ImROC Peer Support Theory and Practice Training
An independent evaluation

November 2023

Dr Simon Bradstreet
Dr Audrey Buelo

ImROC. Matter of Focus

About Matter of Focus

Matter of Focus is a mission-led company and certified B Corp based in Edinburgh.

We work with organisations, projects and programmes to explore, map, analyse and assess the outcomes that matter to them, the people and populations they care about, and their funders. We provide tools and techniques to bring together evidence, data and evaluation to ensure that projects and programmes can meet their outcomes, are successful and adaptable, and can demonstrate that success to funders, service users and other stakeholders.

We have created an innovative and easy to use software tool, OutNav, that enables public service organisations and funders to make effective use of their data and information to learn, improve and tell the story about the difference they make.

Matter of Focus is led by Dr Ailsa Cook and Dr Sarah Morton. Ailsa and Sarah are internationally renowned thinkers, well known for their ability to develop practical tools backed by robust evidence-based approaches, with extensive experience of delivering solutions for public service organisations.

Foreword

We would like to thank Matter of Focus for undertaking this independent evaluation of our core peer support training course in such an inclusive, supportive and sensitive manner. We commissioned this year-long project to assess the quality of our core peer support training and to inform its ongoing development. We chose to work with Matter of Focus because their methodology is sensitive to the complexities of practices like peer support, is built on the experiences of those involved in the initiative being evaluated, and describes what is happening as well as what differences it makes.

It is both reassuring and rewarding to see the findings recognise that ImROC's training team are providing a highly sensitive, responsive, supportive and effective training that changes the way that trainees draw on their own lived and life experience to support others. The training is founded on key principles including mutual and reciprocal relationships, recovery-focused, trauma-informed, person-centred and values-based. For the majority of trainees, it is experienced as safe and strengths focused, building confidence and skills.

The report draws attention to the challenges of providing peer support training: modelling peer values of equality and mutuality whilst enabling values-based learning; meeting the learning needs of trainees with a wide range of difficult life experiences in a safe and supported manner; providing sufficient support for small group work whilst working online; balancing trainers' expertise in education and facilitation with the need for trainers' experience of employment as a peer support worker; providing a level of training that is useful and accessible for trainees with very different levels of experience of peer support … On the whole, ImROC's trainers are negotiating these tightropes adeptly but there are clearly areas that could be improved.

As a result of this evaluation, ImROC's peer training team has developed a wider range of peer support courses to meet the needs of peers at the very start of their journey (introduction to peer support) through the 'peer support theory and practice course' (which is evaluated in this report) to peer support – Next Steps' and we have set up a national leaders' community of practice. In order to maintain the high quality of training, all ImROC trainers are all expected to complete a specified number of accredited Continual Professional Development courses every year. ImROC runs CPD courses every month, these focus specifically on challenges and questions arising during training so that the whole team is continually sharing learning and responding to issues as they arise.

We are not surprised to find that neurodiverse and autistic trainees found the course challenging. We have developed a peer support training for autistic people employed in Learning Disability and Autism services as peer support workers. This training has been coproduced by our autism co-production group and includes more pre-course preparation and assessment, more in-course support for individual trainees and all materials are designed to be clear and accessible. This course is now being evaluated by Matter of Focus.

There remain questions to be asked, more research to be done and of course, more improvements to be made. But this report has helped us to recognise priorities for development and develop a longer-term evaluation plan. It has also given our training team very good reason to be proud.

Julie Repper

Executive Director (Strategy, Innovation and Development) ImROC.

Table of contents

Executive Summary

Background and approach

ImROC have been delivering peer training for over fifteen years and are internationally respected as a centre for excellence in peer training and development. Core to this training is the 'Peer Support Theory and Practice' course that was the focus of this evaluation.

Peer Support Theory and Practice, referred to as *the training*, is a mental health training course, delivered over 40 hours. It is based on Health Education England (HEE) competencies and aimed at people offering mental health peer support in the statutory and voluntary sectors.

In 2022, ImROC commissioned Matter of Focus to undertake an independent evaluation of this course. The underpinning approach used in this evaluation was developed by Matter of Focus to help organisations working with complex, people-based change. It applies a 'theory of change' approach, that aims to uncover not only if, but also how, the interventions or initiatives being evaluated make a difference. It does this by making explicit the 'theory' or thinking behind why it is believed that the work will make a positive contribution to the lives of the people or communities you care about, and then evaluating against the theory of change.

Key findings

This evaluation has found overwhelming evidence that the Peer Support Training is effective and can make a difference in the way outlined in the theory of change for the majority of trainees. The trainers were highly skilled in their approach and ImROC exemplifies both a top-down and bottom-up embodiment of peer support values. It was clear from this evaluation that ImROC staff are the right people to be delivering this training because this is not straightforward training. There is a great deal of depth, nuance and complexity given who they are seeking to train, the values-based approach and the context which surrounds that training.

Trainers modelled peer practices well, such as validating experiences to build connection and careful use of language while also recognising the limits of mutuality in the context of training. However, trainers were relatively inexperienced overall, with half having less than one year of experience in the role, though there was a graded process to becoming a lead trainer that mitigated some risks associated with inexperience. There was also some concern that trainers without direct peer support work experience may not have relevant examples to draw from which might make it harder to embody peer values, but further exploration of this risk is needed.

Trainers fostered a sense of safety by being open and understanding, and by validating trainees' experiences which helped trainees share personal experiences openly and constructively. Breakout rooms were an important tool for trainees to share their lived experiences in a safe and supportive way, but experience of them was varied. Check in and out procedures were again highlighted as being important for building a sense of safety and mutuality, but they were not universally popular. While trainers were aware of the importance of accessibility and adapted their approach accordingly (and therefore some trainees found the training accessible), others reported significant challenges with the pace of delivery, the amount of information, and the software used.

In terms of changes to trainee's behaviour in both a professional and personal capacity, there were again a myriad of benefits experienced. Some trainees used the training to improve their practice, such as becoming more intentional about sharing their lived experiences and being more mindful of pace and safety. Others found the training to be a helpful refresher but did not feel that it changed their practice significantly, while a very small proportion of trainees did not enjoy or value the training, and therefore did not apply the learning to their work. The extent to which trainees were able to apply the values and principles of peer support in practice was highly dependent on the context in which they worked, with some trainees facing significant barriers in their employing organisations. The training helped trainees to improve their personal relationships by making them more understanding, vigilant, and aware of other people's needs while also make them more mindful of the people they encounter in everyday life.

A key theme that emerged from this evaluation is that "one size fits most (but not all)". The majority of people who undertook this training programme found that it inspired hope and change in their personal and professional lives. But given the wide variety of experience and background of trainees, from those completely new to peer support to those who have been running their own peer support programmes for many years, a one-size-fits-all approach that introduces peer support at a foundational level may not be the best approach as more trainees are required to do this course as part of their professional training. Trainees with more prior experience of peer working found the training less useful than less experienced trainees. However, they still appreciated the opportunity to learn from others and to further develop and refresh skills.

Recommendations for improvements to the ImROC training include continuous review of breakout rooms, increased materials and options for accessibility, and improved readiness screening for trainees beginning the course to ensure they will get the most out of it.

Overall, our evaluation of the ImROC training highlighted the highly skilled nature of peer support work and the need for corresponding training to be done in a sensitive, trauma-informed and recovery-focused manner. The context in which peer supporters work is currently very challenging, as peer support values are often in contradiction with traditional (often medical) views of mental health. The ImROC training programme for peer support workers navigates this complex and nuanced context extremely well and the theory of change was shown to be accurate.

Introduction

Background

ImROC is an English mental health support and development organisation. Initially developed in 2007 by the National Health Service, it is now an independent consultancy and training organisation recognised globally for its recovery-focused approach and expertise in the translation of its values into practices.

Core elements of the work of ImROC include, but are not limited to, supporting the realisation of recovery-focused values and practices in statutory and voluntary health and care services, the promotion and development of the Recovery Colleges and peer support practices and services.[1]

A significant part of the work of ImROC is the design and delivery of training for peer support workers employed in voluntary and statutory services, primary care and secondary care, for long term conditions including mental health problems. There has been a rapid expansion in the development of formalised peer support in voluntary and statutory mental health services across the UK and internationally, most notably through the training and employment peer support workers. ImROC describe peer support workers as: "someone employed to support others by drawing on shared lived and life experiences rather than through professional interventions and approaches."[2]

ImROC have been delivering peer training for over fifteen years and are internationally respected as a centre for excellence in peer training and development. Core to this training is the 'Peer Support Theory and Practice' course.

Peer Support Theory and Practice, referred to as *the training* from hereon, is a mental health training course, delivered over 40 hours. It is based on Health Education England (HEE) competencies[3] and aimed at people offering mental health peer support in the statutory and voluntary sectors. ImROC are commissioned by HEE to deliver the training and trainees are nominated by Trusts and VCSE organisations through regional HEE offices. Trainees complete a pre-course questionnaire provided by ImROC to both inform them about the course and identify any particular learning needs that ImROC can support, and any organisational questions and concerns regarding the organisations that have nominated them for the training.

Training is spread across fifteen modules with learning outcomes mapped to the competency framework, which describes nine domains of peer support work:

1. Understanding the values of peer support and the principles that underpin them
2. Knowledge for peer support workers
3. Core relational skills

---

[1] More information on the work of ImROC is available here: https://imroc.org/
[2] https://imroc.org/why-imroc/peer-support/#1656252939731-3b526806-c35d
[3] HEE Competence Framework: https://www.hee.nhs.uk/sites/default/files/documents/The%20Competence%20Framework%20for%20MH%20PSWs%20-%20Part%202%20-%20Full%20listing%20of%20the%20competences.pdf

4. Supporting people as a peer support worker
5. Working with teams and promoting people's rights
6. Self-care and support
7. Meta-competences for peer support workers
8. Optional skills: Using psychological approaches to support personal recovery
9. Competences for organisations supporting the peer worker role

The training has gone through a continual process of refinement and improvement, most notably since 2020 when significant changes have been made to facilitate online delivery. At the same time the reach of the programme is being considerably extended as a result of additional funding from HEE. There are currently around twenty trainers involved with the programme and something in the region of one thousand trainees per annum.

In 2022, ImROC commissioned Matter of Focus to undertake an independent evaluation of this course. This is the first structured and independent evaluation of the training to date.

At the outset we agreed that this evaluation should seek to understand and explore how the training contributes to trainees going on to thrive in their roles as peer supporters. Additionally, we agreed the evaluation be primarily prospective, in other words, it should be forward looking as opposed to focusing on what has happened in the past. We also agreed it focus on the experience and views of trainees and trainers and that it should not seek to evaluate training materials or competencies, nor assess the support provided to organisations in which the trainees are employed.

Our method

The underpinning approach used in this evaluation was developed by Matter of Focus to help organisations working with complex, people-based change. It applies a 'theory of change' approach, that aims to uncover not only if, but also how, the interventions or initiatives being evaluated make a difference. It does this by making explicit the 'theory' or thinking behind why it is believed that the work will make a positive contribution to the lives of the people or communities you care about.

In seeking to understand how the training contributes to trainees going on to thrive in their roles as peer supporters we adopted the following method over four phases.

Phase one

Initially, to better understand the context for the delivery of the training and wider evidence on peer support training, we completed a document and evidence review (October to November 2022). The findings of this review are reported in Appendix 1.

Phase two

The second phase (November to December 2022) involved building an evaluation framework in the form of a theory of change (or outcome map) describing how the training contributes to trainees going on to thrive in their roles as peer supporters. This was achieved via one in-person

and one online workshop. These involved staff and trainers from ImROC, many of whom had previously participated in the training as trainees, as well as representatives of Health Education England.

The Matter of Focus approach applies a framework using six simple headings to structure a theory of change, creating rational threads connecting each level of change:

- **'What we do'** (what are the key activities?)
- **'Who with'** (who is engaged and involved?)
- **'How they feel'** (reactions and what is key to positive engagement?)
- **'What they learn and gain'** (knowledge, skills, attitudes)
- **'What they do differently'** (behaviours, practice and policy changes)
- **'What difference does this make?'** (longer-term social outcomes)

Drawing from contribution analysis,[4] this approach aims to assess whether and how a project or approach, amongst many other contextual factors, has contributed to outcomes, rather than making potentially reductive claims of cause and effect.

