How community based peer support could be beneficial for people at risk of poor mental health and health inequalities in Wigan, with a particular focus on women.

Introduction

Four years ago, I founded Remade Wigan as a Community Interest Company, with an idea of providing upcycling activities to women going through tough times. We're now a registered charity working alongside around 150 women a year, with two workshop sites in Wigan and Leigh, and a team of 5 freelancers. Remade provides a different kind of space to women – not a home, not a workplace, but somewhere that any woman can come to, feel cared for and useful, and give and receive help.

I was fortunate to meet other collaborators on my journey who have invited me into their work and communities, and despite having worked in the voluntary and community space for nearly 14 years prior to Remade, that's meant I've learnt more doing this than ever before. The last few years has given me opportunities to reflect on the inequalities within communities and community work, and how the work is shaped by political and funding priorities that don't benefit a majority. I've thought about how necessary it is to make systems redundant for more community centred work to grow, and how organisations and leadership often reduce community power rather than nurture and support it. I've also thought about my own position within that power imbalance and sought to reduce my own impact within the Remade community.

I was, and am, hesitant to identify Remade as a mental health project, a domestic abuse project, or a creative health project. It gets talked about as all of those things, as the women who attend spaces align to some or all of the traditional perceptions of those topics. I also didn't know much about peer support before I started Remade either, and wasn't sure about calling it that either. The labelling and framing of work has an impact on it's perception, development and placement within and alongside existing systems. When I've talked to other people about peer support, their understanding of what that is varies from person to person, and to mine – and that's led in part to this report where I had more conversations about what peer support can be and what it can do.

My interest in peer support was piqued through an in person visit to People Focused Group (PFG) in Doncaster. The demonstration of how impactful the PFG approach has been on themselves, their neighbourhood and onto the systems around them was significant. They've not only improved the wellbeing of the individuals involved in their

day to day work, but have positively influenced commissioning, training and system development in mental health, anti poverty and disability support around them.

They came over to Wigan to meet some of Wigan's commissioners and professionals, as well as spending time in the Community Corner community. One of the key messages I took from that meeting was the importance of reciprocity in peer support, simply put as 'there are times I can give support, there are times I need it' Subsequent discussions with peer support practitioners showed that mutuality and reciprocity was potentially missing from those relationships in professional peer support services here in Wigan.

Remade exists on a tiny budget, sub £60k on it's most funded year so far, which was 2023-24 largely due to a winter cost of living lottery grant. That means we're a micro organisation, but belong to the 80% of UK registered charities with an income of under £100k. Lots of the organisations making up the local voluntary, community and faith and social enterprise (VCFSE) sector in Wigan are very small. Despite our size, we have significant impact on the communities we sit within – through delivering direct support, preventing people from entering high cost services such as A&E, tier 3 mental health services, from becoming or remaining homeless, activating people's economic potential and alleviating poverty – but also through providing training, employment, consultation and education opportunities and all the other embedded social value actions taken as part of our daily practice. Remade's own social return on investment lies in a range between £17 to £32 return on a £1 investment. The mental health minimum investment spend in GM for 2022-23 was £593 million.

For an individual or a community, contemporary understanding of health is that it's a combination of factors – physical health, environment, occupation, community and mental health. Health inequalities are understood as similarly socio-economic – so a question of why funding itself remains in silo's can't be far from any consideration of health inequality.

This report is funded by a health inequality programme, so it's worth noting now that there is significant inequality within the way funding and commissioning takes place around women's mental health – reducing the impact we can have.

Peer support as a concept straddles a number of social issues. It's not specific to any one area of work, but has been increasingly mentioned as a method of delivery in many borough and GM strategies. Along with 'lived experience', it's a term deserving of thought as the implications and applications of both are far reaching and potentially radical.

