM pathways. They cited a combination of supportive human resources tools such as induction processes, supervision sessions, and real-time feedback. Induction was seen as a crucial element of the onboarding exercise by organisations. Similar findings have been reported by Jones (1986), Holton III (1996), Bauer and Erdogan (2011). PMs described that being able to gather knowledge about the organisation, learn expected behaviours and norms supported their integration into the organisation. As part of this process, it also enabled newcomers to become familiarised with the subtle nuances of the organisation (Sak and Ashforth, 1996; Anderson, 2001). Furthermore, this approach was particularly useful to PMs as some would have never worked in an organisation before, while others needed to re-learn workplace social skills. In addition, as Fountain and Hicks (2010) argued in their study of community engagement and improving access to health care, support mechanisms similar to those described above were very useful in engaging Black and Ethnic Minority individuals, who are usually further marginalised, to foster their development and engagement. Notably, previous research identified role conflict, job dissatisfaction and high staff turnover due to lack of knowledge about the organisation, where onboarding process was not properly implemented (Stohl, 1986; Klein and Weaver, 2000; Morrison, 2002; Hart and Miller, 2005; Gailliard et al., 2010; Sears et al., 2017). Participants in my study recognised how instrumental these socialisation processes had been in supporting their transition on the pathway and preventing burn out as discussed in section 6.4.

Managers across the four organisations also advocated using the initial months of induction to include regular supervision meetings also known as the onboarding process of socialisation discussed in section 3.4 (Bauer and Erdogan, 2011; Ohr et al., 2020). These meetings facilitated opportunities to either provide timely feedback or support feedback-seeking behaviours by the PMs as part of the adjustment and transition process. Supervision offers an effective vehicle to provide leadership and promote shared vision to support integration of PMs (Wanberg and Kammeyer-Mueller, 2000, Sears et al., 2017). There were other benefits related to successful

onboarding processes such as promoting effectiveness, organisational commitment, and reducing PM attrition (Bauer et al., 2007). Regular meetings with managers gave both parties the chance to identify activities which supported personal development and helped to inform the formulation of an individualised learning experience. This was very apt in the case of PMs as it allowed their managers to assess their proficiency and learning needs continuously. It also helped to inform them if the PMs' work capacity and training needs where appropriate.

While all organisations in my study provided 'onboarding processes' such as induction and training opportunities, PMs commented that this process was patchy at times and depended on the individual PM managers or service location. Similarly, some PMs mentioned that despite the fact they had been given the right support by their manager and the organisation, they recognised that continuing in the alcohol and drugs field was not part of their long-term goal. They admitted that the roles were more challenging than they had originally envisaged. Other PMs used their exposure in the field as an opportunity to recognise that they would like to return to further education.

Although training was consistently provided to all PMs to support their development, this does not eliminate the challenges one might face when transitioning from service user to PM roles. Similar observations have been made in previous research, which reported that some peer workers in Hepatitis C services found the transition challenging at times (Tookey et al., 2018).

Recognition of PM's contributions

Recognition for those providing help and support for substance misuse was highlighted by the PMs as a significant positive factor as part of their pathways. The feedback and recognition for their contribution substantially influenced organisational assimilation, identification, and transition into an individual's role, as asserted by Bullis and Bach (1989) and Myers and Oetzel (2003). This phenomenon was initially identified by McGregor (1960), who argued that recognition involves acknowledging and appreciating the contributions that employees make to an organisation. PMs

frequently referenced recognition from their supervisors or managers, primarily on a day–to–day basis or during supervisory sessions, as a significant reward. Equally, Hussain et al. (2019) observed that recognition in the form of written or verbal praise was as influential as monetary rewards resulting in employees feeling valued and recognised. PMs, likewise, valued praise and acknowledgement of their contribution as an integral determinant of their existence in the team. Additionally, they contended that recognition validates their recovery journey, reinforcing positive non-substance misuse behaviours and healthier choices and promoting their self-worth and self-esteem, thereby fostering a sense of belonging and organisational identification which is crucial during socialisation and transition.

The need for recognition is not peculiar to PMs. It has been observed as relevant to other types of staff and as a contributory factor to productivity, well-being, and staying with a team or organisation, especially when recognition comes directly from their managers, as reported by Saunderson (2004) and Brun and Dugas (2008). Several studies have emphasised that PMs are valuable elements of services and should be recognised for their contribution to health outcomes (Dennis, 2003; Barker et al., 2018; Kennedy et al., 2019; Reingle et al., 2019; Laval and Gardien, 2019; Miler et al., 2020; Lakey and Cohen, 2000). PMs and senior managers agreed that internal service reports, feedback from stakeholders, and recognition through service and commissioner events are examples of positive recognition from within and outside the organisations. Enhancing the recognition and acknowledgement of PMs' contribution is more likely to increase productivity, wellbeing, and retention.

Policy Drivers – Organisation and External Factors

The present study has established that all stakeholders, especially managers and recovery staff, referred to local and external factors like national and international policy drivers, which have had a profound influence on the PM's entry into and progression through the pathways. Correspondingly, chapter one discussed the national policies and drivers that have informed the framework for PM involvement,

and how they might transition into these roles (NTA 2010; Strang, 2011; HM Government- Alcohol Strategy, 2012), along with the drug strategies (HM Government, 2017 and 2021). These policies have played a crucial role in translating theoretical ideologies into practical applications, aimed at supporting PMs to live fulfilling lives. Nevertheless, the findings reveal that some staff were sceptical and disillusioned regarding whether policies provided clarity and went far enough to inform those at the local level managers responsible for interpreting and implementing them. In addition, the study found that the size of the complexity appeared to influence each organisation's capacity to deliver against these strategic drivers. As previously mentioned, a few of the national alcohol and drug providers had core policies relating to PMs but with localised interpretation based on service contracts. Notably, each organisation had adopted its unique approach to engaging PMs, with varying policies and procedures developed and implemented to support PMs to assimilate and progress in their roles. Duke (2013:41) supported this argument and suggested that 'the various stakeholders in drugs policy have different frames that lead them to view and interpret drugs policy issues differently and to support different directions for policy and practice'. Furthermore, some stakeholders have questioned the drug policies' relevance to meet the current and ever-changing challenges within the alcohol and drugs field.

However, despite the recent disruptions caused by the COVID-19 pandemic, the study establishes that the pathways have contributed both positively and negatively to the PM's transition following treatment. Similarly, recent drug policies, such as the 2021 Drug Strategy (HM Government, 2021), and the publication of DHSC Black report (DHSC, 2021), have offered some solutions towards refocusing the policies and national drivers. These solutions provide the impetus to rechannel conversations around the role of PM in alcohol and drug services while paying attention to their functions within services and the wider community, their pathways, and their opportunities for development. Consequently, government promises of financial injections, ringfencing of funding, refreshing commissioning approaches such as longer contracts, and leveraging lived experiences to inform service design and delivery could strengthen the PM's position, making their roles more prevalent (DHSC, 2021). The next section will focus on some of the barriers highlighted to PMs

progression along the pathways. Equally, DHSC (2021) advocated for the use of PMs within wider social settings such as jobcentres which presents further opportunities for PM roles to be developed beyond substance misuse services whilst positively impacting those affected by alcohol and drug misuse.

Barriers to PM Pathway

Across all four organisations, participants emphasised several factors that hampered or completely blocked the progress of PMs along the identified pathways. These factors include relapse, inadequate human resources processes or competency frameworks, disinvestment, and short-term contracts. The following section explores these factors in greater detail to highlight PMs' challenges.

Risk of Relapse for PM as a Pitfall

As explored above, PMs can play a crucial role in reducing the risks of relapse for others (Reif et al., 2014) but can also increase these risks for themselves if PMs are not adequately trained and supported. As we have seen, PMs have an overwhelming desire to give back, which can be fulfilling. However, this can also contribute to potential relapse or stagnation of their own recovery development. There are several reasons, such as risks of burnout, revisiting old personal traumas or unresolved issues and a natural predisposition to relapse. Both PMs and staff reported bearing witness to these occurring.

Participants in my study have observed that PMs can become so overzealous or so involved in service users' recovery and care, that they neglect their own and burn out (Dugdale et al., 2016). As Tracy et al. (2012) reported, these burnout and relapse episodes can not only lead to curtailing recovery pathways but can also increase stress and drop out; for some, it even led to death as a result of returning to more chaotic alcohol and drug use. Similarly, several studies highlighted that working with others who experience substance misuse difficulties can increase vulnerabilities for

this workforce group and re-expose them to traumatic personal experiences. (Tracy et al., 2012; Barker et al., 2018; Chapman et al., 2018). These factors can also be further heightened depending on the transitionary phase in the PMs recovery and pathway - for instance, during the early stages of recovery (Tracy et al., 2012; Dugdale et al., 2016; Sears et al., 2017).

Conversely, other researchers have disputed that continuously working closely with service users prompted potential relapse for PMs (ColÓn et al., 2010; Tober et al., 2013). Instead, working with others offered them opportunities for reflection, provided insights and reminded them of their journeys and becoming better at spotting flashpoints (Tober et al., 2013; Dugdale et al., 2016). Barker et al. (2018) contended that self-awareness of triggers and controlling the associated emotions would support continued recovery and relapse prevention. In addition, PMs in my study reported how the recovery positives of having structured activities to replace previous substance misuse behaviours had been crucial for their recovery.

Taking these issues into consideration, management needs to support PMs to balance being overzealous and keen to contribute to services and society with taking care not to overreach themselves (Sears et al., 2017). For example, previous studies have stated that doing too much or too little and entering 'employment' can also trigger relapse (Cebulla et al., 2004; Rosen, 2012; Duffy and Baldwin, 2013; Measham, et al., 2013). As we have seen, the process of socialisation can provide appropriate solutions to preventing burnout. Coupled with this, most PMs in this study developed heightened self-awareness of their limitations, which was pivotal to supporting their PM pathway.

Lack of Human Resources processes or competency framework

Some PMs in my sample described a lack of clear policies and competency frameworks to inform progression along the pathway. Only two of the four organisations reference a checklist of the criteria that service users or PMs need to demonstrate to progress onto the next stage of their developmental pathway. As

previously mentioned, there are no set criteria to measure stability. The term 'stability' appeared to be entirely subjective. This level of subjectivity has meant that it can be a barrier to transition for some individuals. It has also meant that individuals rely heavily on a given manager's opinion of their level of stability rather than on more evidence-based and objective measurements. This ambiguity led to frustration amongst some service users and staff who disagreed with the judgment made surrounding the suitability of the individual to progress into the PM role, as reported in Chapter 6, section 6.2. Hewitt et al. (2014) explained the importance of the competency framework as a concept within nursing and health provision. They argued that the assessments could be used to identify the core competency of the individuals' work-related behaviours, knowledge and skills.

Furthermore, the competency framework shows solid relationships are critical for developing a workforce capable of providing high-quality care (Flora et al., 2020). Surey et al. (2021) also strongly supported this recommendation on the importance of using a competency framework for becoming a PM within the homeless team. DHSC (2021) also argued the need for a measurable framework to support the upskilling of the workforce within substance misuse. While this focuses on drug workers and other health professionals, it also applies to PMs who play an integral role in alcohol and drug service delivery. DHSC (2021) advocated that these competency frameworks would help improve health outcomes for service users by having a workforce that can provide consistent and high-quality interventions. In addition, adopting competency frameworks across the workforce would address the issues of equity of access into PM roles and support more transparent requirements for PM's progression.

Additionally, participants in management positions in my study revealed that the organisations' human resources policies needed to be equipped to effectively support the recruitment and retention of PMs. PMs were often considered employees similar to others in the organisation, ignoring their recovery background. While PMs did not expect to receive special treatment, the study emphasises the need for appropriate adjustments during ex-service users' support assessments and where disciplinary issues arise. As a positive cultural shift, three of the four organisations extended their

Employee Assistance Programme (EAP) to include PMs. The organisational policies should take account of the changing workforce, which involves individuals from substance misuse backgrounds. Employees from roles such as PM require access to the EAP for increased support, as a lack of access may increase their chances of relapse and attrition rates. Employers should recognise that support and ongoing dialogue with these potentially vulnerable employees are necessary to provide continued employment, according to the DWP (2017). Service users' reluctance to disclose some personal details such as previous convictions and employers' refusal to employ ex-offenders are other indirect barriers that need addressing. Studies conducted by Metcalf et al. (2001), Klee et al. (2002), and Sutton et al. (2004) have cited these barriers.

Disinvestments and Short-Term Contracts within drug and alcohol services

Drug and alcohol service providers were negatively affected by external factors that hindered the development and sustainability of PM's pathways. Some of the interviewed managers expressed frustration with the lack of resources to develop the PM pathways further. They highlighted the macro factors identified in Chapter 1, which include a decline in the contractual financial envelope allocated to provide the same or more treatment interventions and a lack of ring-fenced money given to the alcohol and drug services. Research by Duke (2013) and Measham et al. (2013) also highlighted these changes to drug provision policies. These included advocating for a shift to abstinence-based recovery treatment verses harm reduction, removal of ring-fenced substance misuse treatment funding and punitive benefit sanctions for those who misuse substances and disengage with treatment services. As a result, Local Authorities in England could divert previously protected alcohol and drugs budgets to other social services, which could be responsible for poor treatment outcomes and increased deaths highlighted in the studies by DHSC (2021) report.

Participants in my study highlighted the predicament faced by service providers forced to shift their focus towards core services due to the reallocation of resources. Similarly, research shows that countries like Ireland, Germany, and the United States have faced similar dilemmas in allocating health and social care funding (Rieckmann

et al., 2010; Henriksen et al., 2012; Johnston et al, 2021). Consequently, the managerial staff interviewed for my study regarded the development of PM pathways as a luxury rather than an essential service for current service users and PMs on their recovery journey, arguably signifying a move away from the recovery-oriented practices endorsed by the Drug strategy in 2010 (HM Government, 2010) and Strang (2011).