Having agreed our theory of change for the training, we worked with ImROC to complete a process of data audit and review. Through this we determined the type of data we would need to be able to assess the impact of the training. From this we developed a data collection and analysis plan.

Phases three and four

During phase three (January to August 2023) we undertook data collection and analysis. Phase four was focused on reporting and dissemination (September to October 2023). It included an in-person session with some of the ImROC staff and trainers involved in the initial development of the theory of change. The aim of this was to explore emerging findings and sense check our interpretation and inform potential recommendations.

The data we collected and reviewed

We reviewed a variety of data to test our theory of change of how the training contributes to trainees going on to thrive in their roles. This included a mixture of routinely collected ImROC information and data specifically collected and analysed for the purposes of this evaluation. The latter is summarised in Table 1 below.

Trainee data was gathered from members of the first 2023 training cohort, with the exception of the post course survey which was also open to people who completed the training at the end of 2022.

[4] Mayne J. (2008) 'Contribution analysis: An approach to exploring cause and effect', *Institutional Learning and Change (ILAC) Initiative, ILAC Briefs*, 16. Available from: https://www.researchgate.net/publication/46472564_Contribution_analysis_An_approach_to_exploring_cause_and_effect

Data collection	Trainees (N)	Trainers (N)
Early-course survey	71	6
Mid-course focus group	15	11
Post-course survey	39	NA
Post-course interviews	3	NA

Table 1. Data collection methods and numbers who participated

We used our theory of change to inform the development of topics guides for focus groups and interviews. All qualitative data were analysed using thematic analysis.

We also reviewed additional data provided by ImROC. This included administrative data, internal evaluation feedback and course assignments. This data was used for descriptive purposes and for validation of findings.

Governance and ethics

The evaluation was overseen by a Steering Group which included representatives from ImROC and Matter of Focus. This group was responsible for oversight of ethical considerations in the evaluation, most notably the review of informed consent procedures. The group also reviewed topic guides, survey text and provided feedback on drafts of this report.

Context for this evaluation

Scoping review

A scoping review of wider evidence and experience of Peer Support Worker training was completed prior to data collection for the ImROC peer support worker training evaluation to inform the approach we took to the evaluation.

The key questions the scoping review aimed to answer were:

1. How do people experience peer support worker training?
2. What are the effects of peer support worker training?
3. How does the training impact on trainees' future practice as a peer support worker?
4. What outcomes have been measured as a result of peer support training evaluations?

This review, and its method, is described in more detail in Appendix 1.

Risks and assumptions

We completed a context mapping exercise in phase two of the evaluation.[5] The purpose of this session was to identify how individual, social and material factors helped or hindered the training to achieve its intended outcomes. From this we derived a set of risks and assumptions which we felt could influence change processes which are summarised in Table 2. The process of working

[5] Structured using the ISM tool: https://www.gov.scot/publications/influencing-behaviours-moving-beyond-individual-user-guide-ism-tool/pages/2/

with assumptions and risks is key to understanding the landscape within which impact can be assessed, bearing in mind the many influences on change.[6] Risks and assumptions also show where attention needs to be focused to achieve success and informs data collection.

Risks	Assumptions
⚠ People are not currently at the stage in their recovery journey for reflection, self-awareness – readiness	⚠ The support workers we train develop, support and maintain a recovery focused approach and culture in their organisations
⚠ Nationally developed standardised training resource lacks attention to the local context of trainees	⚠ Personal experience of mental health recovery is an essential component of learning
⚠ Values differ between employing organisation and peer support training	⚠ People with some experience of peer support are better able to understand and apply training
⚠ Training is not fully accessible to all	⚠ Experiential knowledge and understanding generates learning together
⚠ There is insufficient organisational support for the trainees to fulfil their potential after training	⚠ Organisations receive grant funding for every trainee they nominate to fund their development and support of peer support workers
	⚠ Peer support training can be delivered online
	⚠ Trainee has support from supervisor, management, organisation to attend training

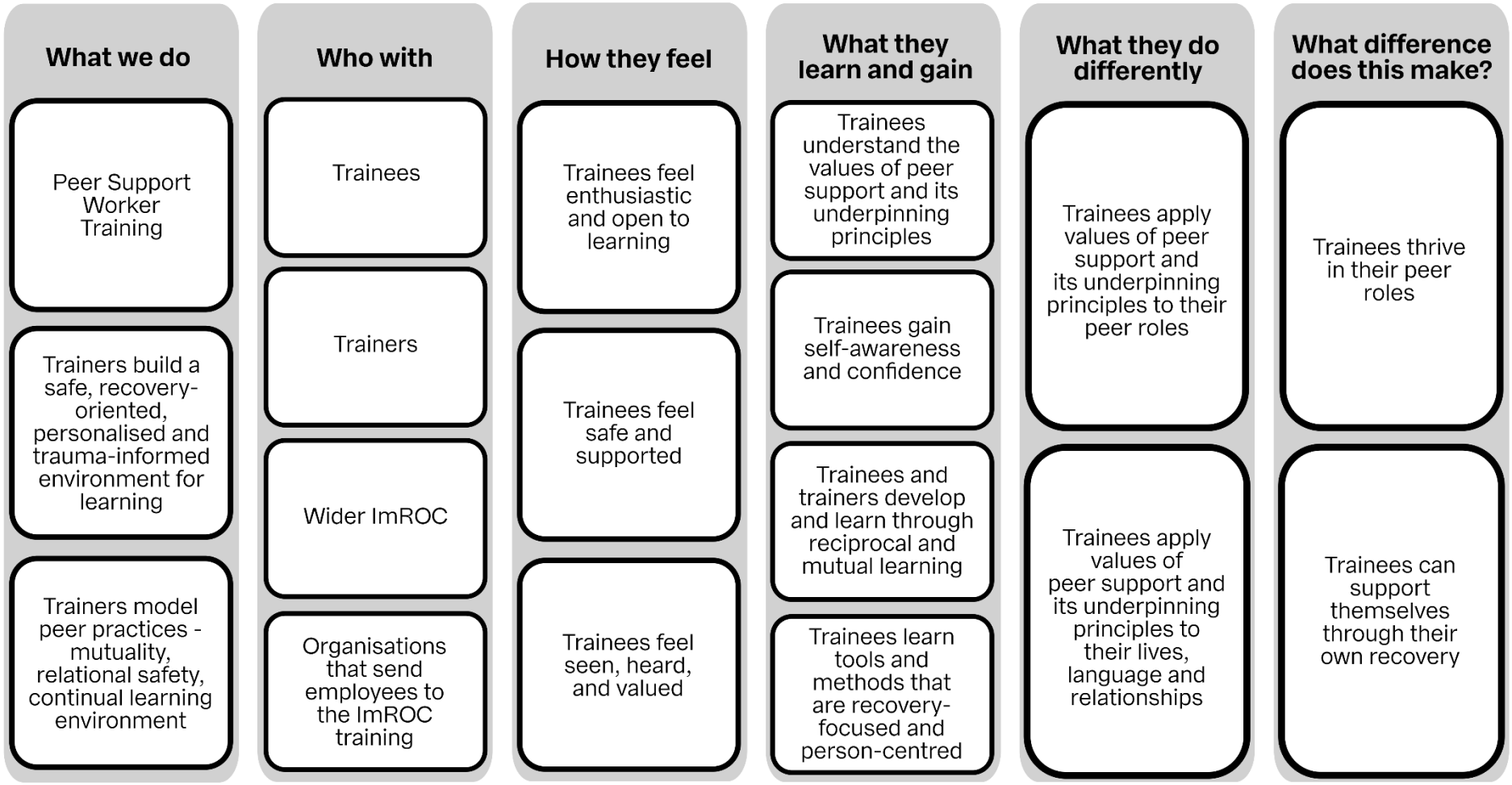
Table 2: Risks and assumptions

The role and any impact of these risks and assumptions is highlighted throughout the analysis and revisited in the Discussion section of this report.

[6] See https://www.matter-of-focus.com/understanding-the-risks-and-assumptions-of-your-initiative/

Our theory of change

Theories of change is an approach to creating pathways to impact that helps to set out the steps that link the activities of a project, programme or initiative to the outcomes and impacts that are important. A theory of change provides a description of the causal pathways that are expected to lead to desired outcomes. It is used to make the underlying assumptions about how change happens explicit. By making explicit how change occurs, theories of change support evaluation using contribution analysis.



Our findings

Our findings are structured in line with the theory of change. We therefore report our results in line with the following column headings:

- What we do
- Who with
- How they feel
- What they learn and gain
- What they do differently
- What difference does this make.

In each section we are seeking to evaluate progress against each key facet or 'stepping stone' in the theory of change column. Where identified risks and assumptions are relevant to a section, they are marked with the symbol to the right to highlight them. 

What we do

In evaluating a theory of change, it is useful to begin with an understanding of what is being evaluated, what was done and with whom, before moving on to assess whether the outcomes related to these activities are achieved. As such, this section ('What we do') is a description of our findings about the core activities of the training. In developing our theory of change these were agreed to be the delivery of Peer Support Worker Training by trainers who:

1. Build a safe, recovery-oriented, personalised and trauma-informed environment for learning.
2. Model peer practices - mutuality, relational safety, continual learning environment.

Key findings

- The training was well-facilitated and encouraged reflection and learning, with peer support values embedded throughout.
- Safety was emphasised through a combination of approaches including check-in and check-out processes and by trainers modelling safe practices. However, given the complexity and sensitivity of the training, there were instances where safety was compromised.
- The training was experienced as being personalised and recovery-focused by trainees who described feeling heard and understood.
- Trainers modelled peer practices well, such as validating experiences to build connection and careful use of language. They also recognised the limits of mutuality in the context of training.
- Trainees found it helpful when trainers were able to provide practice-based examples.

From our evaluation, it was clear that trainers were considered and thoughtful in how they facilitated the training programme and that a reflective culture was encouraged at an organisational level. Peer support values[7] were embedded throughout their work and, as one trainer put it: "*Even when skills are getting taught the values are always front and centre*" [Trainer focus group ID 6]. The evidence we reviewed supported one trainer's observation that: "*the values are throughout the whole thing*" [Trainer focus group ID 2).

A key part of enacting peer values in the training involved creating an appropriate environment for learning. This was both to minimise the inherent risks in encouraging reflection and learning in relation to often deeply personal experiences and to create a space where trainees could genuinely be themselves. A safe, recovery-oriented and trauma-informed environment is hard, if not impossible, to achieve in practice all of the time so a degree of humility and honesty was felt to be important in delivery: "*I think that's really important for the participants to recognise that these are not easy things to hold and keep in place. But it's something we're always striving for and so that vulnerability of saying actually we don't always get it right*" [Trainer focus group ID 4]. The concerns and risks with the act of practicing and learning about peer support are constantly present given the difficult nature of the topic, but trainees described a multitude of ways they aimed to reduce or mitigate risk and increase a sense of safety throughout the training programme.

Safety and reducing the potential for harm

A focus on safety was embedded within the training. This was put into practice through a combination of tools, perhaps most notably through rigorous and genuine processes of checking in and out. We also saw clear and consistent evidence of trainers modelling safe practices, for example, in relation to how and when to share to maintain safe boundaries: "*Acting with consistency and integrity, as a trainer being someone that trainees feel they can genuinely trust, that is genuinely invested in peer work, in the trainees and their developments will further a sense of safety*" [Trainer survey ID 6]. However, given the complexity and sensitivity of this type of training there are inevitably instances where safety has and will be compromised: "*No matter how safe you try and make it, they themselves might not know what their trigger is going to be in a particular situation... it's being open and honest about it*" [Trainer focus group ID 2]. Trainers were clear that it was not possible to anticipate all potential triggers[8] in a group, which meant constant vigilance was needed from trainers. They provided examples of where seemingly low risk activities, including playing music and using grounding techniques, had inadvertently triggered trainees [Trainer focus group IDs 2 and 6].

Further, one trainer suggested that a safe space for learning is one in which people are able to try things out and to make mistakes "*and test these boundaries of what could be right, how it can*

---

[7] The HEE competency framework describes peer support values as respect, reciprocity, mutuality, non-directive, strengths-based and recovery-focused.