I'm largely discussing peer support and it's benefits/negatives through the experience of women I've spoken to. Having a safe space for women is central to Remade – when we started there was one other space in Wigan, now there are two other active projects

offering women only work. We need these spaces because of the high levels of violence against women that oppress women and girls living fulfilling and joyful lives. [i]

I had a number of conversations with women attending workshops about their experience of other services, what they see as helpful and not helpful, and where they found support for themselves. I was fortunate to talk about peer support with people from the Peer Friendly Group in Doncaster, an organisation who have been working on peer support for over a decade. I've explored research around peer support from around the UK and Australia, including a short course on Intentional Peer Support. I've completing an Asset Based Community Development course with Nurture Development. I've had mentorship from Laura Wharton, assistant director of Public Health in Wigan, and received support and mentorship from Angela Fell and Gill Wright from Northern Heart and Soul here in Wigan.

What do we mean by peer support?

Peer support service – two things there, peer support and service. The two are often linked, but there is tension within the two.

When I talk to women and some other grass roots organisations about their experience of peer support, they talk about

'being able to talk about anything without feeling judged'

' other people in the room just get it, I don't feel like the odd one out'

'I'm not always the problem – like, it's not all about me and that helps'

'it's not all about me, I get to help to'

Remade is simply a workshop room where women come and paint furniture, chat and spend time together. We do have some specific groups that have started from this, such as a quilting group, a woodworking group, and a self esteem group supported by an experienced counsellor. There is typically a single facilitator to ensure that any health, safety and safeguarding issues are dealt with, and we pay that person for their time. The workshops don't have a defined schedule, there's no expectation to come for a specific duration, to complete tasks or to attend for a specific number of sessions. We provide tea, coffee, snacks, have a free food cupboard that women can help themselves from. Information about other services is dotted about the room. If someone asks for help and may be supported through a specialist organisation, they are given information about that project and if they want help to get in touch, that's offered too. There's no referral required, we ask women to fill out a form when they're with us so we have an address, an emergency contact and anything they feel we need to know.

Conversations in the workshop have touched on everything from town planning, racism, suicide, responsible dog ownership, home improvements, hoarding, funeral planning, abuse, assault, car maintenance, plastic surgery, debt – there's no limit and no guidance. These come from women talking while they're painting and refinishing furniture. The outcomes have included women moving away from abusive partners, restoring relationships with children, moving house, improving their home conditions to a point where social services aren't involved anymore, sorting out their debt with an advisor, taking better care of their diabetes, going on holiday together, getting back into paid work, staying out of inpatient care at our local mental health unit for over a year, learning new skills and starting their own businesses. This isn't everything – but I wouldn't necessarily know it all. None of this comes through an intervention, or a scheme of work, or a support programme. It's come through conversations with each other, from women as equal peers, supporting one another.

Women check in on each other, socialising outside of the workshop. They've been round to each other's houses to decorate rooms, to help with tip runs, to put up curtain poles. They check in with me if they're worried about someone. We talk about keeping ourselves safe, what our own boundaries mean, where individual responsibility lies and where we can help or harm. This has led to more conversations about what other stuff would help – would it be an offer of support from a specialist service provider?