The shift towards shorter commissioned contracts was a significant contributor to the reluctance of the organisations to invest in the PM's pathway and recovery pathways. Staff as part of this study argued that shorter contracts meant that they did not have ample time to implement the pathway properly; to invest in the infrastructure - like staffing and PM training - and to create sustainability, whilst embedding key performance indicators within service contracts. They also argued that their ambivalence stemmed from selfish reasons and the uncertainly of not reaping the rewards of such pathways if contracts were short-lived and could potentially be awarded to other organisations. Previous research has highlighted the associated issues despite the government's encouragement towards competitive tendering through shorter contracts. McKeganey (2011), Salamon (2015), and McAllum (2018) have all underscored the government's misguided approach of getting service providers to provide more with fewer resources. Overall, given the analysis presented, it is increasingly evident that drug and alcohol service providers require more extensive and longer-term contracts to ensure the progression and sustainability of PM's pathways.

However, this research has highlighted those services are not entirely averse to developing their PM pathways. Instead, providing PM pathways was reserved for larger organisations who were able to spread the cost of implementation and investment in the infrastructure to support them by using funds from a variety of contracts across a larger geographical area. Similarly, in at least three of the four organisations, PMs and recovery were embedded within the organisation’s culture and ethos. As mentioned above, the Dame Carol Black’s report (DHSC, 2021) reported

similar findings and makes recommendations already highlighted above in section 8.4 Policy Drivers – Organisation and External Factors.

8.5 PM experience of liminality as part of their transition

As the findings of the study has demonstrated, PMs undergo a liminal process as part of the service user transition to PM. Using the concept of liminality advocated by Van Gennep's (1960), facilitated a better understand the process of 'transition', where the individual experiences a rite of passage as described in section 3.6. During the transitional stages, the individual no longer identifies as a service user but is not entirely a PM or staff member of the alcohol and drugs team. This 'in-between' stage can potentially be confusing and disruptive to the individual's recovery journey. Beech (2011) argued that liminality encompasses the dialogue between inner and outer selves. This empirical finding highlights the need for tailored support during the liminal process to minimize disruption to the individual's recovery journey. My research and the wider literature also indicate that the liminal state can be fluid and changing and that there are both negative and positive aspects to being within a liminal space. These issues are considered next.

Fluidity and the Multiple Liminal States

The study highlighted that PMs might experience several of these liminal phases as part of their role. Notably, PMs described experiencing their initial liminal state during their transition from service users to a PM. In addition, another liminal stage identified can occur when PMs transition from these roles into, for instance, volunteer, recovery champions or paid employees as described in the pathways section above. Therefore, the liminal stages were not overtly static or sequential as these transitions may impact the individual's recovery and identity.

Moran (2013) contended that individuals' identities, transformations, and liminal phases are not linear but destabilising and in flux. Researchers have argued that recovery is fluid (White, 2007; Measham et al., 2013). Consequently, Meyer et al. (2010) argued that an individual might experience a degree of recursiveness and fluctuation as part of the liminal process. PMs interviewed described a flux and oscillating effect on their identity between one state and another in a forward and backward movement. PMs crystallised this phenomenon by explaining how they sometimes reverted to a service user identity during interactions with specific individuals or groups, such as those who had previously been instrumental in their care. Similarly, where PMs had relapsed in their recovery contributed to a shift in their liminal state. However, they described a different liminal state when using their lived experiences as part of their PM role. During this state, they saw themselves as an expert in their field. They contended that, during this stage, they enjoyed equal status with their colleagues, such as alcohol and drug workers, nurses or doctors. PMs, therefore, saw this as a different and more complex liminal state during their interactions with colleagues and service users.

It could be contended that the associated identities during the transitional phase and within liminal states are situational, fluid, and amorphous for that individual (Czarniawska and Mazza; 2003; Shotter, 2008; Starr-Glass, 2013). Therefore, during an individual's transition through the pathways or recovery, liminal states and identities need to be considered, focusing on relationships between the individual and others, the organisation (at meso level), or society on a macro level. Liminality can also catalyse social change, whether positive or negative, which will be further explored.

Negative impact of Liminality on PMs

During the liminal transition stage, PMs undergo a state of perplexity and instability owing to the unknown. As stated by Turner (1967), Beech (2011), and Starr-Glass (2013), this liminal phase, known as the 'betwixt-and-between' space, is characterized by a suspended state where their previous and future norms are on hold. Chreim's

(2002) research indicates that PMs can also experience a sense of loss and disconnect during this liminal state. The PMs I interviewed described just such a feeling of loss during their transition to their new PM role, as they had to relinquish their old social networks, relationships with key workers, previous service users, and friends - networks that had defined them for some time. Given this, the loss of networks can be disconcerting. Furthermore, Meyer et al. (2010) argue that this unsettling liminal position can result in losing one's prior identity in embracing an emerging new one. Overall, it is clear that PMs face a complex set of challenges during this transitional phase, which necessitates careful support and guidance.

Tannenbaum and Hanna (1985) posit that in the liminal phase, it is common for individuals to cling to their prior identity due to the familiarity of existing attitudes, beliefs, and behaviours. These feelings are often due to the fear of the unknown. While this may prolong the liminal state of PMs, it may present a more comfortable compromise for them. Although Tober et al. (2013) noted that PMs might become overly attached to their role, other studies suggest that the PM role can offer a gradual and more relaxed transition into a stable position, as stated above. This transition is advantageous for PMs as their previous service user identity may have been characterised by chaos during their alcohol or drug use (Nicholls, 2009; Bramley et al., 2020). Furthermore, PMs described their vulnerability as characterised by low self-esteem and self-confidence, stating that PMs universally mentioned that their transition from a familiar service user identity to the new PM identity was challenging. This highlights the need to address the barriers to successful integration into the PM role that may arise from prior alcohol misuse experiences.

PMs feeling unrest during the liminal phase may be strongly connected to their new social identity and perceived disenfranchisement within the organization or society. Nixon's (2020) research highlights that PMs were not consistently acknowledged for their contributions, in this case within the criminal justice setting, by their peers, which can negatively impact the liminal phase. Additionally, PMs reported that a lack of timely support from colleagues and organizational systems contributed to their prolonged liminal phase. Some PMs also felt unwelcomed and unsupported and

experienced indirect discrimination, evidenced by the prevention of their access to staff areas or equipment. Thus, this analysis highlights the critical importance of validating PMs' contributions, offering timely support, and promoting inclusivity and equality within the workplace. However, despite the discomfort associated with change, PMs said that eventually they welcomed the ‘pain investment’ and embraced the liminal space as part of their transition, acknowledging its advantages.

Liminality as a Positive Status

PM's liminal state of 'betwixt and between space' could also usher in a period of opportunity to transform and empower themselves and their roles (Beech, 2011). PMs recounted how they were keen to change their identity and how others perceived them. During the stages of the PMs' transition, they expressed that they were eager to move towards an aspirational identity compared to their current self as a service user or ex-service user. During a liminal state, individuals described disassociation from a previous self to a new and better self (Thornborrow and Brown, 2009). In most cases, PMs asserted that a motivating factor for this change was the need to dissociate themselves from identity-stigmatising events or groups that are negatively viewed (Ashforth and Mael, 1989).

As PMs gained more insight into their role and embraced their new identities, they expressed an increased feeling of certainty and exhilaration (Meyer et al. (2010). All participants also described feeling increased self-confidence and self-esteem as they became more proficient in their roles and acquired better understanding of their position in the organisation. Participants said that some of the enabling factors of their PMs pathway discussed above, such as training, supervision and regular meetings, also supported this transformation and progress through the liminal stages. Tompkins and Cheney (1985) also identified that organisational tools like these mentioned above could positively help the liminal phase.

In addition, arguably, the liminal stage may be positively supported by the organisation's communication of the PM's new identity. For instance, PMs strongly expressed those regular meetings with their respective managers or teams helped support their feelings of belonging and safety in their newly acquired social identity, as reported elsewhere in the literature (Pratt, 1998; Donavan et al., 2006; Yoganathan, et al., 2021). This approach may be essential for individuals such as PMs who are shifting their identity from a service user identity and wanting to identify with different groups such as an organisation, workgroups, or social groups. Chreim (2002) argues that individuals develop their social identity according to how they view their organisational roles. In the main, most PMs viewed themselves positively, recounted feeling empowered and having a sense of positive self-esteem even within the liminal state. PMs in this study contradicted Garsten's (1999) views on the liminal phase and on temporary workers being part of an organisations' periphery. Whilst the respective organisations did not employ PMs, the PMs did not feel detached or easily dispensable, as argued by Noble and Walker (1997). Feeling a sense of belonging was primarily due to the inclusive communication strategy employed by the four organisations in this study. These perceived differences in study findings may be due in part to the wider changes that have taken place in how lived experience is perceived and incorporated into policy and service delivery. Chreim (2002) argued that an inclusive communication strategy could support more positive liminality in new roles.

Significantly, PMs argued that they increasingly saw a shift in their identity due to some of the communication they had received through their meetings, induction phases, regular day-to-day feedback, and monthly or annual organisation reports about their positive contributions. They also argued that these communication tools helped shape and align the PM's identity and values with those of the organisation – a finding that echoes the study by Chreim (2002). Notably, this study also highlighted that several participants within management positions actively advocated that this approach was paramount to PM's onboarding process and recovery identity. Similarly, they identified how tools, such as organisational communication, can be employed. Managers in this study described how they demonstrated a connection between the organisation's communication strategy with their values and belief and that of the PMs. Invariably, this would create buy-in from the individuals (Tompkins and Cheney,1985; Ortlieb and

Ressi, 2022). For example, the managers interviewed from three of the four organisations described how they had used PM celebration days, incentives such as vouchers, and regular communication, which validated the PM's contribution to alcohol service provision. Using this approach, the organisation helped to create individuals' identification with the organisation by appealing to PM's values and beliefs gained from previous socialisation processes, such as during their upbringing, education, lived experiences of being a service user and other significant life experiences (Cheney, 1983; DiSanza and Bullis, 1999).

8.6 Shift in identity as part of the PM role

Most PM participants were keen to demonstrate a shift in their identity from a service user to a member of the alcohol and drug service team. They evidenced this transition by referencing how, as part of their PM role, they had carried out tasks and behaviours resembling their colleagues, such as assessment of service users or facilitating psycho-social interventions- facilitating pre or post detox groups. They also placed a significant value on the knowledge and skills from their lived experiences and training accumulated as part of moving from being a service user to PM or from PM to other roles such as volunteers and recovery champion discussed under the section on PMs pathways above. Others were keen to express that they were returning to a work-related capacity they had inhabited before their alcohol misuse. For example, Freidson (1988,1994) argued that being able to demonstrate and exercise autonomy were traits associated with being an occupational colleague. Similarly, within the context of mental health, Berry et al. (2011) argued that individuals with lived experiences wanted to take ownership of their development. However, this contrasted with several studies which argued that organisations could potentially stifle PM autonomy by limiting their influence to decide how PM roles are established, shaped and implemented (Gates and Akabas, 2007; Van Erp et al., 2010; Moran et al., 2013; Gillard et al., 2015; Gruhl et al., 2016; Vandewalle et al., 2016). An organisation may remedy this by supporting PMs to actively shape their job roles, such as job description and specifications, as seen in the study by Surey et al. (2021) on Hepatitis C treatment.

Conversely, the study also found that PMs were conflicted about adopting an occupational identity. They described a feeling of guilt and betrayal when transitioning from being a service user and adopting an identity based on authority and service provider, especially when working with service users in their PM roles. Berry et al. (2011) suggested that conflict may occur if peers cannot feel they have the autonomy to maintain that essential ingredient of sustaining mutuality in relationships with the service user. Furthermore, Surey et al., 2021 argued that 'retaining peerness' was essential to the role of PM and advocated that these individuals retain their previous identity to provide authenticity in carrying out their roles. Moreover, according to several research studies, this is a significant part of the process that facilitates the metamorphosis of individuals with personal experience into individuals possessing occupational identities (Moll et al., 2009; Van Erp et al., 2010; Stott and Priest, 2018).

The majority of staff interviewed warmly welcomed PMs as valued staff members and perceived them as fellow colleagues. Nonetheless, some staff members expressed concerns that the expanding role of PMs appeared to contribute to the de-professionalisation of their profession. This further underscored and corroborated the findings from other research that staff attitudes can perpetuate the stigma and discrimination experienced by those in PM roles. Prior research had found that PMs continued to experience stigma on both micro and macro levels (Dyble et al., 2014). Additionally, Mowbray et al. (1998) argued that stigma and discrimination could lead to further identity conflict and lack of team cohesion. Consequently, issues previously discussed due to the nomenclature employed in defining a role are intimately connected with an individual's role identity, acceptance, and subsequent integration into a given service (Dierdorff and Morgeson, 2007; Gillard et al., 2015).

Further action is required to address role clarification and professional boundaries to support these new professional colleagues in the developing alcohol and drug workforce. The study highlighted that some organisations had tackled the issue of stigma and discrimination by ensuring that the PM did not operate professionally in the same service or area where they were once a service user. In conclusion, this

research advocates for realistic role development rather than task shifting (Mijovic et al., 2016; Surey et al., 2021) as it provides professional colleagues with a sense of security that their roles and professions were not compromised or at risk due to the introduction of peer roles and also aids PM's transition. Dyble et al. (2014:88) suggested that 'working to modify the system offered clarity and significance to the role, which, in effect, enabled individuals to have a more defined transitional experience and better handle fluctuating identities due to a more explicit focus on the future'. This research establishes the need to enhance role clarification and boundaries with appropriate measures in place to support the professional development of individuals.

8.7 Using organisational socialisation to support PM's transition

Organisational structure and traditional management structures need to adapt if a PM workforce is to be fully integrated. Gates et al. (2010) argued that the failure of an organisation's leadership and strategies to embrace the recovery mission would impede efforts to achieve peer integration. The literature offers insights into how organisational structures and management processes need to develop to achieve successful integration of PMs and ensure their personal progression as well as support the contribution they can make to service delivery. The following sections discuss the findings from my study in relation to this literature.

