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Training mental health peer support training facilitators: a qualitative, participatory evaluation

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ABSTRACT

The facilitator's training for Peer Support Workers in Mental Health course was a recovery-based initiative addressed to professionalize peer support in Catalonia, Spain. Our aim was to elicit participants' motivations, significant learnings, and opinions regarding the training programme. A qualitative approach was used through content and thematic analyses of the course contents and participation narratives. The motivations to attend the course were helping others, learning, and supporting the implementation of the peer support profession. Participants learnt concepts on pedagogy, peer support and recovery. The key themes were organisation and moderation; peer support's role, skills, functions, and values; language; health system knowledge; and types of support. The course programme seems appropriate in preparing people who have lived experienced of mental health problems as facilitators of future peer support training courses. The present analysis identifies the participants' vision regarding their learning needs. It aims to serve as a guide for similar train-the-trainers courses.

KEYWORDS: peer support, recovery, mental health, training, train-the-trainers, qualitative analysis, thematic analysis, content analysis

INTRODUCTION

In the 1990s the foundations for a new vision based on personal recovery in mental health service delivery was proposed (Anthony 1993). As reflected in the first ever released US Surgeon General's mental health report (Satcher 2000), according to this vision, services' objectives should not be limited to the reduction of symptoms, but should strive to restore a productive and meaningful life. Recovery was defined as a personal, unique and multidimensional process of changing one's attitudes, values, feelings, goals, abilities and/or roles leading to living a satisfying and hopeful life, despite the potential limitations caused by disorders (Anthony 1993). It can also be understood as the process of learning to live with one's disability and gradually rebuild and develop a new meaning and purpose for life (Davidson *et al.* 2006).

Recovery covers both internal conditions (attitudes, experiences and processes of change of the persons who are recovering), as well as external ones (the circumstances, events, policies and practices that facilitate recovery; Jacobson and Greenley 2001). Thus, the core principles of the recovery movement are that people with mental disorders can lead productive lives even while experiencing symptoms, and that most of them, if supported adequately, will recover from their disorder (Davidson 2016).

BACKGROUND

Besides fostering changes in service delivery carried out by traditional mental health providers, the recovery movement introduced interventions led by people who had experienced mental illness themselves (Davidson 2016). These include self-help or mutual support groups, consumer-operated services, and peer support (Ahmed *et al.* 2012). Peer support consists of interventions promoting recovery provided to people diagnosed with mental health problems by people who have also had lived experience of emotional suffering.

It is based on psychological theories of change rather than biomedical models of disease, considering that the social proximity of peer support workers promotes motivation, provides an upward social comparison and increases understanding of one's situation (Lloyd-Evans *et al.* 2014). This type of support increases social networks and offers acceptance, support, understanding, empathy and a sense of community, which increases hope, autonomy, self-efficacy and the assumption of responsibilities (Bradstreet and Pratt 2010). Thus, peer support allows the adoption of valuable social roles, no longer restricted to the passive patient's role (Davidson *et al.* 2006). Furthermore, it can be implemented at low cost and maintains its utility combined with traditional care (Ahmed *et al.* 2012).

The tasks that peer support workers (PSWs) perform can be of direct or indirect support to other people with mental disorder experiences (Jacobson *et al.* 2012). The direct tasks include a wide range of activities: advocacy (providing the user with information and support), connecting to resources (connecting the user to the desired services), experiential sharing, building community (connecting to programmes that link the user to the community), relationship building (developing trust with users), group facilitation, skill building and goal setting, socialisation and self-esteem development. As indirect tasks, we find administration, team communication, supervision and training, receiving support, education, and information gathering and verification. On the other hand, PSWs also carry out tasks focused on building relationships with professionals and legitimizing the PSWs' role (Gagne *et al.* 2018). In this way, PSW are required more than lived experience of emotional suffering to perform their duties. Key characteristics that promote the effectiveness of the PSWs' interventions are their lived experience of recovery and resilience, a respectful approach, genuine presence, modelling, collaboration and commitment (Jacobson *et al.* 2012).

Peer support has been extensively implemented in the Anglo-Saxon and German speaking contexts. In the last decade it has been extended to other regions, although the professionalised

practice of peer support is currently only fully implemented in developed countries (Puschner *et al.* 2019). Organisational culture, specific training and role definition have been identified as the main factors facilitating peer support implementation in statutory mental health services (Ibrahim *et al.* 2020). Conversely, in addition to controversies about the empirical legitimation of peer support interventions (Pitt *et al.* 2013, Lloyd-Evans *et al.* 2014, Davidson *et al.* 2018, Jaffe 2018), some problematic issues associated with peer support have been identified. Problems that hinder the integration of PSWs in staff teams are related to negative attitudes towards the recovery approach by other professionals, conflict and role confusion, lack of policies and practices regarding confidentiality, poorly defined work structures and lack of support and networking (Gates and Akabas 2007). As strategies to improve the employment of peer support staff, some authors recommend establishing structures, policies and practices that guide the recruitment of PSWs and help define their position more clearly. All in all, the incorporation of peer support staff only makes sense if other professionals working together with them, such as doctors, psychologists and nurses, are motivated to accept them as part of the team (Eiroa-Orosa and Rowe 2017).