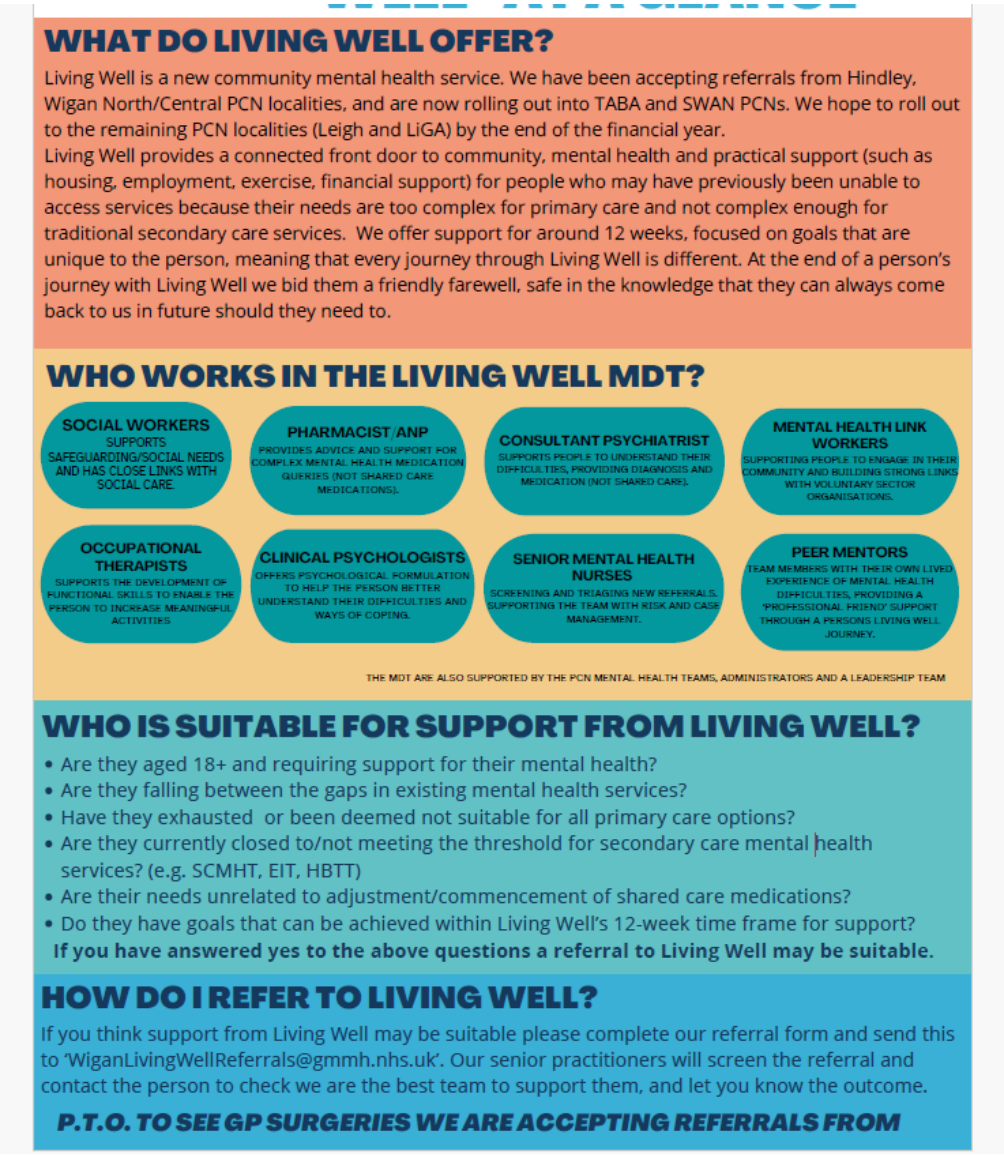
For instance, A is a woman who turns to alcohol when she feels down. This leads to her feeling suicidal and often calling other people to tell them that she's going to kill herself. That obviously feels really harmful for the people receiving the call, they worry about A's safety, and the police have been involved making welfare calls. I suggested that we talk to A about this, offering her more support from people that she wants around her, as an intentional circle of support. This meant that we have a clearer plan, that the responsibility feels lessened by the people around her but A remained supported. As part of this circle they talked to A about a women's only prehab available in Wigan. A chose not to use that, but instead made a weekly plan of action of what she would do on Fridays and Saturdays, the days she would normally go to the pub. Her circle supported her to keep doing that until it became a habit – now she tells us what she's going to do each weekend instead of drinking. She started her own reselling business so uses the money she would have drunk to buy returned goods and resell them. She's now at a point where she has enrolled in a business development course to try to get off benefits completely.