Changes to organisational structures to support PM integration and transition

According to Gidden (1979, 1984) the structure, policies and resources of an organisation are not static but evolve over time as people interact with one another. Furthermore, organisations can support members to accumulate knowledge and skills, through the way they interact (the organisation's culture) with them which can inform their behaviours and beliefs (Allinson et al., 2001; Martin, 1992, 2002; Harpelund,

2019). This was evident from the interviews with participants of this study, and it helped us to understand how a PM connected with their respective organisation as they worked towards shared goals. For example, three of the organisations in this study made several changes to their management structures and processes to integrate peer roles within their organisation. At a strategic level, organisations included appointing individuals with lived experiences as part of the senior management team whose purpose was to effect changes and nurture a different organisational culture. The organisational culture was also informed by the relationships PMs engendered through their integration, adding social value to the communities they served and economic value by securing new contracts. At an operational level, several senior managers and those who directly managed PMs described how they had actively worked to change the culture of the work environment where PMs were concerned. Managers indicated that they had hosted multiple consultation events to help inform and change service delivery. Their objectives were to foster shifts in staff attitudes toward PM integration. However, as discussed already, the research found that some staff were dismissive at times about the PM's contributions. Martin (1992, 2002) contends that this may occur when there is inconsistency in interpretation by organisation members and the organisation's culture regarding 'differentiation' perspectives. In these situations, the executive team promotes one value and frontline management promotes another. Arguably, this can give rise to subcultures which potentially can lead to ambiguity and conflict of approaches. Therefore, it is important to ensure that organisational structure and culture are backed up by progressive and inclusive policies and procedures.

Inclusive policies to reflect emerging roles such PMs

All four organisations described how they had developed and changed their suite of policies to reflect changes needed to integrate their PMs. These included changes to how disciplinaries were handled to make them more supportive, adjustments to Disclosure and Barring Service (DBS) clearances and support around induction processes. Roche (2001) argues that policies and practices are an important vehicle to help inform staff changes. However, while policies and procedures are necessary

to support organisational culture, their applications must not promote rigidity and a one size fits all approach, especially in health settings. Using the institutional theory of organisation structure, Staber (2013) and Ogbonna and Harris (2004) argue that rigidity of policies can lead to conflict, disharmony and inefficiencies due to lack of flexibility surrounding autonomy and decision-making processes.

This study identified a mixed approach to how policies were changed to reflect the changes in incorporating the role of PM. In two of the organisations, an integrated approach was taken, where PMs roles and job titles were specifically referenced, or sections were added to existing policies. Other organisations had created a specific stand-alone suite of documents related to PMs management and their support. Unfortunately, as Gates et al. (2010) argued, more often than not, peer support colleagues operated within organisational systems where there are poor or inadequate policies and human resource processes to support them and their integration into the existing alcohol and drugs teams. Furthermore, whilst the policies and standard operating procedures were promoted by management within this study, they were not always translated into practice where PMs were concerned. A few of the reasons for poor implementation, such as organisational culture, and the inflexible nature of some policies have already been highlighted above. Crosby (1996) also stated that poor support from top management could contribute to failure in their implementation. Stakeholder engagement and creating shared expectations may support buy-in and adherence by members (Davidson et al., 2012; Gillard et al., 2015; Vandewalle et al., 2016). Roche and Pidd's (2010) asserted that policies, like other areas of workforce development, demand considerable time, commitment and resources to create system change for both individuals and the organisation.

The importance of supervision provision

Within the framework of organisational socialisation, supervision was seen as a very crucial element of the PM pathway. According to several authors (Schein, 1971, 1974, 1980; Falcione and Wilson, 1988; Louis, 1980, 1990; Van Maanen and Schein, 1990;

Bauer and Green, 1998; Slaughter and Zicker, 2006), socialisation has a significant impact on newcomers, their colleagues, and the organisation by increasing awareness of one another and increasing social cohesion. Significantly, across all the organisations interviewed, there was clear evidence of supervision being a critical part of every PMs developmental plan. However, its application was again patchy and inconsistent. Notably, in organisations that had dedicated PM managers or staff, uptake was more consistently applied. Gates et al. (2010) argued that within mental health services, individuals who provide peer support are often provided with little or no supervision support from the organisation. Similarly, in previous research in substance misuse treatment, the Black report (DHSC, 2021) also identified that within the substance misuse workforce, supervision was poorly resourced and implemented and accounted for the reduction in quality service provision and increase in service user mortality.

Finally, crisis situations can influence organisational structures and management processes and can interrupt the development of the induction and inclusion of relatively new sections of the workforce, such as PMs. Crisis responses may introduce change more quickly than in normal circumstances, but it may also pose challenges for the transition into PM roles and increase negative aspects of liminal space. As mentioned already, the COVID-19 pandemic occurred during collection of the data for my study and presented an opportunity to consider this aspect of transition to the PM role.

8.8 How has COVID-19 impacted on the role of PM

There is no denying that the coronavirus disease (COVID-19) caused problems in all sectors of society, partly due to its sudden and wide-reaching effects (Liu et al., 2020). This study highlighted how alcohol and drug service were duly affected by COVID-19 as a result of changes to staff and PMs accessibility and work pattern. For example, staff across all sectors, including health settings, were requested to work from home

(Kramer and Kramer, 2020). This had both positive and negative effects for all employees, but for individuals such as PMs, who were still going through the process of organisational socialisation, this may have been particularly disruptive. Previous studies emphasised how by being part of organisational processes, individuals can gain work-related knowledge and skills such as office etiquette (Van Maanen and Schein, 1979; Solinger et al., 2013; Bauer and Erdogan, 2014). Insights can be drawn from previous research conducted during other pandemics such as severe acute respiratory syndrome **(**SARS**),** where remote working was explored. Bailey et al. (2015) suggests that reduced opportunity for interaction with colleagues and the work environment may affect the socialisation process. Uddin et al., *(*2020) describe how perceived support from colleagues heavily influences the social relationships one develops in the workplace, which can affect one's sense of belonging and productivity. Similarly, a lack of social interaction with colleagues affects the organisation's socialisation process (Takeuchi et al., 2020).

PMs described interruption of these integration processes as one of the most profound negatives of COVID-19 which had affected the development on their PM pathway. Socialisation activities such as supervision, buddying, and developing work-related skills were not possible due to social distancing and increased home working. As a result, it can be argued that PM development and progression was either curtailed or stunted during this time. PMs expressed other disadvantages of COVID-19. For example, they described how they felt abandoned during the lockdown's initial stages, a situation that they felt questioned their position within the organisation. While managers explained that this was not intentional, they described how the unknown and the shift in focus to core services would have contributed to PMs perceiving this experience as abandonment.

Conversely, COVID-19 was not entirely negative. PMs described that they were able to benefit from the extra time and the flexibility of home working to develop new skills. While it was an initial struggle for many due to a lack of technological skills and equipment, PMs became more proficient at navigating technology and social platforms such as Microsoft teams and Zoom, which they reported they had previously avoided.

Such unexpected advantages have been reported in other studies. Dubey and Tripathi (2020) reported that individuals working from home increased their online technical skills during the period of a COVID-19 pandemic as well as becoming more conversant with other social medial platforms. Other recent research on COVID-19 showed that due to the need to socially distance, individuals were able to switch to distance learning, which they had not previously used (Pustika, 2020; Hite and McDonald, 2020; Momtazmanesh et al., 2021). PMs also mentioned that they were able to take advantage of online training provided by the organisation as a result of home-based working. Other benefits of being forced to seek an online platform included the increased use of WhatsApp in Organisation A and Organisation D. Significantly, PMs reported that the increased reliance on social media platforms led to greater exposure to more extensive support networks. Organisations in the study also highlighted that they recognised the added benefits of social media platforms to both staff and PMs and adopted this as another support mechanism and mode of communication.

Thus, as PMs acknowledged, profound reliance on social media platforms resulted in expanded exposure to more extensive support networks and recognition by organisations of the benefits associated with social media utilisation for both staff and PMs.

8.9 Summary of the chapter

The chapter discussed how, similar to other health settings, different terminologies were used to describe similar roles for PMs within alcohol and drug services. Although subtle differences existed in the roles described by these terms, two common denominators remain integral to their definitions: lived experiences and some form of abstinence, the latter having a close association with the recovery approach. Individuals with such experiences provide added value through their shared experiences and knowledge, and the ability to engage service users in the uptake of

alcohol and drug services. By championing and personifying recovery through their own lives, these individuals engendered a strong argument for roles like these to be championed and embedded into alcohol and drug services. Abstinence from alcohol served as a motivational factor for PMs, enabling them to sustain their recovery whilst fostering professional relationships with colleagues and service users.

In examining the role of the PM, there was strong evidence to demonstrate that it acts as a transitional mechanism which guides service users towards and through a range of recovery pathways. These pathways allow service users to build on their recovery capital and support their identity transformation. The study identified factors that facilitate a PM pathway, such as a supportive organisational environment that fosters the PM's socialisation and integration into their new role. Enablers like creating induction, supervision, and training opportunities were emerged as crucial to the PM's transition. Conversely, barriers to the PM pathways were also identified, including the risks of relapse, a need for more human resources support, and competencies dedicated to assessing the proficiency of those who carry out the role.

Current treatment pathways have a limited scope, as they only extend until discharge from structured treatment services. This study highlights the need for further empirical research to explore what happens after discharge and what could be done by way of policy and practice to smooth the transition into post-treatment pathways.

Additionally, this chapter revealed how PMs undergo a liminal state during the continuum of their transition from service users to PM roles, as well as their progression into employment. Liminality was seen to provide opportunities as well as challenges for the PMs and the findings emphasised the need for improved understanding on how organisations could support individuals through this experience. Given the transitional nature of the role of PM, it is unsurprising that individuals undergo a transformative process. PMs adopt different identities to match their respective roles, depending on the context. For instance, their personal, social, or professional identity may change to an ex-service user, a new, fledging

professional, or someone who has regained a previously skilled and proficient persona which they had enjoyed before their substance misuse.

Finally, this study examined how the COVID-19 pandemic influenced the role of a PM, showing how the pandemic had disrupted the transitional pathways and created challenges for the PMs and their organisations but, equally, had provided opportunities for learning new skills and new ways of working.

The next chapter presents the conclusion and recommendations from study and considers the study's limitations and contribution to understanding the role of PMs in the delivery of alcohol and drug services.

Chapter 9: Conclusion

This chapter merges a summary of the key findings with recommendations for practice and policy at a service, organisational and national level. There are four key findings; a summary of each is followed by recommendations that flow from the findings. This study's limitations and contributions to knowledge are discussed below. Finally, topics for future research are proposed.

9.1 Implications of key findings: recommendations for practice and policy

This section focuses on how the findings from this study could be applied to future practice and policy development within the alcohol and drug sector at an individual, organisation and potentially at a national level. It is anticipated that these recommendations would support further research and be used to inform future service development, especially regarding how PMs could be supported within the health and social sectors.

The role of PM as a transitional position

The study found that the role of PM was a transitional one, supporting an individual to move from a service user to a service provider while building on their recovery journey. During this transitory stage, PMs experience a liminal state which should be factored in, as they can either advance or deter their progress along their pathway to recovery. The transitional role is a good consolidating position, as it offers the PM an opportunity to formulate a new identity and explore opportunities for further development during the early stages of their recovery. PMs reported that they had begun to explore

opportunities, such as formal training or exploring work opportunities other than the health sector.

Recommendation 1: The sector or organisation needs to acknowledge the transitional nature of the PM role and the importance of support during the liminal state experienced by PM if PMs are to reach their full potential. Similarly, it will be beneficial for service providers to map the different recovery pathways that are potentially available to individuals leaving the treatment. Appreciating that PMs take different pathways on their recovery journey, tailoring a package of support – which appears to be lacking at present – is important. This could lead to a more consistent approach adopted by organisations when supporting these individuals on their recovery pathways and would help to build a person-centred approach that recognises that recovery is not a static or linear state; it needs to be informed by how individuals present at any specific time in their recovery and PM pathways.

Support for PM integration within organisations

According to the findings, the PM role was perceived by other colleagues as being akin to an emerging occupation. PMs possessed expertise, knowledge, and skills which they could offer to the team, but which are unique to them and their position, especially the relationship between service users and paid employees. They can be brokers to support access to services and can reach out to those who are disillusioned or distrusting alcohol and drug services. They can also use their knowledge and experience to address service 'gaps', suggest new ways of working with a disenfranchised group and develop pathways beyond treatment. While there was some concern that the role of PMs encroached on other professional roles and challenged boundaries on certain tasks, PMs were viewed with respect and generally welcomed as a positive addition to alcohol and drug services. Participants in management positions acknowledged that there were remedial actions which could be implemented to support the PM role to be more fully integrated.

Recommendation 2: That PMs are recognised as an occupation with defined tasks. The benefits will be two-fold. First, clearly defined tasks carried out by PMs would address the issues of stigma and discrimination that PMs have experienced from time to time from professionals working within services. Using their lived experiences to inform training programmes for staff can address issues of stigma and discrimination, build on staff members' skills and competencies and inform the sector at large. Second, repositioning how PMs are perceived in the workforce will help address role conflict and boundary crossing. Re-focussing the PM's role as a support for other professionals rather than changing the roles carried out by PMs and professionals may reduce ambiguity surrounding the tasks that PMs carry out and reduce the potential for friction.

The importance of organisational socialisation for the role of PM

The process of transitioning from one identity to another is a challenging one. This challenge is particularly arduous for a service user transitioning to a PM. The significance of organisational socialisation in undertaking PM roles was strongly supported among participants, as it was seen to have a positive impact on their identity and functionality within the role. However, there seems to be an inconsistent approach to the onboarding process, which comprises induction, supervision, and training during the first six to twelve months of the PMs' tenure. It is essential to acknowledge that a one-size-fits-all process is undesirable for those who may have different needs and recovery pathways.

Recommendation 3: A sector-wide uniform organisational socialisation approach to PMs integration is recommended, accompanied by a suite of policies that reflect procedures and practices around recruitment, induction, and supervision processes to support PM during the onboarding stages and over the course of the PM pathway. Similarly, these organisational tools would help to champion the organisation's values and culture for PMs to support their integration at an early stage.

Development and implementation of a competency framework for the PM role

Individuals' accessibility to PMs roles appeared to be patchy and inconsistently applied. Appointment to PM roles were often based on a subjective assessment of an individual's readiness and appropriateness for their PM roles and progression. This was due to the lack of a clear competency framework.

Recommendation 4: Implementing a competency framework would facilitate the establishment of standardised skill sets and training requirements across the field, promoting accessibility to PM positions, while facilitating the identification of developmental milestones to guide PMs' progress. Furthermore, an impartial competency framework would bolster the credibility of PMs' roles and contributions, while serving as a measure of proficiency to ensure fluid transitions between different teams or organisations.