In the international context, a systematic review carried out recently (Ibrahim *et al.* 2020) focused on determining the factors that facilitate or hinder the implementation of PSWs in mental health systems, identified as factors that need to be considered organisational culture (including role support) and staff attitudes. Also recently, the UPSIDES initiative (Using Peer Support in Developing Empowering Mental Health Services), an international community of research and practice for peer support was established (Puschner *et al.* 2019). It includes PSWs, mental health researchers, and other relevant stakeholders in eight study sites across six countries in Europe, Africa, and Asia. This project aims to leverage the expertise of people with lived experience of emotional suffering in high-, middle- and low-income countries. However, literature on training evaluation is scarce as, to date, most of the research effort in

this field has been devoted to testing the effectiveness of the interventions and their contextualisation in mainstream services.

In the Spanish context, the implementation of PSWs is still an incipient field, with some experiences in training and temporary recruitment of PSWs. However, there are survivor and anti-stigma mental health organisations with wide territorial implementation. Additionally, healthcare institutions and providers have shown a very receptive attitude and are beginning to allocate resources to PSW implementation projects (Eiroa-Orosa and Rowe 2017). In this incipient scene, it is appropriate to start training people who can serve as future trainers if institutional initiatives are to be launched. In this context, the facilitators' training of Mental Health Support Worker Course was an initiative that intended to professionalize this professional role in Catalonia (one of the most populated Spanish regions, located in the northeast of the country). Its objective was to provide participants with tools and skills that promote other people's learning, through the acquisition of knowledge about pedagogy, peer support and recovery. Following a participatory methodology, the course included final debate sessions on the learnings acquired.

The present work consists of a qualitative analysis of the first train-the-trainers course carried out in Catalonia. Our aim was to evaluate the impact of the training activities, eliciting participants' most significant learnings and opinions regarding the programme.

METHODS

Participants and procedure

Prior to the beginning of the course, an informative email was sent to the main mental health advocacy organisations in Catalonia (*Veus, Salut Mental Catalunya* and *Obertament;* the local, survivors', relatives' and anti-stigma organisations respectively), who forwarded it to their members. It included a course registration form including sociodemographic information, as

well as two text boxes for motivations and expectations, which was filled out by 43 potential participants. Twenty participants attended the information session and between 10 and 20 participants attended the rest of the training sessions ($\bar{x}$ = 16).

The training sessions took place between November 2017 and February 2018 on Thursdays from 3pm to 7pm at the University of [blinded] School of Psychology and was free of cost for participants (funding was obtained from public and private institutions for its implementation and evaluation, please see funding section). The course consisted of 14 sessions divided into four blocks: 1) pedagogy applied to peer support training, 2) basic concepts of peer support, 3) debate on the agenda in the Catalan mental health system and 4) farewell and evaluation. After each session, participants received a form in which they were asked to detail the lessons learnt in each one through a text box. One of the six moderators of the course facilitated each session and a participatory learning methodology was followed. At the end of the course, a final evaluation took place, where all participants developed a topic of their choice from the ones given in the course. Each of them performed an oral presentation and were evaluated by two of the six moderators. See table 1 for further information.

All participants signed informed consent and were given information about the study. The protocol of the study was approved by the University of [blinded] Institutional Review Board [IRB: blinded]. Participants gave their consent to the use of the form contents and the recording of the debates. The results were subsequently shared with them.

Table 1.

Structure of the course by blocks and sessions.

Blocks	**Sessions**
1. Presentation	1. Presentation
2. Pedagogy applied to peer support training	2. Pedagogy applied to recovery. Lecture methodology. 3. Pedagogy applied to recovery. Participatory methodology. 4. Group dynamics. 5. Role Playing.
3. Basic concepts of peer support	6. Accompaniment and mutual aid groups. 7. Rights. 8. Language and communication. 9. Risks and limits
4. Debate on the agenda in the Catalan mental health system	10. Comparison of training models. 11. Discussion session. 12. Discussion session.
5. Farewell and evaluation.	13. Farewell. 14. Final evaluation.

Analysis

We carried out a qualitative analysis, considered suitable for emerging areas and exploring personal experiences (Suter 2014). The analysis was carried out based on the forms filled out by participants and the audio recordings of sessions. Participants' motivations and expectations prior to the course, lessons learnt and key exercises carried out in each session were analysed through a content analysis (Bonoma and Rosenberg 1978), in which responses were categorised using a spreadsheet. The three discussion sessions were transcribed and analysed thematically (Braun and Clarke 2006) using ATLAS.ti. The analysis of the numerical student's final evaluation marks consisted of calculating the arithmetic means of the scores obtained by the participants.