Community Peer Support

You may have noticed I've used the phrase community peer support above – this is because the peer support Remade gives space for is based in the community, not in a service. Services can be really great, but they can also cause harm. It's easy to become reliant on services providing an answer. Cormac Russel and John Knight use the term 'serviceland' as a way of describing what services have become – an 'otherness' to community. *A person lives in a neighbourhood, may have an problem with their child not attending school – services are called in to address the issue. There's a pile of rubbish dumped outside the local playground – call a council team to remove it. I feel hopeless and depressed – I go to the doctor. The high street is so run down, the council should do something about it. This area is so impoverished, we need to invest in more services to come in and fix it*. We're continually conditioned as consumers to accept that we don't have the power, resources or understanding to fix it, whatever it may be. This supports services to continue in growing their power and influence, while communities are disempowered piece by piece.

At the same time as Remade was developing, GMMHS Living Well was rolling out in the Wigan borough. Living Well is a holistic approach to reducing improving mental health support, and looks different in each area of GM[ii]. Living Well brings a multi disciplinary team together to work with people, centring them rather than the more traditional medical model where a person experiences shifts from one service to another. Two of the essentials are to work with VSCE partners in delivery, and to utilise lived experience as central to how the offer is designed, developed and delivered. In Wigan, the Living Well team is made up of social workers, pharmacists, psychologists, psychiatrists, mental health link workers, occupational therapists, senior mental health nurses and peer mentors. The peer mentors are people with lived experience of mental health services, employed by the NHS and given peer support training. A role was budgeted for to be held within a local VSCE organisation, but unfilled so remains unspent to date.

Unfortunately I was not able to access any information about the experiences of people accessing the Living Well service.



WHAT DO LIVING WELL OFFER?

Living Well is a new community mental health service. We have been accepting referrals from Hindley, Wigan North/Central PCN localities, and are now rolling out into TABA and SWAN PCNs. We hope to roll out to the remaining PCN localities (Leigh and LiGA) by the end of the financial year.
Living Well provides a connected front door to community, mental health and practical support (such as housing, employment, exercise, financial support) for people who may have previously been unable to access services because their needs are too complex for primary care and not complex enough for traditional secondary care services. We offer support for around 12 weeks, focused on goals that are unique to the person, meaning that every journey through Living Well is different. At the end of a person's journey with Living Well we bid them a friendly farewell, safe in the knowledge that they can always come back to us in future should they need to.

WHO WORKS IN THE LIVING WELL MDT?

SOCIAL WORKERS SUPPORTS SAFEGUARDING/SOCIAL NEEDS AND HAS CLOSE LINKS WITH SOCIAL CARE.

PHARMACIST/ANP PROVIDES ADVICE AND SUPPORT FOR COMPLEX MENTAL HEALTH MEDICATION QUERIES (NOT SHARED CARE MEDICATIONS).

CONSULTANT PSYCHIATRIST SUPPORTS PEOPLE TO UNDERSTAND THEIR DIFFICULTIES, PROVIDING DIAGNOSIS AND MEDICATION (NOT SHARED CARE).

MENTAL HEALTH LINK WORKERS SUPPORTING PEOPLE TO ENGAGE IN THEIR COMMUNITY AND BUILDING STRONG LINKS WITH VOLUNTARY SECTOR ORGANISATIONS.

OCCUPATIONAL THERAPISTS SUPPORTS THE DEVELOPMENT OF FUNCTIONAL SKILLS TO ENABLE THE PERSON TO INCREASE MEANINGFUL ACTIVITIES

CLINICAL PSYCHOLOGISTS OFFERS PSYCHOLOGICAL FORMULATION TO HELP THE PERSON BETTER UNDERSTAND THEIR DIFFICULTIES AND WAYS OF COPING.

SENIOR MENTAL HEALTH NURSES SCREENING AND TRIAGING NEW REFERRALS. SUPPORTING THE TEAM WITH RISK AND CASE MANAGEMENT.

PEER MENTORS TEAM MEMBERS WITH THEIR OWN LIVED EXPERIENCE OF MENTAL HEALTH DIFFICULTIES, PROVIDING A 'PROFESSIONAL FRIEND' SUPPORT THROUGH A PERSONS LIVING WELL JOURNEY.