9.2 Study Limitations and Strengths

This study examined the PM role as one of several available recovery pathways. Convenience sampling was used to identify participants, and, in the majority of cases, they had all been previously associated with the service as a service user and had been recently discharged. Consequently, they were more likely to represent a group with a strong connection to the service, and as a result, their views may be positively biased. Similarly, because the researcher relied significantly on gatekeepers and/or PM managers to gain access to PMs, they may have suggested PM participants, who they thought would provide favourable views about their transition from service users to PM roles. Furthermore, the study did not capture those participants who declined the offer to be involved in this study or those who started the PM role but did not continue for various reasons - for example, due to substance misuse relapse or inadequate support received from the organisation. Despite this, the study was able to engage a good cross-section of services and participants (staff and ex-service

users) which allowed for the inclusion of varied perceptions of the PM's role and the contributions that these roles may have on service provision.

Due to COVID-19 restrictions, it was necessary to switch to online interviews from the previous intention of conducting face-to-face interviews; it also meant I could not carry out participant observations and focus groups as previously planned. The use of focus groups may have provided different perspectives on the information gathered.

As mentioned in section 4.8, there were delays in starting data collection. I had to amend university ethical approval to take account of changes in the study design and because there were delays in obtaining ethics approval from the various organisations. However, I do not believe that the delayed start introduced additional problems or biases.

The findings of this study add to the growing body of information regarding the contribution of the PM role to service delivery, and the contribution that the PM role can play in an individual's recovery pathway from alcohol dependency. This research has provided new knowledge on the role's transitory nature and how the concept of liminality and shifting identities may help us understand the experiences and issues that people in this new workforce may encounter. The study contributes by giving voice to PMs and service providers regarding how individuals can transform their identities through a process of socialisation and adaptation into their work environment. The findings illustrate that PMs are perceived as vital team members within the alcohol and drug sector and that the value they add to service delivery lies in their expert knowledge and skills, derived from their lived experiences. The study also shows how the role of PM develops and the potential of the role to contribute to service delivery depends on an inclusive organisational environment and on supportive policy at the national level to ensure that PMs are successfully integrated into current work structures and decision-making procedures. The thesis findings reinforce the importance of implementing more consistent organisational policies and socialisation processes to inform PMs' recruitment and to support their future growth within the PM role and their prospects for developing beyond the role.

9.3 Future research

The thesis highlights several areas for future research – topics which it was not possible to include in this study or which emerged over the course of the work. Further research may be necessary to determine whether the PM role appeals more to a particular gender, age group, or ethnic group as a recovery pathway option.

- Linked to the above question is the issue of whether being a member of a marginalised group (e.g. a particular ethnic group) further deters recovery pathways or limits opportunities to become a PM.
- It would be useful to investigate further tensions between PMs and other professional colleagues to improve the understanding of the factors contributing to the tensions and what could minimise and change tension between these groups.
- Further research is required to examine why some PMs discontinue their roles and the circumstances that affect their decisions.
- Research is needed on the influence of the role on the PM's immediate recovery community, which may include family members, significant others, and carers.
- Finally, research is needed to investigate the level and importance of connections with different types of mutual aid groups as part of PMs' community engagement and reconnection with society.

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Appendix 1: Table 2.4 A summary of articles included as part of the literature review

(The table presents the published articles in the oldest to newest by date of publication along with the name of the article and the journal reference. The second column provides a summary overview of the authors' abstracts).

No.	Author/ Title of article/Journal reference.	Author(s) abstract (summary overview)

1.	Hind, A. (2011)/ The drugs, the NHS, recovery and me . . ./ Advances in Dual Diagnosis/https://doi.org/10.1108/17570971111163019	***Purpose:*** This paper is to describe examples of service user involvement to demonstrate how they can significantly enhance service provision for people with mental health, substance misuse, and co-existing mental health and substance misuse problems (dual diagnosis), and in so doing, enhance their own recovery. ***Design/methodology/approach:*** The personal story of one service user illustrates a range of involvement activities: membership of service user panels, development of an anti-stigma campaign, mentorship of trust staff, and employment as a peer support worker in both mental health and substance misuse services. ***Findings:*** Service provision in mental health and substance misuse services has been enhanced through the genuine involvement of service users. This involvement has been an important factor in building the confidence and skills of service users and supporting them in their own recovery. ***Practical implication:*** The use of those with lived experiences of mental and substance misuse services in shaping and developing both staff and service provisions. ***Originality/value:*** The paper describes several innovative involvement initiatives and highlights the dual benefits of these roles to services and the service users employed in them.

2.	Schinkel, M., and Whyte, B. (2012)/ Routes Out of Prison Using Life Coaches to Assist Resettlement. / The Howard Journal of Crime and Justice/ https://doi.org/10.1111/j.1468-2311.2012.00724.x	***Purpose:*** The article examines the way in which these Life Coaches were recruited and managed, how they were viewed by their clients, and the added value that peer or mentor support can offer. ***Design/methodology/approach:*** A total of 123 client/prisoner interviews were conducted; 49 prisoners, pre-release, 54, post-release, and 20 at both stages. All of the Life Coaches (14) employed by the project were interviewed twice and consulted through focus groups, twice at different points in the life of the project. ***Findings****:* This article discusses some findings from phase one of an ongoing evaluation study of Routes out of Prison (RooP) which uses Life Coaches, many of whom are themselves former prisoners, to support the transition and resettlement of large numbers of short-term prisoners back to the community. ***Practical implication:*** Life coaches were seen as an extra support to prisoners before and directly after their release as part of the societal re-integration. Life coaches also offered practical and emotional support. ***Originality/value:*** The support offered by RooP through life coaches provided a meaningful bridge to community services and an important source of support for ex-prisoner upon their release.

3.	Tracy, K., Burton, M., Miescher, A., Galanter, M., Babuscio, T., Frankforter, T., Nich, C., Rounsaville, B. (2012)/ Mentorship for Alcohol Problems (MAP): A Peer-to-Peer Modular Intervention for Outpatients. / Alcohol & Alcoholism/ doi: 10.1093/alcalc/agr136	***Purpose:*** To pilot to develop a new intervention, Mentorship for Alcohol Problems (MAP), for individuals with alcohol-use disorders in community treatment programs. ***Design/methodology/approach:*** Ten mentors participated for 6 months until 30 mentees received MAP for 12 weeks. Behavioral and biological measures were conducted in addition to fidelity measures. Four focus groups were held with participants and clinician feedback surveys were completed. ***Findings:*** Feasibility and acceptance data in the domains of patient interest, safety and satisfaction were promising. Fidelity measures indicated that mentors adhered to the delivery of treatment. ***Practical implications:*** Mentees reduced their alcohol and substance use and the majority of mentors sustained abstinence. ***Originality/value:*** MAP shows promise to be incorporated into professionally run outpatient alcohol treatment programs to assist in the reduction of alcohol and substance use.

4.	Roberts, M., and Bell, A. (2013)/ Recovery in mental health and substance misuse services: a commentary on recent policy development in the United Kingdom. / Journal of Groups in Addiction and Recovery/ https://doi.org/10.1108/ADD-03-2013-0007	***Purpose:*** The purpose of this paper is to examine the extent to which the two visions of recovery that are now being developed in the UK are consistent with each other and it questions what impact the development of parallel approaches will have on people at the intersections between them. ***Design/methodology/approach:*** The paper looks first at the origins and current implementation of the two approaches and then examines the commonalities and differences in the context of what they might mean for people using both sets of services simultaneously. ***Findings:*** The ideas behind recovery in mental health and substance misuse services have some differences but significant common grounds when focusing on improving quality of life. ***Practical implications:*** This paper could be used to develop new approaches to support people with a dual diagnosis with a consistent recovery focus. ***Originality/value:*** Placing personal recovery at the heart of both mental health and substance misuse services may, over time, improve their efficiency and effectiveness.

5.	Tober, G., Raistrick, D., Crosby, H.F., Sweetman, J., Unsworth, S., Suna, L., Copello, A. (2013)/ Co-producing addiction aftercare/ Drugs and Alcohol Today/https://doi.org/10.1108/DAT-05-2013-0024.	***Purpose:*** The purpose of this paper is to describe the development and delivery of an aftercare programme called Learning to Live Again, which was co-produced between service users and clinic staff. ***Design/methodology/approach:*** In total, 37 semi-structured interviews were conducted with 29 project stakeholders who were service users, mentors, university, and clinical staff. The data were transcribed and analysed using thematic analysis. ***Findings:*** Four overarching themes were identified in the analysis of interview data as characterising the process of co-producing an aftercare programme. These were: achieving common ground, roles and responsibilities, the activities programme and the road to recovery. Interdependence of service users and clinicians was given strong emphasis. ***Practical implications:*** A number of challenges arise in co-producing an aftercare programme which is largely service user-led and adds to the local recovery capital. The benefits of co-producing aftercare outweigh the difficulties and the programme can be set up within existing resources. ***Originality/value:*** Many peer-mentor-led aftercare programmes have been set up and this paper describes stakeholders' thoughts about the challenges and benefits of co-producing an aftercare programme.

6.	Breedvelt, J.J.F., Dean, L.V., Jones, G.Y., Cole, C., Moyes, H.C.A. (2014)/ Predicting recidivism for offenders in UK substance dependence treatment: do mental health symptoms matter? / Journal of Criminal Psychology/ http://dx.doi.org/ 10.1108/JCP-02-2014-0006.	***Purpose:*** The purpose of this paper is to assess whether mental health symptoms affect one-year reoffending rates upon release from prison for participants engaging in substance dependence treatment in the UK. ***Design/methodology/approach:*** A retrospective cohort study was used to assess re-conviction outcomes upon release. The Comprehensive Addiction and Psychological Evaluation (CAAPE) was administered to 667 inmates admitted to the programme. The effect of mental health, drug use, and static risk factors on reoffending was assessed at one-year post release. ***Findings:*** Logistic regression analysis showed that symptoms of Major Depressive Disorder at the start of substance dependence treatment increased the likelihood to reoffend, whilst obsessive compulsive disorder symptoms and length of sentence decreased the likelihood to reoffend. Antisocial Personality Disorder symptoms show a trend towards increasing the likelihood to reoffend. In addition, previously established risk factors for reoffending, including dependence on heroin, crack/cocaine, and poly drug use significantly increased the likelihood of reconviction. ***Practical implications:*** Depressive symptomatology pre-treatment could affect reoffending outcomes for participants in substance dependence treatment in prison. The results have implications for clinical settings where mental health symptoms are not addressed concurrently with substance dependence. ***Originality/value:*** The findings can inform policy makers and practitioners who provide substance dependence treatment in prison. An integrative approach addressing both substance misuse and mental health factors is pivotal. Future efforts to address both simultaneously can be made to improve assessment, training, treatment, and through care for prisoners in substance dependence treatment.

7.	Reif, S., Braude, L., Lyman, R., Dougherty, R. H., Daniels, A. S., Ghose, S.S., Salim, O., Delphin-Rittmon, M. (2014)/ Peer Recovery Support for Individuals with Substance Use Disorders: Assessing the Evidence. / Psychiatric Services/ doi:10.1176/appi.ps.201400047	***Purpose:*** Peer recovery support services are delivered by individuals in recovery from substance use disorders to peers with substance use disorders or co-occurring mental disorders. This review describes the service and assesses its evidence base. ***Design/methodology/approach:*** The searched conducted using PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, and Social Services Abstracts for outcome studies of peer recovery support services from 1995 through2012. Research included two randomized controlled trials, four quasi-experimental studies, four studies with pre-post service designs, and one review. Three levels of evidence research (high, moderate, and low) were chosen on the basis of benchmarks for the number of studies and quality of their methodology. They also described the evidence of service effectiveness. ***Findings:*** The studies demonstrated reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience. ***Practical implications:*** Peer recovery support can offer service users support with relapse rate and improved treatment outcomes. ***Originality/value****:* Peer recovery support providers aim to help individuals achieve and maintain recovery, yet studies to date have not tested the key mechanisms of this intervention.

8.	Bagnall, A.M., South, J., Hulme, C., Woodall, J., Vinall-Collier, K., Raine, G., Kinsella, K., Dixey, R., Harris, L., Wright, N. M.J. (2015)/ A systematic review of the effectiveness and cost-effectiveness of peer education and peer support in prisons. / BMC Public Health/https://dx.doi.org/10.1186%2Fs12889-015-1584	***Purpose:*** Prisoners experience significantly worse health than the general population. This review examines the effectiveness and cost-effectiveness of peer interventions in prison settings. ***Design/methodology/approach:*** A mixed methods systematic review of effectiveness and cost-effectiveness studies, including qualitative and quantitative synthesis was conducted. In addition to grey literature identified and searches of websites, nineteen electronic databases were searched from 1985 to 2012. Quantitative, qualitative and mixed method evaluations was employed. Fifty-seven studies were included in the effectiveness review and one study in the cost-effectiveness review; most were of poor methodological quality. ***Findings:*** Evidence suggested that peer education interventions are effective at reducing risky behaviours, and that peer support services are acceptable within the prison environment and have a positive effect on recipients, practically or emotionally. Consistent evidence from many, predominantly qualitative, studies, suggested that being a deliverer of peer intervention was associated with positive effects. There was little evidence on cost-effectiveness of peer-based interventions. Peer worker is associated with positive health; peer support services are also an acceptable source of help within the prison environment and can have a positive effect on recipients. Research into cost-effectiveness is sparse. ***Practical implications:*** Peer worker is associated with positive health; peer support services are also an acceptable source of help within the prison environment and can have a positive effect on recipients. ***Originality/value:*** There are advantages to peer workers role within prisons not only for the peer workers themselves but also to the prisoners.

9.	Parkman, T.J., and Lloyd, C. (2015)/ Mutual dependence and the 'Goldilocks group': exploring service user dependency on mutual aid recovery groups. / Drugs and Alcohol Today/ https://doi.org/10.1108/DAT-01-2015-0001.	***Purpose:*** The purpose of this paper is to explore the theme of dependence on mutual aid. It is a theme which to date, has had very little empirical attention, especially in a UK context. **Design/methodology/approach:** A phenomenological approach was adopted. Interviews with service users, mentors and professional staff involved with the Learning to Live Again project were undertaken over a ten-month period of data collection. Thematic analysis was used to analyse the data. ***Findings:*** It was found that service users with very little access to recovery capital or social support are at risk of developing a dependency on mutual aid. Dependence seemed to manifest itself in two different forms – those that over engaged with the project and those that under engaged with the project. Consequently, there were a cohort of service users identified that seemed to strike a balance with the project and their life outside the project that was 'just right'. ***Practical implications:*** The 'Goldilocks group' which seem to strike the right balance of engagement with recovery support and continued reliance on mutual aid support. ***Originality/value:*** This paper explored a theme which has had very little attention paid to it. The theme of dependence on mutual aid will raise the awareness of such a threat, thus helping to identify those in treatment most at risk of developing dependency on mutual aid, thus detrimentally impacting on mental wellbeing.