[8] The word 'trigger' is a commonly used and understood term for something that causes a strong emotional response due to previous trauma or memories. We recognise that for some people it does not adequately convey their sensitivities to situation and experiences linked to previous trauma, but to stay close to the data collected during the evaluation, we have included the use of this word.

be used wrongly" [Trainer focus group ID 12]. This could be perceived as putting other trainees at risk as new skills are tested and, therefore, potentially reducing the sense of safety in the group. One trainer characterised their role as that of facilitator, ready to step in and model alternative approaches where safety is breached, often inadvertently by trainees with quite varied levels of experience and knowledge.

Trainers were able to identify specific practices employed to encourage a safe space. These included developing and making reference to the 'Let's Be' group agreement and having regular check ins with people. Having more trainers and supporters available in groups also helped with monitoring trainee responses.[9]

Given the complexity and nuance of safety and risk in this context, it is vital that there is an infrastructure and support system available between trainers. An experienced trainer provided examples of where safety had been compromised, for example "*trainers going into teacher mode, not connecting with trainees as people, but as problems to be taught*" but emphasised "*whilst potentially disruptive I have never felt the actions of another trainer have compromised the long-term safety of the training space*" [Trainer survey ID 6]. These examples were linked to a lack of trainer experience and it had been possible to resolve issues to date.

Given the training is so strongly focused on mutuality and equality, the safety of trainees and trainers is intertwined. It would be impossible, and even unhelpful, to avoid risk in any learning environment so being able to respond positively and openly to mistakes and problems in the group is important. It was felt that ImROC's commitment to safety and openness was an important facilitator of this.

There was a considered approach to trauma responsiveness from survey respondents. One respondent felt it was it was important not to "*go to town*" with trigger warnings [Trainer survey ID 2], given it was impossible to anticipate every reaction and the ubiquity of traumatic past experiences in the group.

Personalised and recovery-focused training

The delivery was described as being personalised with trainers identifying where people may be struggling and reaching out to provide additional support including additional one to one time. Every trainee has a dedicated trainer as a personal tutor, who they can meet with individually throughout the training programme. This is intended to provide a welcoming presence for trainees and a space to raise concerns and get help as needed. Trainers also worked hard to ensure all voices were heard in the session by carefully moderating verbal comments alongside those shared via the online chat function.

Setting the right tone from the start was described as being important by a trainer: *"I ground myself before training and visualise the calm, welcoming persona I want to project in order to enable the trainees to feel safe and heard"* [Trainer survey ID 1].

---

[9] In some groups involved in this evaluation there were up to four trainers or supporters available. However, more typically training is delivered by two trainers with an additional person providing technical support.

To maintain a recovery-oriented environment in the group one survey respondent felt it was important to ensure that *"everyone is on the same page in terms of understanding recovery*" [Trainer survey ID 1]. Other respondents described being recovery focused as meeting people "*where they are at*" [Trainer survey ID 2] and using their practice and ability to model values: "*seeing my place as being the facilitator of their development, holding high expectations for trainees and supporting them to find the best ways for them to get what they need both from the training space and when approaching assignments*" [Trainer survey ID 6].

Modelling of peer practices by trainers

Modelling of approaches was nuanced and tailored individually to trainees as a trainer survey respondent pointed out: "*My main approach working with peers is always to centre a person's own understanding of what has happened to them and their way to communicate their experiences, and to try and model this in disclosing my own life when appropriate, rather than to model a 'recovery from illness' approach.*" [Trainer survey ID 5]

The practice of modelling approaches was also linked with the intentional use of language (including body language) in the training space and gently encouraging trainees to adopt similar approaches to describing experiences: "*...speaking from the* [peer support worker] *perspective helps to model the role for trainees and encourage trainees to consider the use and impact of language when supporting others...Never using diagnostic language when sharing experiences, instead using a broader vocabulary to accurately describe the experience as opposed to using symptomatic language as short hand which often falls short of building genuine understanding*" [Trainer survey ID 6].

Trainer survey respondents highlighted the importance of providing examples from peer practice as a means of demonstrating values. Also considered helpful was continually highlighting mutuality within the training experience: *"...demonstrating that we are learning new ways and new ideas together through group activity and discussion, building mutuality through check ins and discussions and individual contact, being progressive is really important*" [Trainer survey ID 2].

Again though, this was nuanced in the context of peer training. For example, one respondent reflected that it was not always possible to be, and therefore model, a non-directive approach as a trainer as they would not be fulfilling their training role: "*Actually you can't really be that non-directive as a trainer because you need to facilitate and lead the session and be able to say when people are discussing something and they're getting the values wrong*" [Trainer focus group ID 7]. Another commented on the inherent power imbalance between trainer and trainee as having a potentially negative effect but one which could be balanced by "*taking on board participant knowledge as of equal value to my own"* [Trainer ID 5].

One focus group participant described their entire approach to training as being founded on their practice of peer support working and that their modelling of peer values was therefore practice based: "*I delivered the training as a peer support worker. So, the way that I interact with trainees is how I would do in the professional capacity of a peer worker. How I put across information, it's all done through that lens... you're modelling it for trainees that supports people to kind of then take it on for themselves and it also helps as a trainer because you're never*

having to kind of switch hats. You're not having to kind of step out of peer work to train" [Trainer focus group ID 8].

Given some trainers have limited or no experience of being a peer support worker a question is raised about the extent to which they can truly model practices. Trainers emphasised that support and expert advice was always available in the team as well as a "*development pathway*" to support continuous professional development. One respondent felt it was important that members of the training team retain practice roles: "*it is that one to one experience of working with people and practicing the values that really gives an extra layer of confidence and knowing*" [Trainer survey ID 2]. We revisit trainer practice experience in the following section.

Who with

This section, as with the 'What we do' heading section, is primarily descriptive regarding the key characteristics of the trainers and trainees for the training as well as their motivations for becoming involved.[10]

Key findings

- Trainees experience of providing peer support prior to the training varied considerably with a considerable proportion having no or very limited previous experience.
- Trainees were motivated to take part in the training for a variety of reasons, including personal development, career progression, and a commitment to peer support gained through personal experience.
- Trainers were recruited based on their personal experience and values fit with peer support and ImROC.
- Trainers were relatively inexperienced overall, with half having less than one year of experience in the role, though there was a graded process to becoming a lead trainer that mitigated some risks associated with inexperience.
- There was some concern that trainers without direct peer support work experience may not have relevant examples to draw from which might make it harder to embody peer values.

Trainee characteristics and motivations

Routine monitoring data shows that the number of trainees taking part in the peer support worker training programme has increased significantly in the previous few years (Figure 1).

[10] The outcome model includes "Organisations that send employees to the ImROC training" and "Wider ImROC" as relevant stakeholders in this column. However, when developing our data collection and analysis plan, it was agreed to prioritise on trainee and trainer experiences.

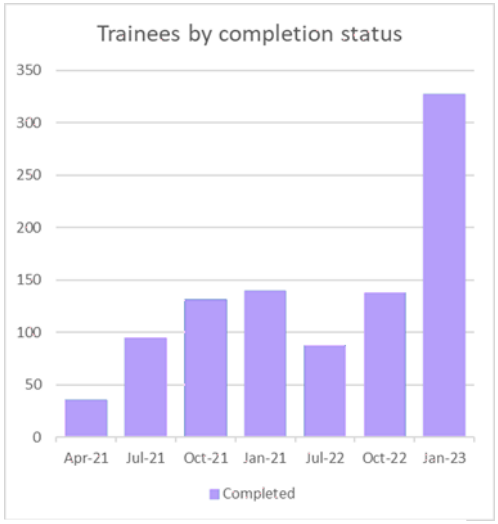


Figure 1. Trainees who have registered for the training from 2021 onwards.

For this evaluation, we were interested in characteristics of both trainees and trainers in the evaluation cohort particularly around their previous work experience and motivations for participating in the training (trainees only). This evaluation primarily focused on trainees from the January 2023 intake which included over 400 trainees. Table 1 describes the demographic details of trainees from the January 2023 cohort, using data from the pre-training monitoring survey distributed by ImROC, of which 153 trainees responded.

As Table 1 demonstrates, most trainees were based in the Midlands (41.2%), in paid employment (69.3%), female (69.9%) and White British (85.0%). There was a range of ages among those who took part in the training cohort, with over 50% of trainees between 26 and 45 years old. The demographics of this training cohort align with previous reported demographics of peer support workers and continues to highlight the need for greater diversity in peer workers, as those who are most affected by mental health difficulties (Black or Black British people) are not equally represented in the peer support population[11].

Characteristic	**Percentage**
Geographic spread	
East of England	17.0%
Jersey or Channel Islands	1.3%
Midlands	41.2%
North East and Yorkshire	6.5%
North West	6.5%
South East	27.5%
Employment status	
Paid employment	69.3%
Volunteer	13.1%

[11] Watson, E. and Repper, J., 22. Peer Support in mental health and social care services: Where are we now?.

Not in work at present	16.3%
Undisclosed	1.2%
Age group	
18-25	12.4%
26-35	30.1%
36-45	22.2%
46-55	19.6%
56-65	14.4%
65 and over	1.3%
Ethnicity	
Asian Indian	2.0%
Asian Pakistani	2.0%
Black Caribbean	1.3%
Black Other	1.3%
Kurdish	1.3%
Mixed Asian and White	1.3%
Mixed Black Caribbean and	2.6%
White	85.0%
White British	2.6%
White Other	0.7%
Undisclosed	
Gender	
Male	28.1%
Female	69.9%
Non-binary	1.3%
Undisclosed	0.7%

Table 1. Trainee characteristics from the ImROC monitoring survey, N=153

As Figure 2 shows, approximately one-third of survey respondents had no prior experience in peer support, with a similar percentage having less than a year's experience in a paid or voluntary peer support role. This figure also shows that approximately one-third of respondents had no prior experience in peer support, with a similar percentage having less than a year's experience in a paid or voluntary peer support role. The remaining third had over a year's experience in peer support, with 18% having over two years' experience. Those who were currently employed in peer support roles described a wide range of experience, from informal roles facilitating peer support cafes for a few months prior to this training to having worked in

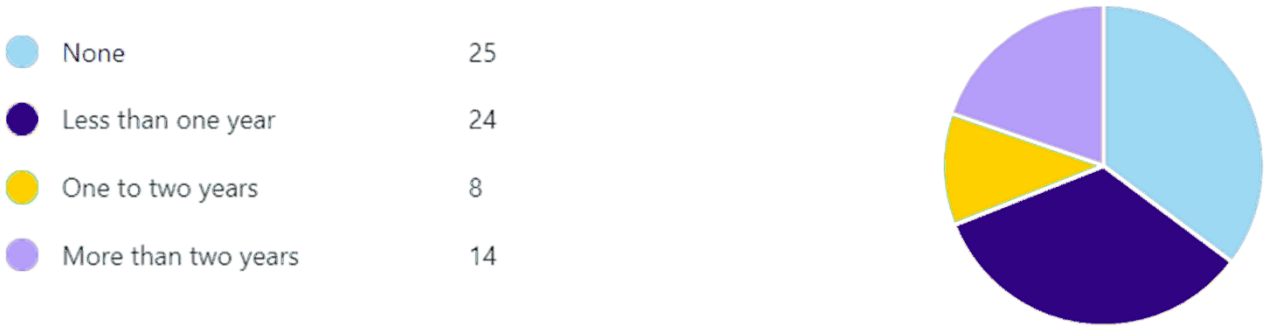


Figure 2 Previous experience (paid or voluntary in a peer support role)

peer support for over 25 years. This breadth of experience highlights the challenges of developing a one-size-fits-all curriculum, as will be explored in subsequent sections.

We asked trainees in the January 2023 cohort about what had motivated them to take part and three main groups were identified from the findings. The largest group were motivated to take part for a variety of personal reasons (48%) and were intrinsically motivated. For example, one person described their motivation to take part as helping them to *"continue my own personal journey of healing and growth by supporting others*" [pre-course survey trainee ID 13]. Another described being attracted to the training by the approach and culture of ImROC: *"They are doing a really really good job. The culture comes from the top and it's clear the basis is really there*" [post course interview 2]. People spoke of being passionate about the topic of peer support and wanting to build a career in the field of peer support as reasons behind their enthusiasm. One trainee said, "*This is a new journey for me and I am very excited. I feel more enthusiastic after each training day. I am ready and want to become a peer support worker to change my life as well as that of others.*" [pre-course survey response ID 20]. Several trainees said that because peer support was so useful to them in their own recovery, they wanted to become a peer supporter to help others.