THE MDT ARE ALSO SUPPORTED BY THE PCN MENTAL HEALTH TEAMS, ADMINISTRATORS AND A LEADERSHIP TEAM

WHO IS SUITABLE FOR SUPPORT FROM LIVING WELL?

- Are they aged 18+ and requiring support for their mental health?
- Are they falling between the gaps in existing mental health services?
- Have they exhausted or been deemed not suitable for all primary care options?
- Are they currently closed to/not meeting the threshold for secondary care mental health services? (e.g. SCMHT, EIT, HBTT)
- Are their needs unrelated to adjustment/commencement of shared care medications?
- Do they have goals that can be achieved within Living Well's 12-week time frame for support?

If you have answered yes to the above questions a referral to Living Well may be suitable.

HOW DO I REFER TO LIVING WELL?

If you think support from Living Well may be suitable please complete our referral form and send this to 'WiganLivingWellReferrals@gmmh.nhs.uk'. Our senior practitioners will screen the referral and contact the person to check we are the best team to support them, and let you know the outcome.

P.T.O. TO SEE GP SURGERIES WE ARE ACCEPTING REFERRALS FROM

Delivering peer support within a 12 week period paid for by the NHS, advocating for people who may have received less than satisfactory treatment by other NHS teams and services may prove difficult. The time limited period doesn't necessarily allow for a trusting relationship to develop, for people to genuinely begin to share their stories. While the people involved in those relationships, the peer mentors, are genuinely interested in doing the best for the individuals attending, is the system that employs them something that can make changes for the better?

Mutual relationships have generally been extremely helpful in allowing people to reconstruct and rename their experiences and take control of their own recovery (Mead, Hilton, & Curtis, 2001). People are able to share their stories with each other and challenge the extent to which their "learned" stories have been based on social constructs or imposed "truths" (Mead & Hilton, 2001). Rather than either person analyzing or assessing the meaning of the other's story, both people are engaged in a mutually enriching dialogue.[iii]

Much of the research about peer support best practice identifies a number of underpinning core principles.

Reciprocity.

Mutuality

Non directive

Recovery focused

Strength based

Safe

Inclusive

Progressive. [iv]

A peer supporter from Doncasters Peer Friendly Group said that sometimes she needs help, and receives it. It's part of her life to generally be able to take an active role in the community, to lead, to give energy and ideas to others, but sometimes she needs to rest and receive support back. For her, the reciprocal relationships around her mean that there's no stigma in asking for help when it's needed.

Anyone can walk into the Peer Friendly Group, and be welcomed. They've grown from a tiny group of people meeting in a park angry with how they felt dismissed and discriminated against by traditional services, and now occupy two buildings welcoming hundreds of people a year. [v] Everyone is considered a peer supporter within those buildings, whether they're paid or not. They've worked really hard to create a community that helps itself – where everyone feels like part of the community, feels empowered and able to give as well as receive. Their demonstrable impact has been recognised by traditional services, and resources have been relocated into the community because of what PFG has created. I recommend looking at their Safe Space project as an exemplar of partnership delivery in a highly complex mental health space. This shift of power from

serviceland to community is perhaps inevitable, given the impossibility of delivering a good quality, safe and affordable healthcare system in it's current format.