10.	Dugdale, S., Elison, S., Davies, G., Ward, J., Dalton, M. (2016)/ Using the Transtheoretical Model to Explore the Impact of Peer Mentoring on Peer Mentors' Own Recovery from Substance Misuse. / Journal of Group in Addiction and Recovery/ https://doi.org/10.1080/1556035X.2016.1177769	***Purpose:*** This study aimed to explore the potential therapeutic impact of this role on peer mentors' recovery from substance misuse. ***Design/methodology/approach****:* Participants were 18 peer mentors (female = 7) from Crime Reduction Initiatives (CRI), a UK-based health and social care charity were interviewed. The thematic analysis was used to investigate peer mentors' experiences, and findings were embedded within the Transtheoretical Model. ***Findings:*** Peer mentoring provided a purpose for participants and allowed them to distance themselves from their previous substance using behaviour, using available support to avoid relapse. Peer mentoring strengthened the ability of peer mentors to maintain recovery through facilitating resources which may contribute to recovery maintenance. ***Practical implication:*** The peer mentoring role helped to facilitate recovery maintenance and sustain abstinence-based recovery by creating opportunities to build recovery capital through the use of resources such as BFO and peer support. ***Originality/value:*** The peer mentoring role offered insight into the benefits to the individuals carry out these roles. It also challenged previous research which argued that it encouraged relapse.

11.	Moyes, H. C. A., Heath, J.J., Dean, L.V. (2016)/ What can be done to improve outcomes for prisoners with a dual diagnosis? / Advances in Dual Diagnosis/ https://doi.org/10.1108/ADD-07-2015-0016.	***Purpose:*** The purpose of this paper is to review the literature on offenders with a dual diagnosis and discuss how prison-based services can improve to better meet the needs of prisoners with co-occurring substance misuse and mental health disorders. ***Design/methodology/approach:*** A comprehensive literature search of PsycINFO, JSTOR, PubMed and Google Scholar, reviewing international studies on dual diagnosis amongst offender and community samples spanning the last three decades, supplemented by international policy, guidance papers and reports was conducted to explore how services can be improved. ***Findings:*** It was found that research into dual diagnosis amongst prisoners internationally was scarce. However, from the evidence available, several consistent factors emerged that led to the following recommendations: integrated treatment needs to be coordinated and holistic, staged and gender responsive; increased availability of 'low level', flexible interventions; transitional support and continuity of care upon release with the utilisation of peer mentors; comprehensive assessments in conducive settings; mandatory dual diagnosis training for staff; and increased funding for female/gender-responsive services. ***Practical implications:*** The recommendations can inform commissioners, funders and service providers of areas where support must be improved to address the needs of prisoners with a dual diagnosis. In addition, social implications – improved outcomes for prisoners with a dual diagnosis would likely have a positive effect on society, with improvements in mental health and substance misuse treatment impacting on rates of reoffending. ***Originality/value:*** This paper brings originality and value to the sector because it reviews relevant research on dual diagnosis and translates it into practical implications for policy makers.

12.	Tracy, K., and Wallace, S.P. (2016)/ Benefits of peer support groups in the treatment of addiction. / Journal of Substance Misuse Rehabilitation/https://dx.doi.org/10.2147%2FSAR.S8153	***Purpose:*** This article reports the results of a literature review that was undertaken to assess the effects of peer support groups, one aspect of peer support services, in the treatment of addiction. ***Design/methodology/approach:*** The authors of this article searched electronic databases of relevant peer-reviewed research literature including PubMed and MedLINE. ***Findings:*** Ten studies met the minimum inclusion criteria, including randomized controlled trials or pre-/post-data studies, adult participants, inclusion of group format, substance use-related, and US-conducted studies published in 1999 or later. ***Practical implication:*** Studies demonstrated associated benefits in the following areas: 1) substance use, 2) treatment engagement, 3) human immunodeficiency virus/hepatitis C virus risk behaviors, and 4) secondary substance-related behaviors such as craving and self-efficacy. ***Originality/value:*** Peer support interventions is defined as giving and receiving nonprofessional, nonclinical assistance from individuals with similar conditions or circumstances to achieve long-term recovery from psychiatric, alcohol, and/or other drug-related problems.

13.	Barker, S. L., and Maguire, N. (2017)/ Experts by Experience: Peer Support and its Use with the Homeless. / Community Mental Health/ https://doi.org/10.1007/s10597-017-0102-2	***Purpose:*** This review aims to assess the effectiveness of IPS as an intervention with young adults and adult homeless persons (including street dwelling and those within services). ***Design/methodology/approach:*** PysclNFO, Web of Science, MEDLINE, and CINAHL were searched, resulting in ten studies, involving 1,829 participants. ***Findings:*** Peer support fostered and developed by professional organisations, termed intentional peer support (IPS), formalises this process. Common elements of peer support are identified, suggesting possible processes that underlie effective peer support. Shared experiences, role modelling, and social support are suggested to be vital aspects of peer support and moderate changes in homeless clients. ***Practical implication:*** Peer support has significant impacts on quality of life, drug/alcohol use, and social support. ***Originality/value:*** Peers with experience of homelessness offer unique perspectives in supporting that experiencing homelessness.

14.	Dugdale, S., Elison, S., Davies, G., Ward, J., Dalton, M. (2017)/ A Qualitative Study Investigating the Continued Adoption of Breaking Free Online Across a National Substance Misuse Organisation: Theoretical Conceptualisation of Staff Perception. / The Journal of Behavioral Health Services and Research/ https://doi.org/10.1007/s11414-016-9512-0	***Purpose:*** This study used normalisation process theory (NPT) to investigate how Breaking Free Online (BFO), a treatment programme for substance misuse, is embedded as normal practice within Crime Reduction Initiatives (CRI), a health and social care charity. ***Design/methodology/approach:*** Interviews were conducted with CRI staff regarding their perceptions of the normalisation of BFO. Thematic analyses were used, and findings structured around NPT. ***Findings:*** There is evidence for the effectiveness of computer-assisted therapies (CAT) in healthcare; however, implementing CAT can be challenging due to new technologies being perceived as 'disruptive'. Results suggest that staff understood the benefits of BFO, particularly for those with a dual diagnosis. However, there was some confusion surrounding job roles and difficulties with the availability of resources. Whilst normalisation of BFO is progressing within CRI, there are still some challenges. ***Practical implication:*** Implementation of computer - assisted therapies can be applied within health care setting. Clear definition of job roles in its delivery needed to be considered as part of embedding this approach. ***Originality/value:*** The use of computer-assisted therapies can have potential benefits to service provisions.

15.	Hay, B., Henderson, C., Maltby, J., Canales, J.J. (2017)/ Influence of Peer-Based Needle Exchange Programs on Mental Health Status in People Who Inject Drugs: A Nationwide New Zealand Study./ Frontiers in Psychiatry/ doi:10.3389/fpsyt.2016.00211.	***Purpose:*** To aim to conduct a national survey to examine key domains of mental health status in people who inject drugs (PWID) in New Zealand. ***Design/methodology/approach:*** PWID were recruited from 24 pharmacies and 16 dedicated peer-based needle exchanges (PBNEs) across the country. The study focused on two mental health outcomes: (1) affective dysregulation, across the three emotional domains of the Depression Anxiety Stress Scale, due to its role in the maintenance of continued drug use, and (2) positive cognition and effective health- and drug-related information exchange with the provider, using the Satisfaction with Life Scale and an ad hoc questionnaire, respectively, in view of their association with improved mental health outcomes. The researchers in this article hypothesized that access to peer support would be associated with mental health benefits for PWIDs. ***Findings:*** The results of a multistep regression analysis revealed that irrespective of sex, age, ethnicity, main drug used, length of drug use, and frequency of visits to the needle exchange programs (NEP), the exclusive or preferential use of PBNEs predicted significantly lower depression and anxiety scores, greater satisfaction with life, and increased health-related information exchange with the service provider. ***Practical implications:*** The efficacy of peer-based needle exchange services in support PWID to access treatment especially those with mental health issues. ***Originality/value:*** This study demonstrates for the first time an association between access to peer support at PBNEs and positive indices of mental health, lending strong support to the effective integration of such peer-delivered NEP services into the network of mental health services for PWID worldwide.

16.	Henderson, C., Madden, A., Kelsall, J. (2017)/ Beyond the willing and the waiting' — The role of peer-based approaches in hepatitis C diagnosis and treatment. / International Journal of Drug Policy/ http://dx.doi.org/10.1016/j.drugpo.2017.08.004	***Purpose:*** To examine the role, value and importance of peer-based programmatic approaches for ensuring the effective roll-out of the new hepatitis C (HCV) treatments among those most affected; people who inject drugs (PWID). ***Design/methodology/approach:*** The researchers examine recent approaches to HCV treatment in Australia including the provision of universal access to the new DAA regimens regardless of acquisition, genotype or severity of disease. These approaches are contextualised within wider global strategies to support HCV elimination as a public health threat by 2030 (WHO, 2016). ***Findings:*** Despite the unprecedented opportunity presented by the availability of the new treatments, most individuals affected by hepatitis C are still largely hidden and disconnected from the health system and are likely to stay that way without targeted education and support. There is a need to expand existing peer-based programmes and developing new innovative peer initiatives, supporting the development of the PWID peer workforce, developing new, targeted peer education resources and promoting linkages and partnerships between peer based and HCV treatment service providers in primary and community settings. ***Practical implications:*** A need to for greater investment in new and innovative HCV and PWID peer education approaches for HCV diagnosis and treatment that add value to existing models of care to improve pathways and support people across their entire treatment journey. ***Originality/value:*** Peer-based organisations and networks provide that unique point of engagement and access for those HCV+ PWID for whom the health system is an unfamiliar, forbidding place or for whom hepatitis C is one of many health needs.

17.	Chapman, S.A., Blash, L.K., Mayer, K., Spetz, J. (2018)/ Emerging Roles for Peer Providers in Mental Health and Substance Use Disorders/ USA American Journal of Preventive Medicine/doi: 10.1016/j.amepre.2018.02.019	***Purpose:*** The purpose of this study was to identify and assess states with best practices in peer provider workforce development and employment. ***Design/methodology/approach:*** A case study approach included a national panel of subject matter experts who suggested best practice states. Researchers conducted 3-to-5-day site visits in four states: Arizona, Georgia, Texas, and Pennsylvania. Data collection included document review and interviews with state policymakers, directors of training and certification bodies, peer providers, and other staff in mental health and substance use treatment and recovery organizations. Data collection and analysis were performed in 2015. Peer providers work in a variety of settings, including psychiatric hospitals, clinics, jails and prisons, and supportive housing. ***Findings:*** A favorable policy environment along with individual champions and consumer advocacy organizations were positively associated with robust programs. Medicaid billing for peer services was an essential source of revenue in both Medicaid expansion and non-expansion states. States' peer provider training and certification requirements varied. Issues of stigma remain. Peer providers are low-wage workers with limited opportunity for career growth and may require workplace accommodations to maintain their recovery. ***Practical implications*****:** Peer providers with lived experience can positively contribute to the treatment and recovery of individuals with behavioral health needs. ***Originality/value:*** Peer providers are a rapidly growing workforce with considerable promise to help alleviate behavioral health workforce shortages by supporting consumers in attaining and maintaining long-term recovery.

18.	Edwards, M., Souter, J. and Best, D. (2018)/ Co-producing and re-connecting: a pilot study of recovery community engagement. / Drug and Alcohol Today/ https://doi.org/10.1108/DAT-09-2017-0054	***Purpose**:* The purpose of this paper is to discuss the design and methodology of the REC-CONNECT project and to determine whether a co-produced approach to research in this area between those with lived experience, those delivering recovery support, and those investigating recovery evidence, generated greater project impact. ***Design/methodology/approach:*** A co-productive approach was taken during project planning, training delivery, data collection and community connecting activity. Workshop evaluations were collected at each training session that provided data on worker/peer/volunteer wellbeing, workshop efficacy and organisational factors. Community connectors used REC-CAP for evaluating improvements in clients' community engagement. ***Findings:*** Whilst co-production as a research approach broke down barriers between theory and practice and delivered a wider community asset map, a number of hurdles emerged: buy-in of all participants; culture/ competing agendas; overcoming sense of disenfranchisement of people in recovery; and resources, tools and timescales of research requirements. ***Practical implications:*** Co-production as an approach to research in the substance misuse field has a meaningful impact on the 'end-user' of people in recovery through empowerment, better connected recovery pathways and evidence-to-practice-based support models. ***Originality/value:*** The project advanced the emerging principle of reciprocal asset-based community development and designed a co-produced model to create a team of professional, volunteer and peer community connectors to engage and connect new individuals to recovery with existing community assets, and who themselves emerged as a community asset through the project.

19.	Harrison, R., Van Hout, M. C., Cochrane, M., Eckley, L., Noonan, R., Timpson, H., Sumnall, H. (2018)/ Experiences of Sustainable Abstinence-Based Recovery: An Exploratory Study of Three Recovery Communities (RC) in England. / International Journal of Mental Health Addiction/https://doi.org/10.1007/s11469-018-9967-8	***Purpose:*** The research project aimed to explore the perceived mechanisms and processes that underpinned support in three abstinence-based recovery communities (RCs) across England. ***Design/methodology/approach:*** Focus groups and telephone interviews were conducted with 44 individuals. This was to identify self-prioritised outcomes for members and other key factors contributing to the delivery of an effective recovery community. Data were thematically analysed. ***Findings:*** Along with a number of other key outcomes, the achievement and maintenance of abstinence by participants was considered to be a key indicator of an effective RC. ***Practical implication:*** Recovery communities were viewed as underpinning the development of recovery capital and maintaining abstinence with those who use them. ***Originality/value:*** The study provides an insight into the processes of RCs and highlights that development and support of recovery capital is an important aspect of service provision and delivery for those in abstinence-based recovery.