A second group described their motivation as wholly external, having been asked to do so by an employer or workplace (27%). A third group described being motivated by a combination of internal and external factors (25%), as they were asked to take part by an employer or workplace but also being would have taken part anyways because of their personal interests in peer support work.

We also examined trainee expectations at the outset. Responses were varied but included a general desire for increased knowledge about peer support and the skills to practice effectively as a peer supporter and to increase confidence in the role. Some expected the course to be helpful for their personal recovery while others saw it as a gateway to career progression. For example, one trainee described their hopes for the course as "*more understanding of hope-inspired recovery, the means to get a job in the peer support industry, and more education on the value of peer support for young people, especially*" [pre-course survey trainee ID 32].

Trainer characteristics and motivations

In the January 2023 cohort, there were 33 training team members. Fourteen were ImROC trainers, seven were part of the registered trainer programme and were being signed off as approved imROC trainers and 12 were assistants for technology and classroom needs. Each session had one lead trainer alongside one to two new or registered trainers and between 21 and 25 trainees in each session.

We asked trainers about their motivations for becoming involved with ImROC and the main themes were because of personal experience and knowing that they were helped themselves by peer support. The values-based culture in ImROC meant that the people were identified and recruited as trainers because of their perceived fit with the organisation combined with relevant personal experience. As a result, trainers were typically recruited from previous cohorts of trainees.

Both trainees and trainers described a strong connection with the values of peer support and of ImROC as an organisation: "*it feels like IMROC has actually lived those values rather than paid lip service... I guess my life's work since I came out of using services regularly myself, and employed as being to do with trying to fight for a place where peoples' experience of their own lives is seen as a valid form of knowledge*" [Trainer focus group ID 6].

Peer values were described as a revelation by one focus group participant because "*it was something that I had implemented in my own life from a young age*" [Trainer focus group ID 3]. Another trainer characterised working for ImROC as a peer trainer as being like a homecoming, speaking again to a strong sense of the centrality of values fit.

Trainers working in the January 2023 cohort were asked about their level of experience training with ImROC. Though the survey numbers are small, Figure 3 suggest that trainers were relatively inexperienced overall with half of those surveyed having had less than one-years' experience in the role. While this may be explained by the need to increase trainer numbers in line with the significantly expanded trainee cohort, given the sensitive nature of the training, it's essential that trainers are well-equipped to deliver the content in a values-based and trauma-informed manner. Importantly, it was clear that there is a lengthy induction and onboarding process for new trainers who are not responsible for leading their own cohorts until they demonstrate readiness. New trainers are gradually introduced to delivery initially assuming assistant roles and gradually developing their skills to becoming established trainers. This typically occurs over a number of training cohorts.

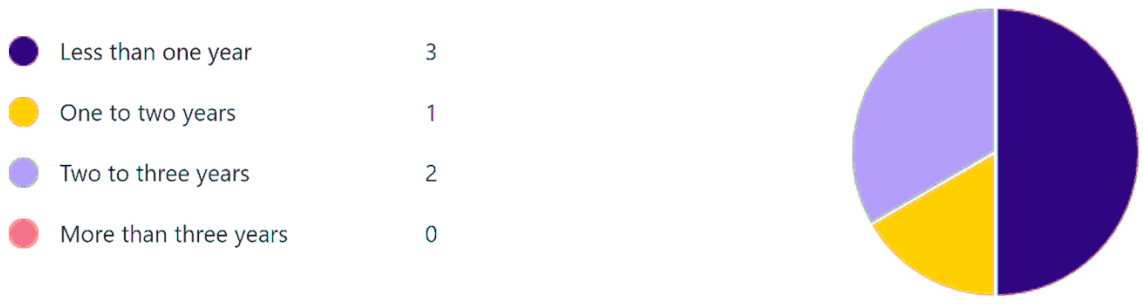


Figure 3. Years of experience of trainers in their role.

In terms of prior experience of the delivery of peer support amongst trainers it was clear that this was not universal: *"I have not worked as a peer support worker myself but I have lots of experience in education and training... Where peer support expertise is needed, it is always there within the group and/or among the training team as a whole*" [Trainer survey ID 1]. There was, though, some concern that not having experience of delivering peer support in practice might make the training feel less authentic with one trainer describing their experience as a Peer Support Worker as figural to their approach.

"My approach is always to deliver the training as a peer support worker, drawing from first hand professional experience and second-hand professional experience from having trained, supervised, managed peer support workers previously. By coming into the space as an experienced peer support worker this allows for me to apply the logic and perspective of peer support to any and all challenges to ensure an answer or approach can always be found. A key benefit for this approach is that - 1) trainees will be able to get a look for what peer work should sound and look like and 2) they will be made to feel the same feelings of safety and equity that someone being supported by a peer support worker should feel." [Trainer survey ID 6].

Sharing mutual experiences is a foundational peer support value and practice. Trainers without prior experience of peer working may be less able to draw on relevant examples in describing concepts in the training and it is possible they may be less able to embody peer values that are founded in practice experience. However, trainers made the point that they could call on advice as needed: "*The most helpful factor in adapting my approach is being able to draw on the experience of the training team leads. [The team leads] always have advice on what we can do to help trainees but also where our own boundaries/limits of possibility lie*" [Trainer survey ID 1]. But it remains possible that employing trainers without direct peer support work experience means that trainers may not have relevant examples to draw from to demonstrate concepts, or may not be as able to embody peer support values to the same degree that those with direct practice experience. For example, a trainee interviewed after the course suggested that one trainer in their group had a tendency to be quite black and white in their approach, which they ascribed to that trainer's lack of practice experience [post course interview 2]. While it is clear that ImROC have a considered approach to introducing and supporting new trainers, the implications of trainers not having direct peer support experience should be explored further.

How they feel

This section describes how we anticipated trainees need to feel when they engage in the training to enable them to go on to achieve positive outcomes as people need to have a positive reaction and engagement with an activity to be able to learn something new or try to do something differently. Namely, our theory of change suggests that in order to gain as much as possible from the training, trainees need to feel:

1. Enthusiastic and open to learning.
2. Safe and supported.
3. Seen, heard and valued.

Key findings

- Trainers fostered a sense of safety by being open and understanding, and by validating trainees' experiences which helped trainees share personal experiences openly and constructively.
- Breakout rooms were an important tool for learning, reflecting, and practicing concepts and skills, but trainee experience of them was varied with suggestions made for their improvement.
- Check in and out procedures were again highlighted as being important for building a sense of safety and mutuality, but they were not universally popular.
- While trainers were aware of the importance of accessibility and adapted their approach accordingly and therefore some trainees found the training accessible, but others reported significant challenges with the pace of delivery, the amount of information, and the software used.

Experiencing a sense of safety, support and openness in the training

Overall, people felt the trainers as well as their peers created a sense of safety, support and openness to share their stories. Early in the course, trainees were asked about how they felt starting the training and if they wanted to explain further. As Figure 4 shows, out of 71 responses, 89% felt open to learning new things in the training, with over half also feeling enthusiastic (55%), and just under half feeling excited (46%). A significant number of trainees also felt apprehensive (42%) and worried (21%). When asked to elaborate, some trainees spoke about how peer support and training was totally new to them, but they were still open and interested to learn new things: *"Whilst I am open to learning, as stated above, training causes me some anxiety"* [pre training survey ID 31]. Some of this group felt unsure about the online format while others worried about their ability to engage in training after a (sometimes long) break in learning and participating in groups: *"I am one of the least experienced members of the course makes me apprehensive in case I say the wrong thing*"." [pre training survey ID 23]. Others described concern about participating in large groups and being in an online environment such as Zoom and Moodle for a long period.

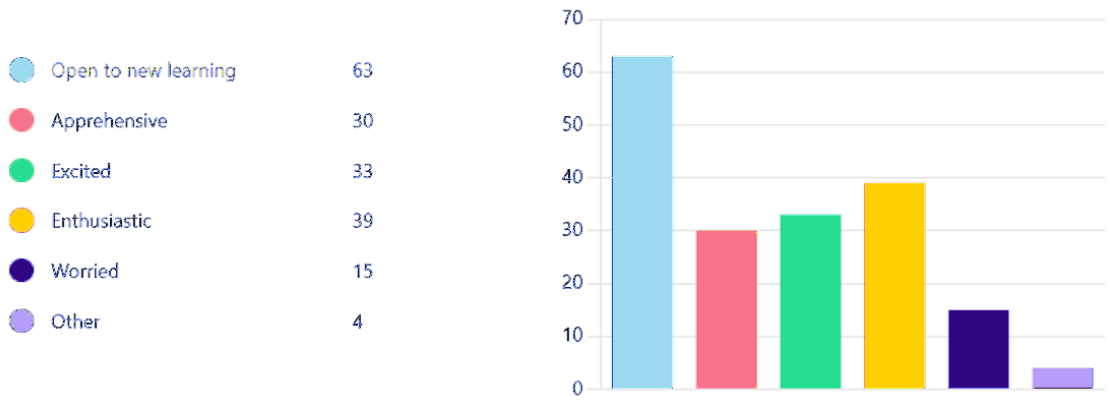


Figure 4. Trainees response to being asked "how they feel about starting the training" during the third week of the programme.

We also explored how people felt while in the training space. Figure 5 shows a high proportion of positive emotions felt by trainees: The majority of trainee felt supported, seen, heard, valued, connected and safe. A smaller proportion (45%) felt challenged and 17% felt vulnerable – though neither of these are necessarily negative emotions that would be prohibitive to learning. In fact, no trainees felt solely 'vulnerable' and/or 'challenged – these were always accompanied by the more prevalent and positive feelings of 'safe', 'supported' 'seen, heard and valued' or 'connected'.

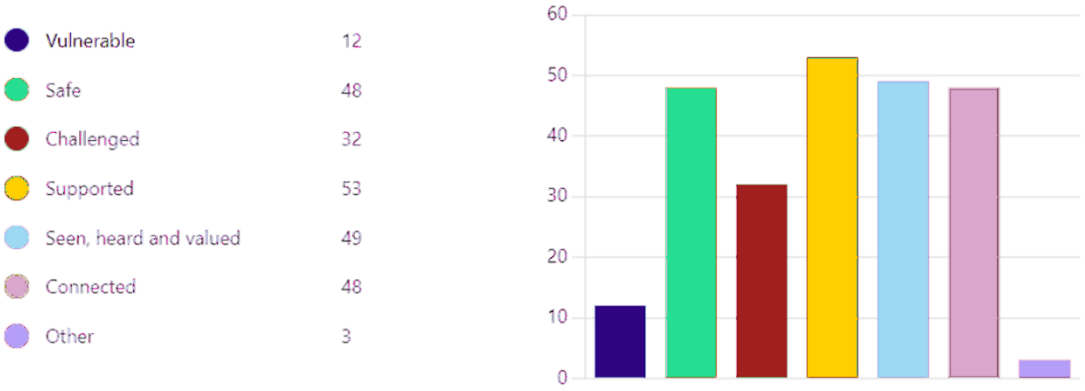


Figure 5. Trainee responses from the early-training survey when asked how they felt while in the training space.

The emotions elicited during the training were explored further as the training programme progressed. In the mid-course focus group with the enhanced evaluation cohort, trainees described feeling safe, supported and listened to by trainers.

> *"The ImROC training was structured, steady-paced, inclusive, and safe...and the "safe" is a HUGE contributing factor to its success (in my opinion)"* [post training survey ID 17].

This sense of safety was described as being fostered by trainers who were "*open and understanding*" and who went to lengths to ensure trainees felt validated: "*[trainers] also are giving body language on the screen [...] they're nodding, and then they're reflecting. So what we've said they reflect on that. So you get a sense that they are listening to you and also that they understand you*" [trainee focus group ID 4]. There were also examples of where trainers

ensured trainees had choice and autonomy during the training which was widely appreciated by trainees. Trainees were encouraged to be autonomous and to be clear about their own needs.