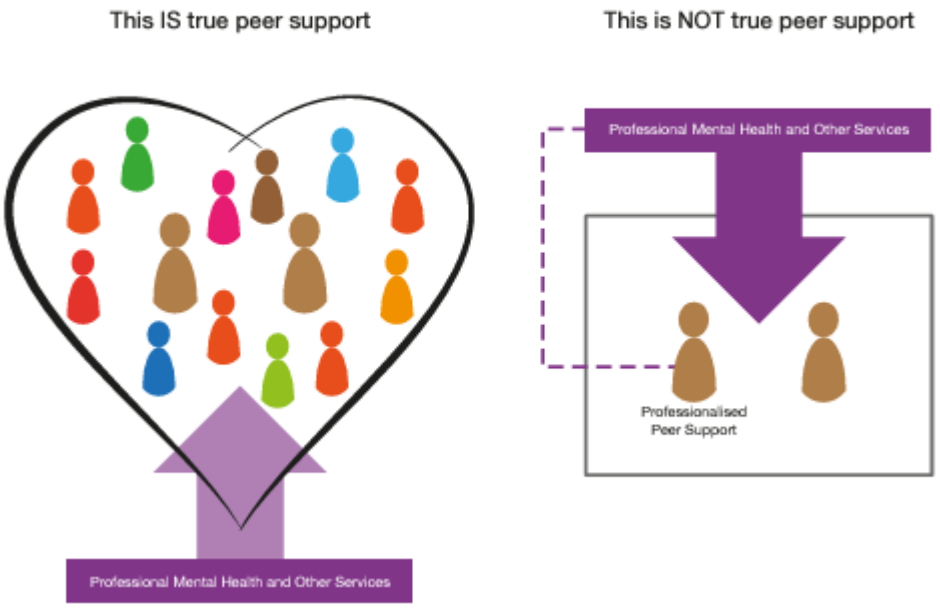
Peer supporters from PFG

Northern Heart and Soul in Wigan started a space called CommUnity Corner, as a way of increasing the level of freely associational[vi] space available to people living in the Springfield and Beech Hill area of Wigan. They welcomed people into the space, and several groups have emerged – Mainly Men on Mondays, a fertility support group for women, crafting on a Friday. They host a peer support group to meet and discuss the learning and development for people who attend the spaces, supporting the community to reflect on what it's function is and can become. Please have a look at what they've been up to this year – as an example of community leading the way. [1]

The risk of professionalising peer support by placing it into a service space, eg the peer mentors in Living Well, is that those peer mentors are NHS employees. As employees, they are subject to the same policies and procedures that can sometimes hinder the delivery of effective support and care. Although peer mentors are encouraged to share their lived experiences, they may simultaneously face the risk of being patronized by the very professionals whose actions contribute to the stigma surrounding mental health. Peer mentors are often positioned at NHS Band 3, while psychologists are classified at Band 8. The disparity in salary can influence the level of job security and confidence a peer mentor may feel when expressing differing opinions in relation to more senior colleagues.

[1] https://northernheartandsoul.co.uk/annual-report-23-24/

When we consider the principles of mutuality and reciprocity, can those relationships grow within the confines of a professional team? Perhaps it actually limits the peer support to the sharing of lived experience, rather than the true giving and receiving of support we see in the community peer support spaces of PFG.



[2]

Risk and Complexity

When we've discussed peer support in the community with people rooted in traditional professional services, their reaction has often been of concern regarding the risks involved. I spent years completing various training in previous roles on professional boundaries – making sure that relationships are clear, that work is left at work. Professional boundaries are often linked to policies and procedures – don't answer your work phone after 6pm, don't talk about your family, don't share your personal experiences, ensure that the interactions are about the person and their support needs. Letting that change into a mutual relationship while ensuring that you don't fall into a trap of fixing people, letting your own resources be drained, being 'triggered' – is complicated and ever changing. So how do we make this work safe?

"It's a misuse of our power to take responsibility for solving problems that belong to other people." - Peter Block

Remade and CommUnity Corner exchange support in what we call a community safeguarding session – where we talk about worries, whether formal referrals to social

[2] Diagram taken from Simon Duffy's report into Peer Support, discussing the risks of professionalising peer support - https://citizen-network.org/uploads/attachment/768/growing-peer-support.pdf

services need to be made, whether someone may be at risk of serious harm. Working where we live offers it's own challenges and opportunities – people in the community know where each other live. Our children go to school with the children of people we work alongside. One of the ways we support ourselves through this work is the ability to trust in each other, to be open and honest about where things are working, and when they aren't. When conflict arises, as it does frequently, is that something requiring intervention or is it something that will generate it's own solution. Having a basis in asset based community development means we start with what's strong, not what's wrong. [3] Being able to step back from a difficult situation and not react, and to have trust that people can solve their own problems without us, is uncomfortable for many people regardless of your background.