20.	Stott, A., and Priest, H. (2018)/ Narratives of recovery in people with coexisting mental health and alcohol misuse difficulties. / Advances in Dual Diagnosis/ https://doi.org/10.1108/ADD-08-2017-0012	***Purpose:*** The purpose of this paper is to use a narrative approach to explore the process of recovery as an individual journey in a social context. It focuses on people who use alcohol in order to explore the impact of alcohol's specific cultural meanings on the recovery journey. ***Design/methodology/approach:*** Existing literature has examined what recovery means to people with co-occurring difficulties but does little to examine experiences of recovery as a process. Ten interviews with people with coexisting mental health and alcohol misuse difficulties were conducted, audio-recorded, and transcribed. The transcriptions were analysed using narrative analysis. ***Findings:*** Most participants' narratives shared a three-part structure, from a traumatic past, through an episode of change, to an ongoing recovery phase. Change and recovery were attributed to several factors including flexible and practical support from services, therapeutic relationships with key professionals, and peer support. Some participants redefined themselves and their alcohol use in relation to ideas of what it is to be 'normal'. ***Practical implications:*** The value placed on professionals having specialised therapeutic skills in working with trauma highlights the need for training in this area. The role for practical and material support underlines the importance of multi-agency working. ***Originality/value:*** The study is able to draw links between personal stories of recovery and wider social influences, allowing comment on the implications for services. Further, the experiences of people with co-existing mental health and alcohol misuse difficulties have rarely been studied apart from the dual diagnosis population in general. This paper can investigate the specific challenges for this population.

21.	Paterno, M. T., Low, M., Gubrium, A., Sanger, K. (2019)/ Mothers and mentors: Exploring perinatal addiction and recovery through digital storytelling. / Qualitative Health Research/ https://doi.org/10.1177/1049732318777474	***Purpose:*** The purpose of this study was to describe experiences of addiction in pregnancy, recovery, and subsequently serving as a peer mentor to other pregnant women with active SUD among women in recovery in a rural setting. ***Design/methodology/approach:*** The study conducted one digital storytelling workshop with five women serving as peer mentors with lived experience of perinatal SUD. The mentors faced significant stigma in pregnancy. They had each done the 'inside work' to achieve recovery and maintained recovery by staying balanced. ***Findings:*** Four major themes through analysis of the transcripts, digital stories, and field notes produced in and around the digital storytelling workshop: addiction in pregnancy, the path to recovery, being in recovery, and the work of peer mentoring. ***Practical implications:*** Peer mentoring supported their own recovery, and story sharing was integral to this process. ***Originality/value:*** Peer-led support models may be an effective, self-sustaining method of providing pregnancy-specific peer support for SUD.

Appendix 2: Table 4.5 (a) Service Mapping Exercise (SME) of London Alcohol and Drug Service Providers

(The table captures information extracted from the websites of the four organisations involved in this research. The data include the type of organisation they are, PM training programmes offered, and whether the PM's roles were paid or non-paid).

Organisation	Training Provided	Paid/not paid roles	Information on provider's websites
Organisation A (Non-NHS)	Yes	Not paid	**Peer mentor roles:** Peer mentors may be people in recovery, people who are stable on medication, people who have left treatment, or people who have had personal experience of supporting a loved one through treatment. Many of the people who come to our services are nervous and unsure what to expect. Some peer mentors, who have been through treatment and had first-hand experience of the challenges of entering recovery can offer them friendly support and guidance to help them engage. As a peer mentor you will be a positive role model for people trying to tackle their problems and will be able to show them that change is possible. Some things a peer mentor might do: Welcome people to services and explain what goes on, talk to people one-to-one about their concerns and needs, lead social groups like breakfast clubs, theatre groups and sports clubs, help organise and run community events to raise awareness of what we do and maybe give talks about our work if you feel comfortable doing so.
	Yes	Not paid	**Volunteer roles:** Volunteers play an integral role in the delivery of our services. You will give inspiration to service users and gain the satisfaction of knowing you have helped

			them to change their lives. Our volunteers bring diverse skills and life experiences to complement our work. Some bring personal experience of the challenges of living with substance misuse or coping with a loved one's misuse. Some roles, such as counsellors and mental health nurses, require specific qualifications. However, most roles do not require any qualifications as we will provide all the training and support you may need.
Organisation B (Non-NHS)	Yes	Not paid.	**Peer mentor roles:** As a peer mentor you need to be stable in your own recovery from drug or alcohol problems and willing to work with someone who is still facing these problems. We usually say you must be at least 3 months free from illicit drug or alcohol use. Before you become a peer mentor, we will give you lots of training, so you feel confident in your abilities to be a great peer mentor. Peer mentoring is about drawing on your experiences of recovering from drug or alcohol dependency to support someone who is at an earlier stage of their recovery journey. The personal experience you have had will give you a unique understanding of the problems they may be facing. Therefore, the peer mentoring relationship can be so helpful. By providing support and guidance you will be able to help the person you are mentoring reduce their drug or alcohol use, stop re-offending behaviour and support re-integration into the community. You won't be paid a wage, but we will reimburse you for your travel expenses.

	Yes	Not paid	**Volunteer roles:** Our volunteers are vital to the work of Organisation B. If you want to be part of an organisation that helps others reach their full potential, volunteer with us today! When you become a volunteer, you can make a genuine difference in your community and help people change their lives. Volunteers have access to comprehensive training opportunities, along with the possibility of joining our staff later down the road. Many of our current workers started as volunteers before joining the staff team. If you are interested, we would be happy to help you take that journey.
Organisation C (NHS)	Yes	Not paid	**Peer mentor roles:** Inspiring and empowering Peer Mentors – people that have overcome drug and alcohol misuse who are now giving their time to benefit others. One of the most significant parts of our work with you may be done with a peer mentor who was someone like you, someone who understood because they had been there and travelled as similar journey to you. This person had made it; they had got through and gave you hope and strength to keep going. **Volunteer roles: ****Author's comments-*** 'This organisation did not have any information on their website to indicate that they had volunteer roles'.

Organisation D (Non-NHS)	No	Not indicated	**Peer mentor roles:** Peer mentors use their own personal experience of recovery to support and empower other service users. Peer mentors provide a variety of support including promoting drug and alcohol services, coaching and mentoring others including facilitating peer-led support groups and referrals, assisting with the delivery of recovery group work sessions, escorting individuals to detox/rehab and benefits appointments, involvement with induction and information giving about services within the Organisation D service and in the community, reception and with form-filling.
	No	Not indicated	**Volunteer roles:** All volunteers make a significant contribution to the recovery of service users at Organisation D making a huge difference to the lives of 1000s of people every year. For many people, volunteering can play a valuable role in their own recovery. Over half our volunteers have had experience of recovery and take up volunteering as a way of supporting others who have experienced problems with alcohol and drugs. It is also a great way to develop practical and work-based skills, gain confidence and meet new people, and for some it can even be a steppingstone towards paid work. Whatever your reasons are for volunteering there are many ways you can get involved. As a volunteer you will be closely supported throughout your time at Organisation D to ensure you get the most out of your volunteer experience.

Appendix 3: Table 4.5 (b) Information for staff on Peer Mentors, Volunteers and Service User Representatives' roles

(The table below provides guidance for staff on the roles and support offered to peer mentors, volunteers and service user representatives used within Organisation B)

	Service User Representatives	Peer Mentors	Volunteers
Background	A Service User Representative represents the voice of their peers, driving forward Service User Involvement initiatives. They are typically someone who is in treatment. Their role will centre on actively engaging Organisation B Service Users in decision making and positive change at every level of the	A Peer Mentor is someone in recovery from drug and/or alcohol use. They give their time freely to support the work of. A Peer Mentor will have undertaken Organisation B's Peer Mentoring training programme and achieved the OCN London Level 2 Award in Peer Mentoring. A Peer Mentor might still be in treatment with Organisation B or another organisation but is stable in	A volunteer is someone who gives their time freely to support the work of Organisation B. A volunteer is someone who may or may not have experience of recovery, but if they are in recovery, they are stable and have completed treatment.

	Service User Representatives	Peer Mentors	Volunteers
	organisation and treatment, as well as attending regular forums and key meetings.	their recovery and free from problematic drug and alcohol use. A Peer Mentor will typically undertake a 3-to-6-months peer mentoring placement and may progress into a volunteering role with Organisation B following this.	

Role	Service User Representatives help to promote and organise service user involvement. This may include: • Communicating, promoting and organising service user initiatives, events and opportunities • Championing Service Users' interests, feedback, values, beliefs and contributions within Organisation B • Identifying Service Users' priorities **Service User Representatives must NOT be responsible for:**	Services are encouraged to adopt a staged approach which allows the Peer Mentor to build upon the Peer Mentoring training and put into practice the skills they have learnt. This must be done in such a way that the Peer Mentor takes on more responsibilities and tasks gradually and that these are discussed and agreed regularly with their supervisor. Peer Mentors carry out a range of support based on the local needs of the service. Service Managers are responsible for developing specific Peer Mentor role profiles in line with service needs. Generic role profile templates (stages 1–3) are available to support this.	Organisation B Volunteers are here to support our service delivery rather than lead. The role and key responsibilities of volunteers are outlined in the role descriptions. **Volunteers must NOT be responsible for:** • Leading groups and facilitating alone (unless peer led and/or risk assessed in advance) • Managing a caseload • Holding an inappropriate level of responsibility

	Service User Representatives	Peer Mentors	Volunteers
	• Leading groups and facilitating alone (unless peer led and/or risk assessed in advance) • Managing a caseload • Holding an inappropriate level of responsibility • Conducting home visits • Escorting service users	**Peer Mentors must NOT be responsible for:** • Leading groups – except for SMART groups once SMART training completed. • Facilitating alone (unless peer led and/or risk assessed in advance) • Managing a caseload • Holding an inappropriate level of responsibility • Conducting home visits • Escorting service users	

	Service User Representatives	Peer Mentors	Volunteers
Safer Recruitment Checks	Safer recruitment checks do not apply in the same way for their roles and involvement in the service.	Before starting in placement all Organisation B Peer Mentors, regardless of their role, must have the following in place: • Completed DBS form received by Organisation B and supporting documentation verified by a member of staff from Volunteer Services or their local service. • Organisation B Declaration and Pre-Risk Assessment completed by the Peer Mentor and then risk assessed and approved by the Service Manager, Ops Manager and Volunteer Services.	Before starting in placement all Organisation B Volunteers, regardless of their role, must have the following in place: • Completed DBS form received by Organisation B and supporting documentation verified by a member of staff from either Volunteer Services. • Organisation B Declaration and Pre-Risk Assessment completed by the volunteer and then risk assessed and approved by the Service Manager, Ops Manager and Volunteer Services. • 1 reference received and approved by Volunteer Services (2 references must be provided in

	Service User Representatives	Peer Mentors	Volunteers
		Peer Mentors must also have achieved the Level 2 Award in Peer Mentoring prior to starting their peer mentoring placement. Peer Mentors will not carry out any one-to-one work with service-users, unsupervised, until their DBS checks have been returned and copies sent securely to the Volunteer Services team. In any post involving families or children, or where Peer Mentors are supporting service users in a residential setting, the role will not	advance of volunteer counsellors starting. For other volunteer roles 2 references must be received within 1 month of the volunteer's start date). Volunteers will not carry out any one-to-one work with service-users, unsupervised, until their DBS checks have been returned and copies sent securely to the Volunteer Services team. In any post involving families or children, or where volunteers are supporting service users in a residential setting, the role will not

	Service User Representatives	Peer Mentors	Volunteers
		commence until DBS checks have been returned. If the Peer Mentor has a DBS certificate at the level required for the role which has been issued within six months prior to joining Organisation B they will not be expected to complete a new DBS form before commencing their placement. However, they will be asked to complete a new DBS form at the start of their placement. All new peer mentors must provide proof of their identity to Volunteer Services/Service Managers in person	commence until DBS checks have been returned. Volunteers undertaking complementary therapist roles must have a valid DBS certificate, third party insurance and provide Organisation B with proof of the necessary qualifications before supporting service users. If new volunteers have a DBS certificate at the level required for the role which has been issued within six months prior to joining Organisation B they will not be expected to complete a

	Service User Representatives	Peer Mentors	Volunteers
		to support existing DBS certificates or new DBS applications. Peer Mentors must provide a copy of their DBS certificate to Volunteer Services once they have received it. This can be done either by bringing the DBS certificate in person to Organisation B Head Office or by sending it securely by post or email to:	new DBS form until they have started in placement. If their DBS certificate falls outside of this six-month window, they will be asked to complete a new DBS form prior to starting their placement. All new volunteers must provide proof of their identity to Volunteer Services/Service Managers in person to support existing DBS certificates or new DBS applications. Volunteers must provide a copy of their DBS certificate to Volunteer Services once they have received it. This can be

	Service User Representatives	Peer Mentors	Volunteers
			done either by bringing the DBS certificate in person to Organisation B Head Office or by sending it securely by post or email to:
Mandatory Training	There is no mandatory training required for this role.	**Face-to-face:** • Level 2 Award in Peer Mentoring training and certificate	**E- Learning:** • Data protection • Health and Safety • Equality and Diversity • Safeguarding (Adults and Children) • Infection, Prevention and Control
Additional training (optional CPD)	Whilst discussing their learning needs, it may be appropriate and support their development to attend volunteer face-to-face training:	**Volunteer face-to-face training:** • Working with Service Users Part 1 and 2 • De-escalation Training • Drug and Alcohol Awareness	• Organisation B Corporate Induction • Face-to-face training available to Organisation B staff

	Service User Representatives	Peer Mentors	Volunteers
	• Working with Service Users Part 1 and 2 • De-escalation Training • Drug and Alcohol Awareness • Professional Boundaries and Safeguarding NB This is subject to spaces being available, agreed and booked in advance with the Volunteer Coordinator/Manager. Please note travel expenses will need to be agreed by their Service Manager if appropriate.	• Professional Boundaries and Safeguarding **E - Learning:** • Data protection • Health and Safety • Equality and Diversity • Safeguarding (Adults and Children) • Infection, Prevention and Control Requests for e-learning accounts are to be sent to the (name of the learning) team on – email address.	**Volunteer face-to-face training:** • Working with Service Users Part 1 and 2 • De-escalation Training • Drug and Alcohol Awareness • Professional Boundaries and Safeguarding • All Organisation B eLearning modules

	Service User Representatives	Peer Mentors	Volunteers
		NB This is subject to spaces being available, agreed and booked in advance with the Volunteer Coordinator/Manager. Please note travel expenses will need to be agreed by their Service Manager if appropriate.	
Case Management Systems	Service User Representatives will NOT have access to case management systems.	Peer Mentors will NOT have access to case management systems.	Volunteers can have access to case management systems where appropriate and relevant to their role. NB This is subject to satisfactory safer recruitment checks and manager's approval.