> *"You can say if you're having a bad day, I think that's really important when you are training. So people are aware that you need to have space to yourself as well, and I think some of the other people have found that really beneficial as well when they're like, I just need to have my camera off or whatever* [trainee focus group ID 8]."

The most common barrier to trainees feeling safe were their own concerns around sharing personal information in a large group. It was described by some as being quite overwhelming and several mentioned the importance of the smaller breakout rooms to allow them to share further. Additionally, a lack of self-confidence and inexperience contributed to a few people saying they were less comfortable in the large group setting. It is though important to keep in mind that this information was collected relatively early in the course and that shifts in confidence are assessed later in the theory of change.

Some instances of safety being challenged at this early stage of the training included feeling like others were oversharing at the detriment of hearing quieter individuals; an online environment being difficult to create a sense of connection; pace of the course being too fast at times; and individual interactions between some peer trainees being negative. Some trainees felt that providing an agenda for the upcoming week's session would help trainees know what topics were being discussed. This would allow them to prepare mentally if something challenging was going to be discussed, thus improving their feelings of safety in the session.

It is hard to get online trainings right for everybody all of the time. One trainee, who was recommended by their line manager to take part, spoke of feeling triggered, anxious, depressed and scarred by the life experiences others shared during the course, and wondered whether they were emotionally strong enough to be a peer supporter at this time in their life. While this learning may in fact have been helpful on a personal basis for that trainee it also speaks to the challenges of designing and implementing a peer support course that suits people at different stages of their life and recovery. Another trainee who took part in a post-course interview mentioned that when people had their cameras off (which trainers mentioned they encouraged to ensure people felt safe), it was challenging to engage them in breakout rooms. She could not tell if they were unwell or just did not want to contribute. While having the option to turn your camera off can foster a sense of safety for those who choose to do so, there are implications for others – again speaking to the complexity of creating safe spaces in an online environment.

Support for trainees to feel seen, heard and valued

There were several tools used in the training to ensure that trainees felt seen, heard and valued. Some of this is more relational, such as, how trainers build a supportive, listening environment in their sessions and respond sensitively to the needs of trainees, as described earlier in the 'What we do' section. In addition, trainees and trainers highlighted the important role of breakout rooms and the use of 'check in' and 'check outs' as intentional methods designed to build inclusion and a sense of safety.

Breakout rooms were an important tool in the peer support training, providing trainees with the opportunity to learn, reflect, and practice concepts and skills within a small group. Most trainees enjoyed the breakout rooms, finding them to be a good chance to discuss the topics covered with their peers, learn from others' lived experiences, and practice sharing their own stories in line with peer values. The breakout rooms also provided an opportunity for quieter or more introverted trainees to speak, as they did not always feel comfortable sharing in the larger group.

However, there were also less positive views on the breakout rooms. For example, some trainees felt that there was not enough time in the breakout rooms to cover everything that was requested, and that the requests were sometimes confusing. Others felt that the length of time in the breakout rooms could be shortened significantly and topics to discuss clarified: "*Instructions for discussions were often vague and we spent ages working out what was desired*" [post training survey ID16].

There are advantages and disadvantages to more frequent monitoring and inclusion of trainers in the breakout rooms and we understand that the training team have tested a variety of methods, including trainers staying in them, dropping in and out of them, and monitoring them through Zoom features. During this evaluation, the approach was more a hands-off approach in which trainers checked in on breakout rooms infrequently at the beginning of a session to facilitate discussion.

Check in and out procedures were another regular feature of the training sessions and are intended to provide an opportunity to check how everyone is doing at the start and end of a training session, and to encourage connection and support in the peer group. Many trainees commented on the value of this approach:

> *"I've never had that on training before and I've personally found it beneficial. There are some things obviously within the training that are very like triggering for people that have gone through personal experiences. And I have found like some of the training to be quite emotional and quite triggering myself. So to have that space at the end to just go, yeah, this has been hard. And to talk that through is actually quite nice"* [mid training focus group ID 8].

They were described as helping to build a sense of safety and mutuality with the trainers and trainees in the course. They also provided an opportunity for trainees to build connections with other trainees describing similar experiences. However, the feedback was not universal with one trainee describing a feeling of "*mental decline for the rest of that day*" [post training survey ID 29] after a check in.

Overall, both breakout rooms and check in and out procedures were useful tools for building safety and inclusion in the training space. However, in the context of this training, their application is a skilled task and one which requires regular review. Gathering and responding to trainee feedback should help ensure as many people as possible benefit from these practices.

Accessibility of online training

ImROC made various accommodations for accessibility in the training and some trainees experienced it as an accessible course with materials that were *"easy to use*" [post training survey ID 25]. However, a reasonable number of trainees (including those with neurodivergence) reported challenges. For example, some felt that the slides were too text-heavy and the pace of delivery was too fast. Others suggested that they did not have enough time to prepare for potentially challenging conversations:

> *"Just for me, I need to know what I'm doing in that day, so I can prepare. And it just sometimes makes it very difficult when they're like spring, an activity on us and it's like, oh, well, we're going to talk about this trauma led something. And I'm like, ohh. OK, that's gonna be very difficult. So I've not. I've not prepared myself to be able to talk about that issue or think about it if that makes sense"* [mid-course focus group ID 8].

Some trainees reported feeling overwhelmed by the amount of information conveyed while others struggled with the software used to support learning and communication, most notably in relation to the learning platform Moodle.

Trainers were certainly aware of the need to make the materials as accessible as possible and to adapt their approach accordingly. However, one trainer described limits in the extent to which content could be made accessible and felt some responsibility lay with the organisations sending trainees.

> *"...I had a trainee with visual impairment who could not see the screen, so participating in online training would only have been possible for her with a dedicated support worker. A hindrance is that trainees' workplaces should really think these things through in advance and provide the support - but they often don't"* [Trainer survey ID 1].

Training not being fully accessible to all was identified as a risk to the agreed theory of change for what happens through this training at the outset of this evaluation. Trainee feedback we have reviewed suggests that this was an accurate assessment and we revisit accessibility in the conclusion and recommendation section of this report.

What they learn and gain

This section is about the changes in knowledge, skills, attitudes and capacity that trainees experience as a result of the training. Specifically, our theory of change proposed the following outcomes.

1. Trainees understand the values of peer support and its underpinning principles.
2. Trainees gain self-awareness and confidence.
3. Trainees and trainers develop and learn through reciprocal and mutual learning.
4. Trainees learn tools and methods that are recovery-focused and person-centred.

Key findings

- Trainees reported gaining increased confidence and self-awareness through the training.
- Trainees learned how to share their lived experiences in a safe and supportive way, a core element of peer support working.
- Trainees developed mutual and reciprocal learning relationships with each other and with trainers which meant there was a strong sense of equality in groups.
- Trainees learned about specific tools and approaches to apply peer support but the strongest emphasis was upon the development of relational practices.
- Trainees with more prior experience of peer working found the training less useful than less experienced trainees. However, they still appreciated the opportunity to learn from others and to further develop and refresh skills.

Learning about peer values, principles and tools

Overall, trainees agreed they had a better understanding of peer support values, or at very least, it was a good refresher for those that had already been working in peer support and received training. For trainees who attended as part of a team it was felt that it provided a common language and the core peer support values that gave organisations consistency in their approach to peer support. This was in spite of the training having varying degrees of usefulness for trainees with significant previous work experience and study in peer support related areas, as one trainee described "*the course hasn't impacted on me in particular (due to previous training and degrees) but I know it will have done on other colleagues because they have less prior education... it has helped provide a set of core values that I have noticed colleagues are more aware of*" [post course interview 2].

There were limited references to trainees learning about specific tools in our review of final assessments. Those that are cited include check in and check outs, utilising the GROW model and applying Tuckman's theory to peer support groups. This perhaps reflects that the training is primarily focused on the peer support values and relational practices over applying specific peer or recovery-focused tools.

Several trainees spoke about building a safe and welcoming environment with the person they are supporting, by asking questions and creating a conducive environment for connection. One trainee wrote in their final assessment that they "*have learnt the ability to build a connection with someone, from any background by learning about the eight core values of Peer Support, being in a mutual and reciprocal relationship with them*" [trainee assessment]. Trainees also spoke about learning how to keep conversations hopeful, recovery-focused and trauma informed. One trainee voiced previous concern that they would not be able to relate to the people they were supporting but realised through the ImROC training that "*I was able to see how an effective peer relationship could be made not necessarily through having shared specific experiences or diagnoses, but also through the variety of thoughts and feelings that occur when navigating a mental health journey*" [trainee assessment].

Increased confidence and self-awareness

Trainees were asked at the beginning of the course about how comfortable and confident they feel sharing their lived experience with others in a peer support role. Many felt comfortable sharing details of their lived experience and personal recovery journey, but some felt that they had less confidence in sharing. People described concerns about knowing where the boundaries were for the role, or how to share most effectively to help others. Knowing when and how best to share their lived experience to help others was less clear, specifically around avoiding oversharing.

Some shared specific concerns about sharing their experience. For example, one trainee wrote that "*I lack some confidence that I may be too far along in recovery that I don't relate enough*" [early-course survey ID 68]. Others also said they may not feel comfortable or confident sharing their recovery journey if they did not feel safe or the subject was too personal or painful. Many survey responses said they hoped to gain more confidence through practice and experience by taking the ImROC training.

After the training, trainees were asked again about their confidence levels to share stories of lived experience. The vast majority said their confidence had improved as a result of the course. For example, when asked about the extent to which trainee confidence improved in sharing lived experience as a result of the training, three quarters of respondents rated either four or five on a rating scale of improvement (where one represented 'not at all' and five 'very much').

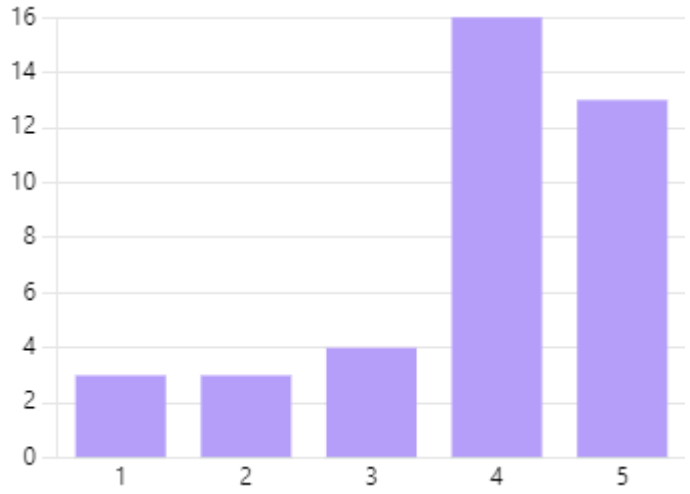


Figure 6 Confidence gained in sharing lived experience

People described feeling more confident about what to share and in how much detail, feeling more assured that they were setting appropriate boundaries and ensuring their own safety, as well as taking a trauma-informed approach to sharing. It appears that the concerns described in the beginning of the course about not feeling safe or their story being too painful were largely assuaged, as they learned and practiced how to share relevant, safe details about their recovery journey. A key part of this was about learning to share with purpose - some trainees felt they were "*remembering I don't need to share things that would be beyond my boundaries and also being conscious of sharing lived experience that has a hopeful point to it*" [post course survey response ID 26].

Trainees also reported that their self-awareness improved as a result of the training. They spoke of becoming more aware of the language they use, how to make connections whilst also being "*more assertive [...] in order to protect my own wellbeing*" [post course survey ID 6]. Some also described gaining greater clarity on how their actions and language may be perceived by others. For others with this increased confidence and awareness came the opportunity to explore fairly complex emotions constructively:

> *"It brought me head-head with how much Imposter Syndrome I "manage" on a day to day basis, and did so by providing a safe space for it to exist and be shared. This encouraged others to share theirs which helped me to better manage mine and see it for the reality of what it is and where it comes from*" [post training survey ID 17].

For those who said their confidence and self-awareness did not increase, it was generally due to them starting the course already feeling confident because of prior experience in peer support roles. For example, one trainee said "*I had been in the role for so long, everything taught was already part of my day to day work*" [Post course survey response ID 14]. Another described, "*I am very confident already in sharing my story*" [post course survey response ID 15], which again speaks to the diversity in backgrounds and experiences of trainees.