Do we really trust the people we work with to do the right thing?

As part of the Fairer Health for All Fellowship I completed a foundation in Public Health. During break out rooms discussing case scenarios involving principles of public health, I heard other attendees who were from health and statutory services saying

'but it's not like we could trust a community group to say the right thing so we'd have to be there'

'they (families) just don't know any better, its up to us to tell them what to do'

I found that problematic to hear that lack of trust in the community those attendees serve. The workshop women often talk about their experience of unreliable health and statutory services.

'that mental health team don't care one bit, they never turned up when they were supposed to'

'the doctor prescribed me more of these but that would take me over the limit that anyone's allowed to take, I read the leaflet in the packet thank god'

Addressing this lack of trust on both sides is essential in reducing health inequalities. Within the relationships in Remade, trust means that we can support one another in a genuinely respectful and responsible way. It's ok for someone to say no, to set a boundary for themselves. Telling someone that you don't agree with their behaviour doesn't result in a breakdown of those relationships. Having trust also means that women are more likely to share aspects of their lives that they may keep hidden, such as substance use, domestic abuse, caring difficulties – all of which are supported when discussed, with women finding solutions through telling their stories and sharing experiences.

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[3] **TEDx Exeter Talk, *Sustainable Community Development: From what's wrong to what's strong* at https://youtu.be/a5xR4QB1ADw.**

Trust has been identified as a key component in reducing health inequalities[vii]

Trust is multi dimensional and worthy of reflection in and of itself – a recent consultation in Edmonton raised lack of trust as a barrier to health equity, and identified lack of trust on both sides (community and service) as a problem. [viii]

Being able to reflect on your own interactions and impact is something that may need support. That might look like formal therapy, creative health activities, external supervision – centring healing spaces within community is an essential element to resource and not to be overlooked. Trust reduces the complexity of community based peer support – it's still hard work, but worth it.

What's this got to do with health inequalities?

There's a growing amount of evidence saying that peer support can be a sustainable approach to improving mental health at an individual, community and population level. When considering the transformation and reformation of mental health services, community based peer support can play a large part. As noted above, professionalised peer support may be only offer an adaptation of the status quo, rather than something genuinely different.

High waiting lists for mental health support services, and a lack of trust within those services to provide sustainable and meaningful support – one woman said *'I waited for ages, saw someone and told them everything that was going on, and then last week was told it's our 8th session and there's no more support, that's it – what am I supposed to do now?'*

Some of the risks to community based peer support are coming from traditional health and resourcing structures, and these could at best reduce the effectiveness of what our community can offer, at worse create long lasting harm within a community. Being able to show the benefits of letting a community deliver it's own mental health support, to provide a seed of genuine cultural change to sway commissioning away from traditional structures, could lead to a tangible outcomes not only for individuals, but for neighbourhoods and communities.

There is a wealth of evidence for the economic value of a range of prevention activities to promote good mental health and reduce the impacts of poor mental health. The original economic case for prevention was created in 2011 (Knapp, McDaid & Parsonage 2011) updated in 2017 by LSE, which showed an ROI range between £1.26 and £39.11 per £1 spent on prevention activities.

Peer support occurs within those prevention activities, but perhaps has been overlooked as a critical element that creates the positive outcomes experienced.

Wigan has high levels of deprivation as measured on the indices of multiple deprivation – relevant to our discussion regarding mental health as evidence from GM shows:

people from deprived areas have a higher use of secondary MH services that those from less deprived areas.

Females also have a higher referral rater into secondary MH services than males.

People from deprived areas have worse talking therapy outcomes than those from least deprived areas, as do women.