	Service User Representatives	Peer Mentors	Volunteers
Access levels – IT/Intranet	Service User Representatives can have an Organisation B email address, where this can enhance their role and it is appropriate for the service (this can be requested through IT from the Service Manager).	Peer Mentors can have an Organisation B email address where this can enhance their role and is appropriate for the service (this can be requested through IT from the Service Manager).	All Volunteers should have an Organisation B email address. Volunteers can be given access to the Organisation B intranet.
Staff areas	Service User Representatives are NOT permitted in the staff areas.	Peer Mentors are NOT permitted in the staff areas where confidential discussions take place about service users.	Volunteers are permitted in the staff areas.
Expenses	Any expenses would have to be agreed to be in advance with the Service Manager for ad hoc support that is provided.	Travel and lunch expenses will be reimbursed, with appropriate receipts (where required). **Travel Expenses** will be reimbursed up to £15.00 per day.	Travel and lunch expenses will be reimbursed, with appropriate receipts (where required). **Travel Expenses** will be reimbursed up to £15.00 per day.

	Service User Representatives	Peer Mentors	Volunteers
		Lunch expenses: Peer Mentors volunteering for at least four hours on a particular day can claim lunch expenses (£4.00 per day or less, with appropriate receipts).	**Lunch expenses:** Volunteers volunteering for at least four hours on a particular day can claim lunch expenses (£4.00 per day or less, with appropriate receipts). We are unable to cover expenses for Social Work Students.

Appendix 4: Table 4.5 (c) A list of participants (using pseudonyms)

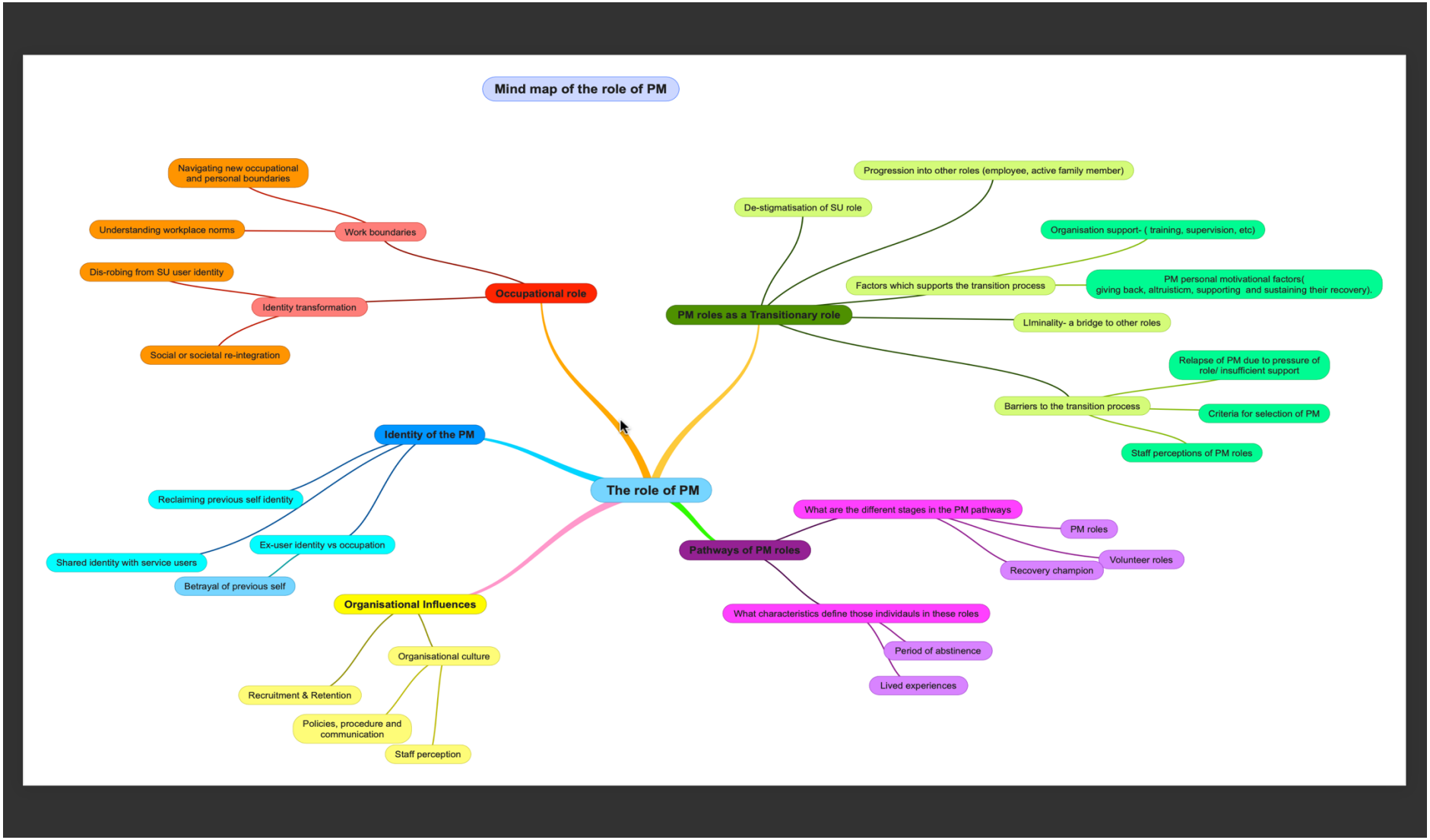
A list of participants (using pseudonyms) interviewed by the associated organisations and participants' designations.

Organisation D	
Participants	**Designations**
Jane	Peer Mentor
John	Peer Mentor
Liam	Peer Mentor
Gary	Peer Mentor
Jean	Peer Mentor
Beth	Peer Mentor
Ronald	Peer Mentor
Peter	PM Manager
Kath	PM Manager
Selma	PM Coordinator
Shellie	PM Coordinator
Charlotte	Team Manager
Robert	Team Manager
Robert	Team Manager
Sophie	Team Manager

Julie	Service Manager
Marie	Senior Manager
Organisation C	
Participants	**Designations**
Tony	Peer Mentor
George	Peer Mentor
Raj	Peer Mentor
Debbie	Peer Mentor
Amanda	Peer Mentor
Chris	PM Manager
Mira	Team Manager
Organisation B	
Participants	**Designations**
Sharon	Peer Mentor
Mike	Peer Mentor
Jack	Peer Mentor
Stuart	PM Manager
Tracey	Team Manager
Leslie	Senior Manager

Organisation A	
Participants	**Designations**
Josh	Peer Mentor
Brandon	Peer Mentor
Sue	Peer Mentor
Gemma	Recovery Champion
Steven	Recovery Champion
Patrick	Recovery Champion
Hari	PM Manager
Marvin	PM Manager
Paul	PM Manager
Michael	PM Co-ordinator
May	Team Manager
Claire	Service Manager
Sandra	Senior Manager

Appendix 5: Mind Map of PM role



Appendix 6: First Ethical Approval

Middlesex University London

Health and Social Care Sub-Committee

The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 0208 411 5000

12/10/2018

APPLICATION NUMBER: 4375

Dear Anand Jordan Soondar

Re your application title: Roles and Career Progression of Peer mentors and Volunteers

Supervisor: Betsy Carmel Rachel Clancy Herring Thom

Co-investigators/collaborators:

Thank you for submitting your application. I can confirm that your application has been given approval from the date of this letter by the Health and Social Care Ethics Sub-Committee.

Although your application has been approved, the reviewers of your application may have made some useful comments on your application. Please look at your online application again to check whether the reviewers have added any comments for you to look at.

PLEASE NOTE THE FOLLOWING RECOMMENDATION: Both PIS versions: Section 3, amend to 'Researcher' will want to....

Also, please note the following:

1. Please ensure that you contact your supervisor/research ethics committee (REC) if any changes are made to the research project which could affect your ethics approval. There is an Amendment sub-form on MORE that can be completed and submitted to your REC for further review.

2. You must notify your supervisor/REC if there is a breach in data protection management or any issues that arise that may lead to a health and safety concern or conflict of interests.

3. If you require more time to complete your research, i.e., beyond the date specified in your application, please complete the Extension sub-form on MORE and submit it your REC for review.

4. Please quote the application number in any correspondence.

5. It is important that you retain this document as evidence of research ethics approval, as it may be required for submission to external bodies (e.g., NHS, grant awarding bodies) or as part of your research report, dissemination (e.g., journal articles) and data management plan.

6. Also, please forward any other information that would be helpful in enhancing our application form and procedures - please contact MOREsupport@mdx.ac.uk to provide feedback.

Good luck with your research.

Yours sincerely

Gordon

Dr Gordon Weller

Chair: Health and Social Care Ethics Sub-Committee

Appendix 7: Second Ethical Approval

Middlesex University London

Health and Social Care Sub-Committee

The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 0208 411 5000

09/04/2020

APPLICATION NUMBER: 4375

Dear Anand Jordan Soondar and all collaborators/co-investigators

Re: Amendment to your original application title: Roles and Career Progression of Peer mentors and Volunteers

Supervisor: Dr Rachel Herring

Thank you for submitting an amendment to your original application. I can confirm that your amendment application has been given APPROVAL from the date of this letter by the Health and Social Care Ethics Sub-Committee.

The following documents have been reviewed and approved as part of this research ethics application:

Document Type	File Name	Date	Version
Amendments	Participation Information Sheet- Staff or Comissioner FINAL 20	08/04/2020	V6
Amendments	Participation Information Sheet- Peer mentor and or Volunteer FINAL 20	08/04/2020	V6

Although your application has been approved, the reviewers of your application may have made some useful comments on your application. Please look at your online application again to check whether the reviewers have added any comments for you to look at.

Also, please note the following:

1. Please ensure that you contact your supervisor/research ethics committee (REC) if any changes are made to the research project which could affect your ethics approval. There is an Amendment sub-form on MORE that can be completed and submitted to your REC for further review.

2. You must notify your supervisor/REC if there is a breach in data protection management or any issues that arise that may lead to a health and safety concern or conflict of interests.

3. If you require more time to complete your research, i.e., beyond the date specified in your application, please complete the Extension sub-form on MORE and submit it your REC for review.

4. Please quote the application number in any correspondence.

5. It is important that you retain this document as evidence of research ethics approval, as it may be required for submission to external bodies (e.g., NHS, grant awarding bodies) or as part of your research report, dissemination (e.g., journal articles) and data management plan.

6. Also, please forward any other information that would be helpful in enhancing our application form and procedures - please contact MOREsupport@mdx.ac.uk to provide feedback.

Good luck with your research.

Yours sincerely

Gordon

Dr Gordon Weller

Appendix 8: Sample of Email/Letter sent to Organisation's Gatekeepers

Organisation Logo

To: Anand Jordan Soondar

Middlesex University

Date: 29th June 2018

This letter is confirmation of permission for the above named, Mr Anand Jordan Soondar to access this organisation to undertake research study.

Titled: **'Peer mentors as a transitional and emerging position in alcohol and drug services'.**

within your alcohol and drug service and collect data as agreed (via interviews and focus groups with peer mentors, volunteer and staff. The study may proceed subject to approval from the Middlesex University Ethics Sub-committee.

Signed: [redacted]

Dr [redacted] MSc FRCPsych

Consultant Psychiatrist and Clinical Lead, Honorary Clinical Lecturer UCL Medical School

[redacted]

Tel: [redacted]
Email: [redacted]

Appendix 9: Consent Form for all Participants

Version Number: V3

Participant Identification Number:

CONSENT FORM

Title of Project: 'Peer mentors as a transitional and emerging position in alcohol and drug services'.

Name of Researcher: Anand Jordan Soondar

Please initial box

1. I confirm that I have read and understand the information shee dated .....……..…for the above study and have had the opportunity to ask questions. 1

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. 2

3. I agree that this form that bears my name and signature may be seen by a designated auditor. 3

4. I agree that my non-identifiable research data may be stored in National 4

Archives and be used anonymously by others for future research. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers.

5. I understand that my interview may be taped and subsequently transcribed. 5

6. I agree to take part in the above study. 6

_____ _____

Name of participant Date Signature

_____ _____

Name of person taking consent Date Signature

(if different from researcher)

_____ _____

Researcher Date Signature

1 copy for participant; 1 copy for researcher.

'Completion of this questionnaire is deemed to be your consent to take part in this research.'

Appendix 10: Participant Sheet for Peer mentors and/or Volunteers

MIDDLESEX UNIVERSITY

PARTICIPANT SHEET (PIS)- Peer Mentors and/ or Volunteers

Participant ID Code:

1. Study title: **'Peer mentors as a transitional and emerging position in alcohol and drug services'**

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

3. What is the purpose of the study?

This research will focus on the roles and career progression of peer mentors and volunteers in alcohol services. This will be done in context of how peer mentors' and volunteers' roles are represented in a systematic approach within workforce development. The aims of the research are:

1. To examine the perceptions of peer mentors and volunteers of their role and their ambitions for their career progression.
2. To consider whether there are differences in the way women and men perceive their roles as peer mentors/volunteers and their career progression.
3. To investigate the perceptions of key stakeholders of the role, development, career progression of peer mentors and volunteers within specialist alcohol treatment services.
4. To make recommendations to support the recruitment, support provisions and development as part of a Human Resource framework.

4. Why have I been chosen?

It is important that we assess as many participants as possible, and you have indicated that you are interested in taking part in this study. You have been invited to take part in this research because of your current role as a peer mentor, your gender and your previous experiences of London based alcohol services. As part of this research, the researcher will interview peer mentors, volunteers, alcohol and drug staff and commissioners. It is expected that no more than twenty people in total will be interviewed.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw your consent for a limited time; two weeks after you have given. Please note that withdrawal of consent can be done so without giving any reason. If you do decide to withdraw from the study then please inform the researcher as soon as possible, and they will facilitate your withdrawal. If, for any reason, you wish to withdraw your data please contact the researcher within a month of your participation. After this data it may not be possible to withdraw your individual data as the results may have already been published. However, as all data are anonymised, your individual data will not be identifiable in any way.