Overall, the logic between stepping stones in 'How they feel' and 'What they learn and gain' sections in the ImROC pathway appeared to hold from the data collected. When people feel safe to share their stories and can learn from their peers and the trainers, their confidence as a peer supporter grows. Setting up a safe environment to learn, share, 'overshare', reflect and grow as a result is critical to gaining the confidence required to share one own's personal recovery journey to support peers.

Developing and learning through mutual and reciprocal learning

All trainer survey respondents could provide examples of where they had learned from trainees, suggesting mutual learning was taking place for this group.

> *"Gosh - where to start?!... Trainees' stories of suffering, resilience and recovery are incredible, and the learning I gain from each cohort carries forward to the next. I have learnt about different organisational settings, appropriate use of language, neuro-diversity... Fundamentally, I think it's essential for trainers to come from the position that we are all peers within the group and that we have as much to learn from trainees as they do from us"* [Trainer survey ID 1].

Other examples provided by trainers included learning about the delivery of peer support in specialist settings and gaining a better understanding the impact of intersectionality as experienced by trainees. Trainers described how an expectation of mutual learning was designed into the training. Reciprocity in the group was developed in part through trainers acknowledging they were fallible, and that they were themselves on a learning journey: "*I've learned so much from the trainees and, you know, all their different experiences and stuff... It's a nice relationship. It's not just a teacher and a student*" [Trainer focus group ID 2].

Trainees mainly spoke of how they learned from each other in mutual and reciprocal ways by sharing experiences in breakout rooms. Having the chance to share their own stories and hear

others' allowed trainees to connect over mutual experiences and build confidence, as one trainee in the post-training survey exemplified: "*Sharing experiences in the breakout rooms allowed me to feel that I am not alone and helped to increase my confidence in speaking out more knowing the impact it can have on others people's wellbeing that I am working with for them to feel that they are not alone too*" [post-training survey ID 35].

Trainees also said that sharing stories in the breakout rooms helped them understand the impact of their words and gave them the opportunity to gauge the impact of their words and ideas in a low-risk setting, preparing them for their roles as peer supporters: *"It helped me practice 'how' to discuss my story with my peers and to keep it relevant and succinct"* [post training survey ID 41].

What they do differently

This section relates to changes in behaviour which were anticipated as a result of the things which were learned and gained through taking part in the training. Specifically, our theory of change proposed that trainees would:

1. Apply the values of peer support and its underpinning principles to their peer roles.
2. Apply the values of peer support and its underpinning principles to their lives, language and relationships.

Key findings

- Some trainees used the training to improve their practice, such as becoming more intentional about sharing their lived experiences and being more mindful of pace and safety.
- Others found the training to be a helpful refresher but did not feel that it changed their practice significantly while a very small proportion of trainees did not enjoy or value the training, and therefore did not apply the learning to their work.
- The extent to which trainees were able to apply the values and principles of peer support in practice was highly dependent on the context in which they worked, with some trainees facing significant barriers in their employing organisations.
- The training helped trainees to improve their personal relationships by making them more understanding, vigilant, and aware of other people's needs while also make them more mindful of the people they encounter in everyday life.

Overall, trainees took what they needed from the training and applied what they learned in different ways. Trainees apply the peer values, mutuality and methods of support that are recovery-focused and person-centred from the 'What they learn and gain' column to their personal recovery, relationships and work settings.

Applying the values and principles of peer support in practice

The vast majority of trainees who completed the post-training survey were already in voluntary or paid peer roles (84%), making them well-qualified to comment on how the training had changed their work.

Most trainees said that the training had either helped them in their roles or confirmed that they were already doing things well. For example, trainees said that they were now able to support others in a more recovery-focused and positive way, and that they were better able to assess personal safety and boundaries in the peer relationship. We also heard that the training had led to more consistent practices in teams where multiple people had attended. One trainee provided an example of how they had changed their practice around sharing lived their experience so that it was more intentional: *"I learnt from ImROC that Peer support is not about randomly sharing lived experiences but to assess timing and situation when deciding if it will benefit the patient"* [post training survey ID 42].

Another trainee emphasised how their learning in relation to being trauma-informed had helped them understand the need to be more conscious of pace and safety:

> *"I think in the past I may have been a bit quick to expect someone to start to acclimate to groups/sharing and recovery quicker than maybe I should have. I sometimes didn't take into consideration that the shares of others in a group may be very difficult for others to hear... I am now more vigilant of other service users if a session has been heavy and try to ensure that all members of the group not just the sharer are ok"* [post training survey ID 18].

Even by the mid-course focus group, some participants reported applying what they had learned to their own peer support working. For example, one trainee reported using methods that had experienced in the training, including check ins and breakout groups, in a weekly peer group that they ran to good effect: *"it's been brilliant"* [mid-course focus group ID 3].

Some did not feel like the training helped them in their roles. For the majority of this group this was ascribed to their work experience or previous training. However, many described a sense of affirmation from the training which provided a refresher. One trainee described how they wished they had received the training much earlier in their career: "*It would [have] helped my confidence so much, given me the structure I needed straight away, and would have saved me a lot of imposter syndrome, worry and stress in the beginning*" [post course survey ID 19].

A very small proportion of trainees reported that the training had not helped them in their roles because they did not enjoy or value the course more broadly. This meant they were unable to progress past the 'how they feel' column in the outcome map.

Getting the timing right for when people receive training is an important consideration for ImROC and employers. For some, the training is seemingly too early in their recovery journey, which increases the risk that they have negative reactions to course content or the disclosures of others. For other, more experienced, trainees the training may be too basic and would have been more helpful earlier in their careers.

The application of peer values and principles in practice is highly contextual

The extent to which trainees were able to apply the values and principles of peer support in practice was in large part determined by the context in which they worked. At the outset of the evaluation, we identified two risks to our theory of change that related to the application of values and principles and from the evidence we reviewed we found these to be highly salient.

1. Values differ between employing organisation and peer support training.
2. There is insufficient organisational support for the trainees to fulfil their potential after training.

Over one-third of trainee respondents to our post course survey (36%) felt that there were significant barriers to maintaining a peer and recovery-focused approach where they worked. Key themes included peer support not being taken seriously in employing organisations and peer workers being hindered in their role by hierarchical structures, where peer support workers sat at the bottom rung. This combined with a lack of role clarity led to people being asked to perform duties that they felt clashed with peer values shared on the training, for example, in relation to ensuring compliance. Trainees also described tensions between peer approaches and the principles and practices of other colleagues in multidisciplinary teams and a lack of appropriate supervision.

We heard from both trainees and trainers that the context in which peer support was being delivered presented them with personal and ethical dilemmas. This was most notable in statutory service settings like NHS Trusts. While there have been significant efforts to support the integration of peer workers into existing services this evaluation suggests significant challenges, which have been widely described in research literature, remain.[12] This means the extent to which any peer support training course can achieve its intended outcomes is highly contingent upon the setting in which trainees are asked to apply their learning.

The application of peer values and principles in wider life

Several people said that the course had improved their personal relationships. One trainee described applying their learning to help them better connect with their daughter: *"I started to, instead of jumping in like I always do with, you know, being a mum"* [mid-course focus group ID 1]. Others described the more intentional use of language, improving listening skills and generally being *"more understanding, vigilant, and aware of other people's needs"* [post training survey ID 7].

Some people ascribed these impacts due to increased self-awareness as a result of the training:

> *"More self-aware of my mental health challenges, how they manifest and how I present them to others. Prior to the training this had been negatively affecting my relationships, but now I've turned this round. Learning about how to be recovery focused but trauma informed had a huge impact here as I developed an*

[12] See, for example, Mutschler, C. *et al.* (2022). Implementation of peer support in mental health services: A systematic review of the literature. Psychological Services, 19(2), 360–374.

understanding of how my trauma and recovery can exist in a healthier balance" [post training survey ID 12].

Impacts were not limited to close personal relationships. For example, one trainee described an increased mindfulness about the people they encounter in everyday life. They described being *"a lot more mindful of the characters I may encounter in public life. It reminded me that I do not know a person's story or their circumstances, and a person's behaviour will be intrinsically influenced by this, and to be mindful of this in measuring my responses and reactions"* [ID17].

Overall, from feedback we reviewed it is clearly important not to underestimate the impact that the training had on many people's wider lives and relationships. There is no doubt that the training provided many trainees with relational knowledge and skills which could be applied in a variety of settings.

What difference does this make?

In this final section we are explore the ultimate difference the training made to trainees. We anticipated the following outcomes would be realised at this stage in the theory of change, assuming prior outcomes related to learning and gaining and behaviour change were realised.

1. Trainees thrive in their peer roles.
2. Trainees can support themselves through their own recovery.

Key findings

- The training is effective in helping trainees to learn and apply the values and principles of peer support and creates the conditions in which trainees are more able to thrive in their roles. However, the extent to which this happens is largely outside the control of the training.
- The training had a positive impact on the personal recovery of two-thirds of trainees.
- Increasing self-confidence through the training seemed to be an important antecedent to improved personal and professional outcomes.
- There were unexpected benefits for some trainees, such as increased self-acceptance and a renewed sense of purpose.

We found that these two outcomes were closely connected and that the extent to which they were realised was in large part contingent upon the trainees and what they brought to the training in terms of their characteristics and experience.

The confidence with which we can specifically state that the training enabled people to go on and thrive in their roles is limited by the relatively short follow up period available in this evaluation. We also described earlier how the extent to which trainees can thrive in their roles is highly contextual. This means achieving this outcome is, to a significant degree, outside the control of ImROC, its trainers or even trainees and consequently its framing should be reviewed in future theory of change for this training. However, we saw more than enough examples of learning and

behaviour change because of the training to suggest that it does create the conditions for trainees to be more able to thrive in their roles.

When we asked people about the extent to which they felt that training had impacted their personal recovery, two thirds agreed that it had done so and roughly a third reported no impact. Additionally, one trainee said there was a negative impact (Figure 7), which they ascribed to interpersonal difficulties.

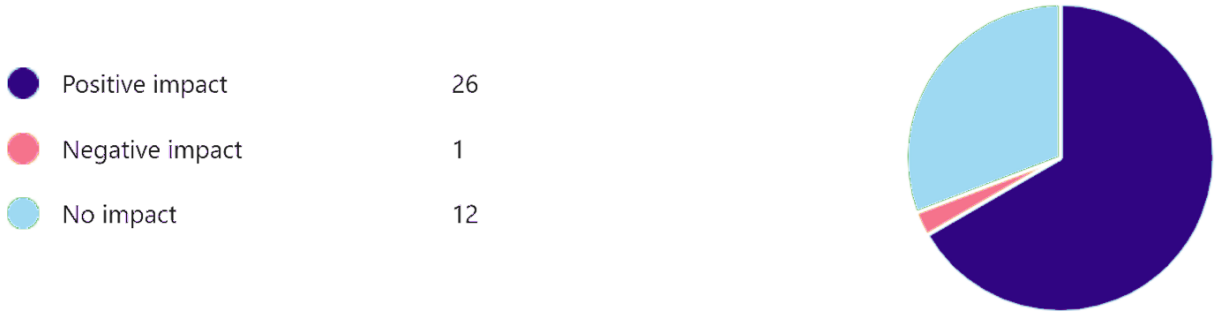


Figure 7. The impact the training had on their recovery journey.

Trainees who felt that their recovery was unchanged as a result of the training, generally attributed this their recovery being "*well established*" [post training survey ID 25] before the training. For people in this group, the training also had limited impact on their peer roles as a result of their prior work experience or training. It did, however, provide useful reinforcement and validation:

> "*The ImROC training has not changed my practice or my role, self-awareness or confidence in work or in my personal life. I found that in doing the training I confirmed that what I have already been doing in my role for 7 years was correct*" [post training survey ID 13].