Women attending Remade have formed lasting connections within the community, have reduced attendance at crisis services, have gone into work, feel less unwell and report sustained higher levels of wellbeing than before being in contact.

The medicalisation and commodification of wellbeing, and onus on personal responsibility, is a contemporary assumptive model that is largely unquestioned. Andy Burnhams' hubs and social prescribing models and Living Well MDTs all play to tradition, where systems, professionals and policy makers have a solution, rather than solutions emerging from the relevant communities.

In Conclusion

Community based peer support is more sustainable that a professionalised version. Having a diverse range of associational spaces where people can connect with one another leads to a myriad of changes within people's individual lives, as well as their community lives. Holding these spaces within a traditional service model (eg health, statutory authority) removes opportunities for reciprocity and iterative growth.

The ripples coming through people coming together in agenda-less spaces such as Remade and Community Corner can be categorised as positive outcomes in reducing health inequalities.

Women come together in the Remade workshop and say 'this is my antidepressant' 'you've no idea how depressed I was before, I'm a changed person'

Women go from seeing themselves as a collection of issues (repeated sections, psychiatric diagnosis, experiences of abuse, substance use, homelessness, criminality, long term health conditions etc) to women who introduce themselves to new attendees with their names and what they're proud of, giving reassurance and listening space to others freely.

The potential for funding spaces such as Remade and Community Corner independently through asset acquisition, trading and social enterprise, means that the

resource requirements reduce over time – rather than increase as they would within Living Well. The Joint Forward Plan proposes a 5% increase year on year for adults to be supported within community mental health teams – which means more 'peer support workers' to deliver those 12 weeks of support.

With a limited pot of money to support communities around mental health, if commissioning could trust communities to deliver solutions using a peer support approach, I believe we could see a genuine transformation in mental health support that would reach the populations experiencing greater health inequity in Wigan and beyond.

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[i] https://w https://kareningalasmith.com/2020/01/20/the-importance-of-women-only-spaces-and-services-for-women-and-girls-whove-been-subjected-to-mens-violence/ & www.unfpa.org/sites/default/files/resource-pdf/UNFPA%20UNFPA%20Women%20and%20Girls%20Safe%20Spaces%20Guidance%20%5B1%5D.pdf

[ii] https://www.innovationunit.org/projects/greater-manchester-living-well/ https://hub.gmintegratedcare.org.uk/mental-health/wp-content/uploads/sites/6/2023/02/Living-Well-in-Greater-Manchester_-a-Guide-Version-1.pdf

[iii] https://www.intentionalpeersupport.org/wp-content/uploads/2014/04/CrisisAndConnection.pdf

[iv] https://citizen-network.org/uploads/attachment/768/growing-peer-support.pdf & https://www.derbyshirehealthcareft.nhs.uk/application/files/6816/5512/3758/The_eight_core_principles_of_peer_support.pdf & National Association of Peer Supporters (2019). National Practice Guidelines for Peer Specialists and Supervisors. Washington, DC: N.A.P.S. & Intentional Peer Support by Shery Mead

[v] https://peoplefocused.org.uk/people

[vi] If you're wondering what a freely associational space is, consider where you are able to go where you don't spend money, and don't have to follow an agenda belonging to someone else? A space where community can emerge from and grow. https://www.researchgate.net/publication/266620692_Creating_Sense_of_Community_The_role_of_public_space

[vii] Lansing, A.E., Romero, N.J., Siantz, E. *et al.* Building trust: Leadership reflections on community empowerment and engagement in a large urban initiative. *BMC Public Health* **23**, 1252 (2023). https://doi.org/10.1186/s12889-023-15860-z

[viii] https://www.newlocal.org.uk/wp-content/uploads/2023/01/Community-Powered-Edmonton-Report-Final.pdf

If you would like to hear more about community peer support please go and watch this film featuring Simon Duffy talking about PFG:

https://peoplefocused.org.uk/library/the-value-of-peer-support