A decision to withdraw at any time, or a decision not to take part, will not affect your employment at the service in any way.

6. What will I have to do?

a. The duration of the research will take one and half years.
b. You will not be required for the whole of this duration and will be contacted during the interviewing and focus group stages which will form part of the data collection stages.
c. It is expected that a maximum of five whole days will be required. This will be broken into the duration of the interview and if there is any need to make contact with you again for clarity of information once the tapes have been transcribed.
d. Interviews and focus group will last no longer than one and half hours at a time. There may be an added thirty minutes on each occasion to support with preparation prior the sessions.
e. All interviews and focus group will occur at your service in comfortable rooms which will also offer confidentiality and privacy from the general service areas.
f. Interviews will be a combination of open-ended questions and semi-structured questions.
g. Interviews individually with peer mentors, volunteers, service staff and commissioner. The focus group will be held only with peer mentors and volunteers.
h. Prior to the interview commencing, the researcher will give you a chance to clarify any questions that you may have and there will also be an opportunity to re-visit your consent to take part with the research.
i. All interviews and focus group will be recorded using a Dictaphone.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

7. Will I have to provide any bodily samples (i.e., blood/saliva/urine)?
You will not have to provide any bodily sample as part of this study.

8. What are the possible disadvantages and risks of taking part?

There is no known risk in participating in this project. Appropriate risk assessments for all procedures have been conducted and will be followed throughout the duration of the study.

Appropriate risk assessments for all procedures have been conducted and will be followed throughout the duration of the study.

Peer mentors, volunteers, substance misuse staff and commissioners will not be disadvantaged in any way as interviews will not take place in during working time. The study will have any negative impact on participant's progression within the services.

9. What are the possible benefits of taking part?

The information we get from this study may help us to better understand how to support peer mentors, volunteer and staff in identifying the formally roles of peer mentors and volunteers. The research will also hope to better understand how services and organisations can help to promote work force development, career progression and support for these roles. However, this cannot be guaranteed.

10. Will my taking part in this study be kept confidential?

The research team has put a few procedures in place to protect the confidentiality of participants. You will be allocated a participant code that will always be used to identify any data you provide. Your name or other personal details will not be associated with your data, for example, the consent form that you sign will be kept separate from your data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic data will be stored on a password protected

computer. All information you provide will be treated in accordance with the UK Data Protection Act.

11. What will happen to the results of the research study?

The results of the research study will be used as part of a Postgraduate dissertation. The results may also be presented at conferences or in journal articles. However, the data will only be used by the researcher or the project advisory group and at no point will your personal information or data be revealed. It may be possible for you to request summary findings report. A summary of the research findings will be available via email at the end of the study; Please advise the researcher if you would like to receive a copy.

12. Who has reviewed the study?

The study has received full ethical clearance from the Research ethics committee who reviewed the study. The committee is the Middlesex University Ethic Committee.

13. Contact for further information If you require further information, have any questions or would like to withdraw your data then please contact: Anand Jordan Soondar, Middlesex University, The Burroughs, Hendon, London, NW4 4BT.

Supervisor- Dr Rachel Herring, Professor Betsy Thom, Professor Carmel Clancy- Middlesex University, The Burroughs, Hendon, London, NW4 4BT.Thank you for taking part in this study. You should keep this participant information sheet as it contains your participant code, important information and the research teams contact details.

Appendix 11: Interview Schedule for Peer mentors and/or Volunteers

Schedule guide for the Peer mentor and/or Volunteer interviews.

Introduction

- Thank you for taking the time to speak to me for this interview. It will take between 30 minutes and an hour, but you can stop at any point in time if you want to.
- There are no right or wrong answers, I am just interested in your own thoughts and opinion. If you do not want to answer a question, you don't have to and we can move on. Anything you say will be kept private and no one, except me will know what you have said so you are free to be as honest as possible.

Housekeeping points

- It is important that you understand what the interview is about, so I would like to read through some of the information so we both have a clear understanding, and it also helps me to ensure that all the relevant points are covered.
- With your permission, the interview will be audio recorded and transcribed verbatim i.e., exactly what you say.
- Direct quotes may be used but it will be entirely anonymous
- Given what I have explained, are you happy to sign the consent form and continue? (Get them to sign the consent form).
- Are there any other questions at this point before we start?

Contextual Information

1. **Tell me how did you became to be a peer mentor/ recovery champion/ volunteer? (From here on, depending on the title the person identify with**

the researcher will continue to use, e.g., recovery champion, peer mentor, etc)

Probe the following:

- How long have you been in this role? Have you been a peer mentor before? (If so, ask where/how long/ why they left the role; as appropriate)
- Was there a particular reason/s why you wanted to be a peer mentor?
- What do you find are the most enjoyable things about being a peer mentor?
- What are the least enjoyable about being a peer mentor?
- Is it a requirement of the role for the peer mentor/ recovery champions/ volunteer to be out of treatment? If yes, for how long after you have been a service user are you meant to be out of treatment?

Roles and Responsibilities

2. **Can you tell me what do you do as a peer mentor in the service?**

Probe the following:

- Can you tell me how many days you work as a peer mentor?
- Will you be share with me, how many hours you work as a peer mentor on those days?
- Are your roles set or do they vary?
- How did you learn about what your roles and responsibilities as a peer mentor are within the service?
- Do you think it is important to have had 'lived experience' to carry out these roles? [explain]
- How has having 'lived experiences' helped you when you carry out your roles? Can you give me some specific examples?
- How has having 'lived experiences' hindered you when you carry out your roles? Can you give me some specific examples?
- Do you have an opportunity to choose what roles you carry out at the service?
- Are you aware of how your colleagues regard the role of a peer mentor in the service?

- Do you receive payment for being a peer mentor? If yes, do you mind me asking how much? If no, can you tell me more the reason why?
- Are you working in a paid capacity at the moment? If yes, do you mind telling me more?
- If no, would you like to gain paid employment? If yes, please can you to tell me more?

Recovery journey

3. **Has being a peer mentor personally helped you in your recovery in anyway?**

Probe the following:

- If yes, can you tell me more about how being a peer mentor has shaped your recovery? [explain]
- Does being a peer mentor ever put pressure on you? [explain]
- Do you feel being a peer mentor helps you to get back to be part of society? [explain]

The Future

4. **What plans, if any, do you have for the future?**

Probe the following:

- Are there any other roles/ jobs that are you interested in, for the future? If yes, can you tell me more? If no, can you tell me more?
- Are they like this one; being a peer mentor?
- Would you like to work in this field of work, or would you like to try something different?
- Are there any courses or training that you are interested in to develop new skills? [explain] If yes, what are these training or courses? If not, can you tell me more?
- Do you have any support currently to develop those new skills you might need for your next job? [explain]

5. **Can you describe whether the COVID-19 pandemic has had any positive or negative effects on the using of peer mentor/volunteers or you as a peer mentor /volunteer in the service? Can you give me any examples?**

6. **Has there been any adaptations which has been put in place because of this?**

Anything else?

7. **Is there anything else that you would like to add?**

Appendix 12: Participant Sheet for Staff

MIDDLESEX UNIVERSITY

PARTICIPANT SHEET (PIS)-

STAFF

Version 5, Date 30/03/2020

Participant ID Code:

1. Study title: 'Peer mentors as a transitional and emerging position in alcohol and drug services'

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. What is the purpose of the study?

This research will focus on the roles and career progression of peer mentors and volunteers in alcohol services in the London area. The aims of the research are to understand how peer mentors and volunteers view their roles and how they progress from these roles either within alcohol services, within or outside of the organisation.

Similarly, the research will also capture how substance misuse staff and commissioners perceived the roles of peer mentors and volunteers, the career progression of this staff group and whether there are formal and structured approaches to develop this area of the workforce.

We are also interested in if there are differences in the way women and men perceive their roles as peer mentors/volunteers and their progression in their career. Finally, the research will want to make recommendations on how to support the recruitment, provide support and development of peer mentors and volunteers in alcohol services.

4.Why have I been chosen?

You have been invited to take part in this research because of your current role and your previous experiences of London based alcohol services. As part of this research, the researcher will interview peer mentors, volunteers, alcohol and drug staff and commissioners.

5.Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw your consent for a limited time; two weeks after you have given consent. Please note that withdrawal of consent can be done so without giving any reasons.

If you do decide to withdraw from the study then please inform the researcher as soon as possible, and they will facilitate your withdrawal. If, for any reason, you wish to withdraw your data please contact the researcher within two weeks of signing the consent form. After this time, it will not be possible to separate individual's data from

the full data set. However, as all data are anonymised, your individual data will not be identifiable in any way.

A decision to withdraw at any time, or a decision not to take part, will not affect your employment at the service in any way.

6.What will I have to do?

This research project will ask to you participate in one face to face interview. At these sessions we will explore your views on the peer mentors and volunteers' roles, the support and training they have received for the role and your understanding of their future plans. Equally we would like to explore, how likely they are to progress in their roles or other job opportunities. Whether you believe that they have received sufficient induction and training.

The interviews will be done on a one-to-one basis. Interviews will take up to an hour of your time and will be arranged according to your schedule.

All interviews will occur at your service in comfortable rooms which will also offer confidentiality and privacy from the general service areas. Your permission will be requested to record all interviews using a Dictaphone.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

7.What are the possible disadvantages and risks of taking part?

There is no known risk in participating in this project. Appropriate risk assessments for all procedures have been conducted and will be followed throughout the duration of the study.

8.What are the possible benefits of taking part?

The information we get from this study may help us to better understand how to support peer mentors, volunteer and staff in identifying the formal roles of peer mentors and volunteers and help to better understand how services and organisations will help to promote career progression and support for these roles.

9.Will my taking part in this study be kept confidential?

The research team has put a number of procedures in place to protect the confidentiality of participants. You will be allocated a participant code that will always be used to identify any data you provide. Your name or other personal details will not be associated with your data, for example, the consent form that you sign will be kept separate from your data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic data will be stored on a password protected computer. All information you provide will be treated in accordance with the UK Data Protection Act.

The University has a Safeguarding Adult policy, and the research team members are guided by professional codes of conduct which requires us to report any information to the appropriate authority, where a person may be at risk of serious harm. We will always endeavour to discuss this with your first.

10.What will happen to the results of the research study?

The results of the research study will be used as part of a Postgraduate thesis.

If you would like a summary of the research findings, please send your request by email to the researcher on AS3208@live.mdx.ac.uk.

The results may also be presented at conferences or in journal articles, but you will not be identifiable in any public outputs. Only by members of the research team will have access to the data and at no point will your personal information or data be revealed.

11.Who has reviewed the study?

This study has been reviewed by the Middlesex University, School of Health and Education, Health and Social Care Ethics Sub-committee.

12.Contact for further information

If you require further information, have any questions or would like to withdraw your data then please contact:

Student: Anand Jordan Soondar – AS3208@live.mdx.ac.uk

Supervisors- Dr Rachel Herring, Professor Betsy Thom, Professor Carmel Clancy.

Dr Rachel Herring– Email: r.herring@mdx.ac.uk. Tel: 020 8411 5281

Address: School of Health and Education, Middlesex University, The Burroughs, Hendon, NW4 4BT.

Thank you for taking part in this study.

You should keep this participant information sheet as it contains your participant code, important information and the research teams contact details.

Appendix 13: Interview Schedule for Staff

Schedule guide for the Service Provider Staff interviews.

Introduction

- Thank you for taking the time to speak to me for this interview, it will take between 30 minutes and an hour, but you can stop at any point in time if you want to.
- There are no right or wrong answers, I am just interested in your own thoughts and opinion. If you do not want to answer a question you don't have to, and we can move on. Anything you say will be kept private and no one, except me will know what you have said so you are free to be as honest as possible.

Housekeeping points

- With your permission, the interview will be audio recorded and transcribed verbatim i.e., exactly what you say.
- Direct quotes may be used but will be entirely anonymous
- Do you have any questions before we start?
- Are you happy to sign he consent form and continue? (Get them to sign the consent form).

Contextual Information

1. **Can you tell me how peer mentors/volunteers fit into your service?**

Probe the following:

- When was peer mentors first used in your service?
- What were there reasons why the peer mentor roles were set up?
- Were there any goals that were set at the start for having peer mentors?

- In your own words, how would you define a peer mentor?
- Is there a set period of time that the peer mentor needs to be out of treatment?
- Is there a particular rationale for the period of time that peer mentors need to be out of treatment?
- Does peer mentor have job descriptions? Do you have a copy that you will be happy to share with me?

Roles and Responsibilities

2. **Can you tell me more about how you decided what roles and responsibilities are carry out by peer mentors?**

Probe the following:

- Are the roles of the peer mentor set or do they vary?
- Can you describe how peer mentors learn about what their roles and responsibilities are within the service?
- Does the peer mentor have an opportunity to decide with you what their roles and responsibilities are at the service? If yes, can you explain
- Can you describe how you support the peer mentors in their roles?
- Can you describe how your organisation support peer mentors in their roles?
- Will you explain how you regard the role of a peer mentor in the service?
- Do other people in your team have similar views of peer mentors in the service?
- If no, can you tell me what are the differences in their views?
- Are having peer mentors one of the service's key performance indicators? If yes, can you tell me more?

Recovery Journey and Support

3. **Do you think that being a peer mentor helps someone in recovery?**

Probe the following:

- Do you see peer mentoring as a progression in a service user's recovery?

- Can you give me some examples of these?
- In your opinion, do you think that being a peer mentor facilitates identity transformation for a service user? If so, explain please?
- Do you feel being a peer mentor helps a service user to get back into society? [explain]
- Are there any opportunities available to support peer mentors to develop in your organisation?
- Do you view peer mentors as a professional colleague?

Future for peer mentors

4. **Are there any plans to further development peer mentoring in either your service or organisation? If yes, please explain.**

Probe the following:

- Do you think it is important for peer mentor to be part of a service key performance indicator or expected care intervention?

5. Can you describe whether the COVID-19 pandemic has had any positive or negative effects on the using of peer mentor/volunteers or you as a peer mentor/volunteer in the service? Can you give me any examples?

6. Has there been any adaptations which has been put in place as a result of this?

   Anything else?

7. Is there anything else that you would like to add?