Two thirds of respondents reported that the training had a positive impact on their recovery, with a higher proportion of the 2022 cohort (78%) describing the impact as positive compared to the January 2023 cohort (57%).[13]

A finding emerged that strengthens the logic of the theory of change: self-confidence has a positive relationship on improved personal and professional outcomes. Trainees in the post-course survey spoke about feeling valued, appreciated and supported in the training environment which in turn increased their own sense of self-confidence and self-acceptance: "*The training helped embed skills which I use a lot. This in turn has helped my own confidence in my role. I feel better equipped to help others and so that simply makes me happy*" [post training

[13] Based on available evidence it is not possible to explain this difference, but it may be linked with the shorter follow up period for the January 2023 cohort when compared to the 2022 cohort, as alluded to by one respondent: "*I think this is difficult for me to answer because the training wasn't completed too long ago; therefore, my mind needs sufficient time to process all the information it took in over four months*" [post course survey ID 21].

survey ID 18]. Another respondent described being better equipped *"in a myriad of different ways"* and how that their increased confidence had been noticed by colleagues. Another spoke of how they changed through the training:

> *"I was extremely hesitant about attending the course as I have always felt conscious about sharing my views within peer groups. I now feel more confident and assured in my role as a peer, I feel that the training has really enhanced my role as a peer, and I am now a more well-rounded peer"* [post training survey ID 30].

For some people the gains from taking part in the course were unexpected, like the trainee who reported feeling re-energised to go back to old hobbies like gardening and going for walks. For others, the training helped build a new and more liberating understanding of personal recovery: *"I now understand it as a continuum - a state of recovery*" [post training survey ID 28] and the training "*Made me realise it was not my fault*" [post training survey ID 24]. The importance of these types of personal outcomes being realised through a professional training course should not be underestimated. It is also of note that such impacts were not limited to trainees who were new to peer or recovery principles, speaking to the quality of this training and its delivery:

> *"I've spent nine years in twelve step recovery but have never experienced as much acceptance and encouragement as I did on this course which has helped with self-acceptance. It has helped me remember that I need to look after myself and not hide that I can have difficulties with my mental health. It's also given me faith that there are people who want to support rather that fix"* [post training survey ID 8].

Discussion of key findings

The final section of this report brings findings together across stepping stones and highlights key takeaways from this evaluation. We discuss some of the broader themes that emerged through the evaluation that did not fit neatly into a specific section of the theory of change as well in the Conclusions and Recommendations section.

Revisiting risks and assumptions

Throughout the Findings section, we highlighted where risks and assumptions were relevant to the theory of change and if the analysis conducted supported them or not. Overall, we found a few risks that were realised:

1. Values do sometimes differ between the employing organisation and peer support training;
2. There is insufficient organisational support for the trainees to fulfil their potential after training; and
3. The training was not an accessible experience for some trainees, particularly those who are neurodivergent.

These risks were not applicable to every trainee but rather affected a subset. For trainees that worked in an organisation that did not embody peer support values, it was challenging to apply the training in an environment that directly contradicted what they had learned in the training.

Regarding accessibility, several trainees spoke of how the course could be made more accessible; these suggestions are discussed in the Conclusions and Recommendations below. Some of the responsibility around accessibility should lie with the organisations that send trainees onto the course. ImROC does provide preparatory support, workshops and training with employers to educate them on their roles and responsibilities towards the people they nominate for the training, with the intention to provide ensure trainees that enter the course have support to access the course as they need to. However, ImROC staff have reported low uptake of this. Generally, it was felt that the training was deliverable online (another assumption), though there were individual preferences for face-to-face.

Other risks and assumptions not explicitly mentioned in the Findings section were reviewed. The risk, “People are not currently at the stage in their recovery journey for reflection, self-awareness and readiness”, was found to be accurate for a very small set of trainees who spoke about feeling distressed as a result of the training. Related to this risk was the assumption that “Personal experience of mental health recovery is an essential component of learning” – this was discussed in the mid-training focus group and trainees agreed that this was the case, though pointed out that essentially everyone has had lived experience of poor mental health or trauma at some point in their lives. It was more important that trainees were further along in their recovery journey to be able to help others as a peer support worker. Additionally, being aware and able to work through one’s triggers was considered a necessity before doing this training and going on to work in peer support.

The assumption, "People with some experience of peer support are better able to understand and apply training", was not directly evaluated but several trainees said in the post-training survey that they wished they had taken this course when they first started the training, as it would have given them a better foundation when starting peer support work: *"I had already been doing the job for 6 months when I did the training, It would have made a massive difference to myself if I had done it before I started the job"* [post-training survey ID 5]. The assumption "Experiential knowledge and understanding generates learning together" relates to the assumption of needing experience in recovery to be able to create learning in the training. This was not specifically evaluated but our findings reiterate that timing of when to take this course is key – the benefits of it are much less if taken too early or too late in a trainee's own recovery and work experience.

The assumptions, "Organisations have grant funding to develop and support peer support workers" and "Trainee has support from supervisor, management, organisation to attend training" were not evaluated as they were out with the scope of the evaluation that focused on trainers and trainees, as it would involve speaking to employing organisations.

Limitations and data improvement

There were a few limitations to this evaluation. The evaluation was primarily limited by a lack of long-term follow-up, which would be helpful in further understanding the 'what they do differently' and 'what difference does this make' sections of the theory of change. The only data that was not collected during or immediately after the training was the post-training survey data from the October 2022 cohort, which followed up with them approximately 5 months after their training ended. Future evaluations should endeavour to continue to follow up trainees to see the wider impact of the training on their lives. This could provide additional evidence for the 'What difference does this make' section of the theory of change.

Other limitations within our evaluation design was the focus on anonymity throughout the data collection. Whilst done for reasons of confidentiality and to encourage openness, having anonymised responses for all data collection meant we could not link responses (and therefore trainees) together across data collection methods. This may have led to some trainees being over or underrepresented in the findings, depending on if they participated in several data collection methods or none. We aimed to include a wide range of quotes across each method of data collection to minimise the risk of this. The anonymity limitation also means that the few negative responses in the mid-course survey, post-course survey and interviews and focus groups may have come from a single or very small group of individuals. However, we were not able to distinguish this.

Another minor limitation included the smaller sample size in the post-training survey (39 respondents) compared to the early-training survey (71 respondents). It could be that enthusiasm for the evaluation waned over time, or busyness of final assessments or peer support roles had commenced. Incentives to taking part such as a small voucher could be provided to encourage participation after the training is completed.

Lastly, we were unable to reach out to trainees who withdrew from the training. Speaking to them and exploring reasons for drop-out or withdrawing could provide further information about

wider contextual factors that impact on lack of success in the training or if the theory of change did not hold and why.

Conclusions and Recommendations

This evaluation has found overwhelming evidence that the Peer Support Training is effective and can make a difference in the way outlined in the theory of change for the majority of trainees. The trainers were highly skilled in their approach and ImROC exemplifies both a top-down and bottom-up embodiment of peer support values. It was clear from this evaluation that ImROC staff are the right people to be delivering this training because this is not straightforward training. There is a great deal of depth, nuance and complexity given who they are seeking to train, the values-based approach and the context which surrounds that training.

A key theme that emerged from this evaluation is that "**one size fits most (but not all)**". The wide range of backgrounds that trainees brought to the course calls into question the appropriateness of having a one-size-fits-all training programme. It might be that there has been a transition over time as peer support work becomes more mainstream and the benefits of the training course (of which there are many) are more widely realised, that the demographic of the course no longer matches with who the intended audience of the programme used to be. Currently, the majority of people who undertook this training programme found that it inspired hope and change in their personal and professional lives. But given the wide variety of experience and background of trainees, from those completely new to peer support to those who have been running their own peer support programmes for many years, a one-size-fits-all approach that introduces peer support at a foundational level may not be the best approach as more trainees are required to do this course as part of their professional training. One example of this became apparent when we interviewed a trainee who had a postgraduate degree in counselling and was required to take the ImROC training with their colleagues at a peer support crisis service. At times, the trainee felt like they were a trainer in the course because of their previous knowledge and expertise in peer support and said they were even mistaken for a trainer during the course.

The evaluation team began thinking of the trainees as fitting **underneath a bell curve** as seen in Figure 8 below. For the majority of trainees in the middle section, the theory of change holds true and they experience a myriad of benefits. For the trainees that fall in the tail end on the right-hand side, they are generally very experienced in peer support and its principles already. They have had several years of work experience; previous trainings in peer support or similar subjects and are generally further along on their recovery journey. These individuals report not receiving as many positive outcomes from the ImROC training as those in the middle group – they said it was nice to get a refresher but oftentimes felt bored or that it was not very useful for them. The group on the lefthand side were generally less experienced with peer support, training or further education more generally and not as far along in their recovery – they reported feeling distressed during difficult conversations during the training and were not sure if they were at a good-enough place to experience positive outcomes in the training. It would be interesting to

evaluate in future work if those that withdrew or did not complete the course were more likely to come out of the 'not ready' group or the 'overly prepared' group.

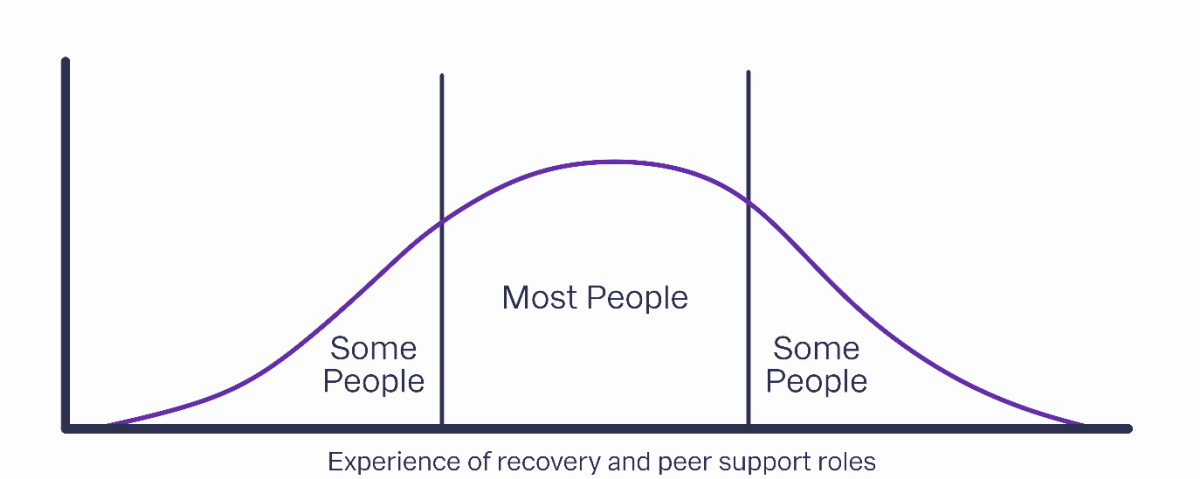


Figure 8. A sample bell curve showing how trainees experienced the course.

To better accommodate the range of experiences and backgrounds of prospective trainees, we suggest a **tiered or levelled peer support training course** that can cater to different audiences. Some of this is currently outside of ImROC's control due to current funding models, but examples of this may include:

- A training for people with lived experience wanting to get peer support roles for the first time or having recently started working in this area.
- Training for healthcare or allied health professionals who want to provide more peer support in their roles.
- Training for advanced peer support principles and more detailed exploration of the academic literature, for those with previous training in similar areas or a significant amount of work experience as a peer supporter.

Improved readiness assessment and screening could also help ensure the training is only offered to those who could benefit and are prepared to take part. There currently is a pre-course survey to assess readiness but ImROC reports that organisations often do not complete this and may push trainees on the course regardless of how prepared they are. It is worth exploring how this survey could be adapted (or even mandated) to better screen potential trainees, and ImROC should consider not accepting everyone who signs on (though this could mean a financial loss). Again, it is important to note that some of this is outside of ImROC's control because current funding models means it is only this training programme that is funded for organisations, whereas other trainings need to be paid for. This model may need revisited to ensure a suitable fit between trainees and the most appropriate training programme for them. One possible solution could be if ImROC played a more directive role in admission to their training, alongside Health Education England's funding covering different courses rather than just the one. This would allow organisations to receive funding for a number of courses and could place their trainee in the most suitable one based on their preparedness.

A key point from our evaluation is that training delivery by ImROC trainers is **highly nuanced, difficult and done to a very high quality**. The challenges trainers face to deliver a course like

this are significant. For example, it seems an inherent contradiction to balance the peer support value of mutuality and non-direction alongside the assumed hierarchy and power as a trainer in a course like this, as one trainer mentioned: *"Actually you can't really be that non-directive as a trainer because you need to facilitate and lead the session and be able to say when people are discussing something and they're getting the values wrong"* [Trainer focus group ID 7]. The trainers are a carefully selected and thoughtful group and given the challenging nature of this role and peer support work generally, trainers from other areas outside of peer support may not be prepared to do this type of relational and sensitive training. The careful identification and nurturing of training talent must not be diminished in the face of increased demand for peer support worker training. It was clear from the evaluation that trainers highlight and show a good awareness of the challenges they face in balancing power in the group. It would be concerning if we did not see this level of awareness in the training and future recruitment should be remain mindful of these sensitivities.

Given some trainers have limited or no experience of being a peer support worker it is perhaps legitimate to query the extent to which they can truly model practices. There were references in the data collection about safety being compromised by less experienced trainers, including those with no practical peer support experience – though trainers stressed that long term safety was not compromised. Trainers pointed out that support and expert advice was always available in the team as well as a "development pathway" to support continuous professional development. One respondent felt it was important that members of the training team retain practice roles: *"it is that one-to-one experience of working with people and practicing the values that really gives an extra layer of confidence and knowing*" [Trainer ID 2].

This raises the question: **Can trainers model peer support practices without direct experience of being a peer supporter previously? Is it or should it be an essential part of the peer support trainer role?** This should be explored further in subsequent evaluation work and ongoing discussions with trainers and trainees. In the meantime, the current model that ImROC has with experienced trainers and trainers with peer support experience always in the session seems appropriate. A future risk may be that as the training grows and the need for trainers continues to grow, the number of trainers per cohort alongside the intensive process to become a lead trainer may be less sustainable. Future models might want to consider incorporating opportunities for trainers to get practical peer support experience on a semi-regular basis to ensure their training approach is grounded in practical, professional experience.

Another recommendation based on key findings are around the use of **breakout rooms in the training space**. We suggest that their use is reviewed, as we heard significant evidence to suggest that for some people these had at time not been positive spaces for learning. We heard from trainees for example that they had been mistaken for trainers because they felt compelled to step in to help discussions remain focused, whereas others spent a long time trying to discern what the tasks for the breakout room were, or other trainees were not participating. While there are advantages to letting the peer group 'get on with it' and practice their new skills in breakout rooms groups, the risk that these spaces if left entirely unmoderated then lose focus or become unsafe is too high for them to be left entirely unmoderated. ImROC has reported that they have tried many different options for breakout room moderation, but maybe this needs to be a live,

flexible tool that varies for each cohort and session based on content. Simple improvements can be made, such as adding the facilitation questions to breakout room chats, regardless. Perhaps there is a middle ground for trainees to raise a flag or moderation be tested, or perhaps specific trainees are asked to lead a discussion in each group to practice facilitation.

As mentioned, one of the key risks that was found to be relevant for some trainees was around **accessibility**. Because of the challenging nature of the topics in this training programme and the relationship between mental ill health with learning disabilities, additional steps to include accessibility for the course should be taken. Examples include:

- Providing presentations, materials and key session questions and objectives beforehand.
- Providing more accessible slides: less text, more images and ensure they can be read with a screen reader.
- Simplifying the information on Moodle and providing additional support to navigate it effectively.
- Alongside this, trainers could provide a document with key points covered in the presentation before or after the session.
- Varied formats for course materials also were mentioned as being potentially useful - such as videos, short readings, audio, etc.
- Additional clarity in the assessments regarding word count length and some of the prompts.

Overall, our evaluation of the ImROC training highlighted the highly skilled nature of peer support work and the need for corresponding training to be done in a sensitive, trauma-informed and recovery-focused manner. The context in which peer supporters work is currently very challenging, as peer support values are often in contradiction with traditional (often medical) views of mental health. The ImROC training programme for peer support workers navigates this complex and nuanced context extremely well and the theory of change was shown to be accurate. The recommendations that arose from the evaluation are mainly to ensure that prospective trainees are appropriately prepared for the training and relatively minor changes to the training format so it is an accessible and beneficial experience for the most trainees possible. Other training programmes for peer supporters should look to the careful and skilled implementation of peer support training by ImROC as an example of excellent practice.

Appendix 1: Scoping review of wider evidence

Introduction

A scoping review of wider evidence and experience of Peer Support Worker training was completed prior to data collection for the ImROC peer support worker training evaluation to inform the approach we took to the evaluation.

The key questions the scoping review aimed to answer were:

1. How do people experience peer support worker training?
2. What are the effects of peer support worker training?
3. How does the training impact on their future practice as a peer support worker?
4. What outcomes have been measured as a result of peer support training evaluations?

Method

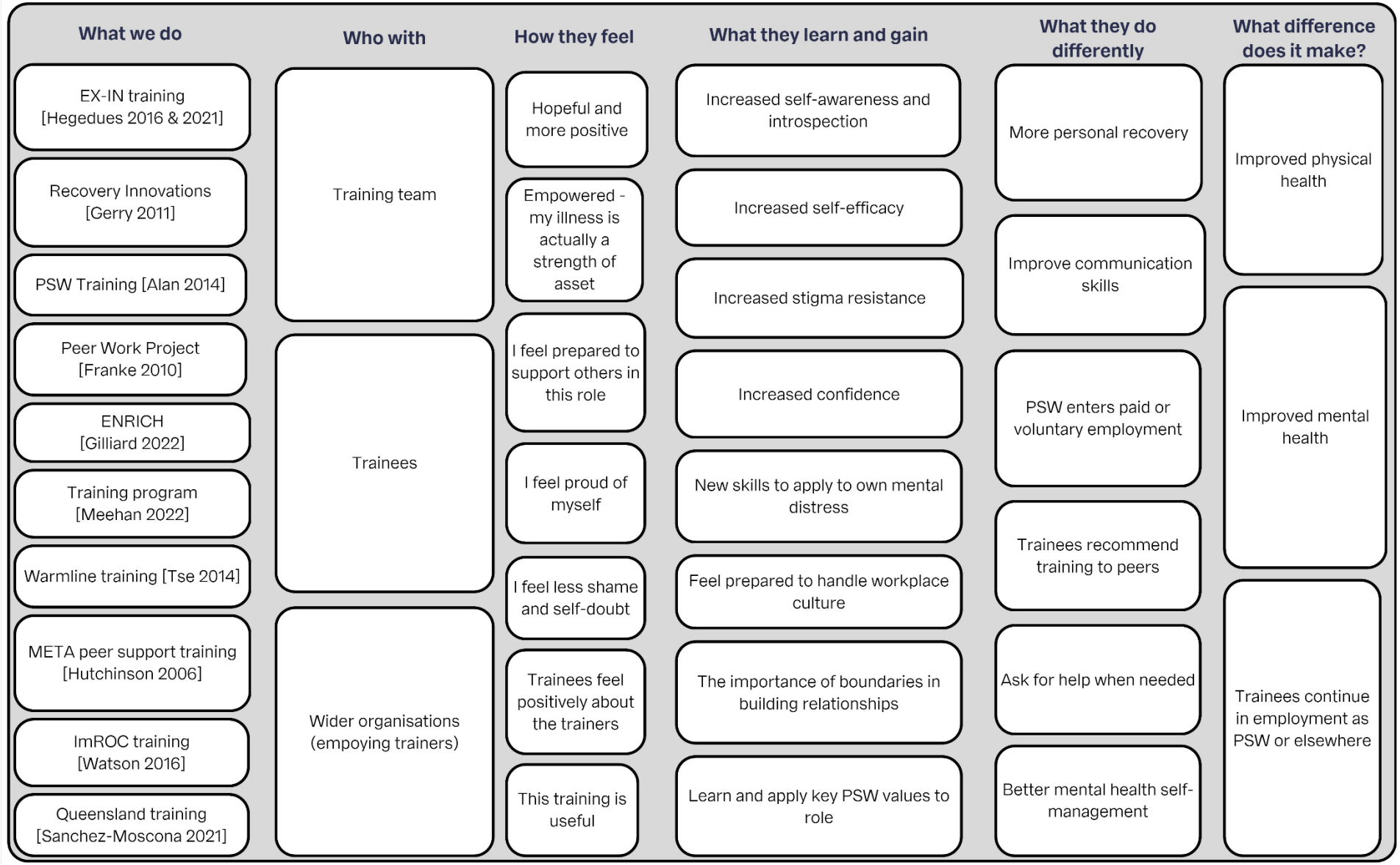
The scoping review was a pragmatic, condensed version of more traditional systematic review methods. To search for relevant papers that answered one or more of the research questions above, a search in Google and Google Scholar was carried out using terms such as "peer support worker training evaluation", "experiences of peer support worker training" and similar evaluations. The evaluation Steering Group were also asked for literature recommendations. The first five to ten pages of Google and Google Scholar were hand-searched by title and abstract. Potentially relevant references were downloaded into reference management software and then a more detailed review was completed. Reference lists of included papers were also searched.

Data extraction took place in OutNav. Outcomes (mainly in the results section of the included papers) were added into the appropriate Matter of Focus headers as stepping stones. For example, if a paper described a qualitative evaluation of peer training and people spoke about feeling more confident as a result of the training, 'Increased confidence' was added into the 'How they feel' header as a stepping stone. Each paper's specific training programme was added into the 'What we do' header.

Results

Our findings are summarised in the form of an outcome map (Figure A.1). We included ten studies which helped us understand how the impact of peer support training has been assessed, and key findings from included studies. Overall, we found that the theory of change developed for the ImROC evaluation reflected previous evaluation findings. We made only minor adjustments to the theory of change based on the findings of the review. We were satisfied that any differences outcomes were explained by the differing contexts within which training was delivered. None the less, this exercise provided a useful means of validation for the ImROC training theory of change.

Outcome map developed from peer support training review



Reference List

Franke, C.C.D., Paton, B.C., Gassner, L.-A.J. (2010) Implementing mental health peer support: a South Australian experience. *Australian journal of primary health*. **16**(2), 179–186.

Gerry, L., Berry, C., Mayward, M. (2011) Evaluation of a training scheme for peer support workers. *Mental Health Practice*. **14**(5).

Gillard, S., Foster, R., White, S., Barlow, S., Bhattacharya, R., Binfield, P., Eborall, R., Faulkner, A., Gibson, S., Goldsmith, L.P., Simpson, A., Lucock, M., Marks, J., Morshead, R., Patel, S., Priebe, S., Repper, J., Rinaldi, M., Ussher, M., Worner, J. (2022) The impact of working as a peer worker in mental health services: a longitudinal mixed methods study. *BMC Psychiatry*. **22**(1), 373.

Hegedüs, A., Burr, C., Pfluger, V., Sieg, D., Nienaber, A., Schulz, M. (2021) Peer support worker training: Results of the evaluation of the Experienced Involvement training programme in Switzerland and Germany. *International journal of mental health nursing*. **30**(2), 451–460.

Hegedüs, A., Seidel, E., Steinauer, R. (2016) Participants' employment status and experiences in the year after the Experienced Involvement training. *The International Journal of Social Psychiatry*. **62**(3), 214–220.

Hutchinson, D.S., Anthony, W.A., Ashcraft, L., Johnson, E., Dunn, E.C., Lyass, A., Rogers, E.S. (2006) The personal and vocational impact of training and employing people with psychiatric disabilities as providers. *Psychiatric rehabilitation journal*. **29**(3), 205–205.

Meehan, T., Bergen, H., Coveney, C., Thornton, R. (2002) Development and evaluation of a training program in peer support for former consumers. *International journal of mental health nursing*. **11**(1), 34–39.

Sanchez-Moscona, C., Eiroa-Orosa, F.J. (2021) Training mental health peer support training facilitators: a qualitative, participatory evaluation. *International Journal of Mental Health Nursing*. **30**(1), 261–273.

Simpson, A., Quigley, J., Henry, S.J., Hall, C. (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom. *Journal of Psychosocial Nursing and Mental Health Services*. **52**(1), 31–40.

Tse, S., Tsoi, E.W.S., Wong, S., Kan, A., Kwok, C.F.-Y. (2014) Training of mental health peer support workers in a non-western high-income city: preliminary evaluation and experience. *The International Journal of Social Psychiatry*. **60**(3), 211–218.

Watson, E., Lambert, M., Machin, K. (2016) Peer support training: values, achievements and reflections. *Mental Health Practice*. **19**(9).