RESULTS

The following topics include participants' motivation prior to the beginning of the course, lessons learnt in each session, a debate on the different model possibilities and a final evaluation.

Motivation to participate in the course

Prior to the beginning of the course, participants were asked what motivated them to sign up for the course and what they expected from it. Their motivations varied between helping others, learning, supporting the implementation of the PSW role and the possibility of a future job. Their expectations were similar to their motivations; participants hoped to learn, to be able to apply what they would learn by helping others, to promote peer support, to have professional prospects and/or have fun and meet other people. For a more detailed analysis, see table 2.

Table 2.

Participants' motivations and expectations prior to the course: definitions, examples, and frequencies.

	Categories	Definition	Examples	N	%
Motivations					
	Helping others	To help other people who have mental disorders.	To help people that, like me, have a mental disorder.	20	43.48
	Learning	To increase knowledge related to mental health.	To learn more about mental illness and intellectual disabilities.	19	41.30
	Improving the mental health system	To support the implementation of the PSW's role and promote the rights of people with disorders to improve the mental health system.	[…] I have the conviction, like many of us, that the attention to people who use mental health services must change urgently and that the worker's role is crucial and indispensable.	5	10.87
	Laboral future	To acquire tools to work as a PSW in the future.	[…] to gain experience, both personally and in a future job.	1	2.17
Expectations					

	Learning	To acquire knowledge, tools, and skills related to peer support in mental health. To be trained to help others.	To learn mutual aid strategies and resources.	38	84.44
	Applying one's knowledge	To help other people who have mental disorders by applying one's knowledge.	To get more prepared to help people with a mental health diagnosis, to have tools to empower them in a real and effective way.	14	31.11
	Laboral future	To promote the PSW's role in order to work as one in the future.	(I expect) to get a training so that, in the future, I can practice in an environment that I like and that fills me as a person.	4	8.89
	Having fun and meeting other people	To have fun and meet colleagues with similar experiences and interests to your own.	To share experiences and to learn from colleagues.	3	6.67

Learnings of each session

After each session, participants were asked to fill out a form in which they could detail their learnings from that session. Since the first session was an introduction to the course, no form was requested to be filled out. The categories extracted from the analysis of these forms are presented below, preceded by a brief description of each session. For a more detailed analysis, see supplementary table 1.

Sessions 2 and 3: Pedagogy applied to recovery

Description

The central axis of these sessions was to understand the approach to recovery in mental health, the key concepts and the factors involved. In session 2, the traditional and inverse teaching models (King 1993) as well as the concept of learning objectives and its classification (Bloom *et al.* 1956) were introduced. Then, a lecture on recovery was made as an example of a traditional teaching model. In session 3, the same contents were developed, but using a participatory approach using an inverse model. In addition, in the form provided after session 2, an exercise was included in which participants had to write some learning objectives about a hypothetical session on the recovery mental health approach. In session 3, an exercise on the CHIME model (Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment) was carried out (Leamy *et al.* 2011). In this exercise, participants had to link facets of their life with the mentioned five recovery dimensions. Both exercises are also included in the following analysis results.

Analysis of self-reported learning

Session 2: lecture methodology

In this session, participants reported learning about basic pedagogical concepts, the two learning models (traditional and inverted) and their differences (n=7).

> "I have learnt to name the different stages of learning […] (and) that (learning) is used in a pyramidal system […]. I have learnt that if we start from the top in this same model […], we get a learning model that starts from experience […].

They also learnt what learning objectives and its application are (n=7).

> "Bloom's Taxonomy, its application and how the traditional and inverted models work."

Some of them additionally understood the recovery concept (n=3).

> "Understanding the magnitude of the recovery concept."

Session 2: exercise

Most participants identified empowerment as a learning objective of a hypothetical session on the recovery philosophy in mental health (n=8). Regarding empowerment, they referred to acceptance and awareness of the disorder, hope and confidence in the environment, involvement in the process itself, changing attitudes, improving the relationship with the environment and/or fighting stigma.

> "For me, recovery is to regain expectations for the future, even if they are not the same that I used to have. It is to hope again, train and empower yourself. To have a good relationship with the environment, either family, friends, neighbours or professionals […]."

In other cases, they referred to the concept of recovery as a learning objective, as well as to understand its terminology, its principles, and its criticisms (n=5).

> "To detect the main incentives of the philosophy of recovery in mental health […]."

Some participants considered as learning objectives to be healthier (n=2),

"[...] (to get) good sleeping, eating and exercise habits in order to stay stable. To do some intellectual activity to exercise the brain, and for me, to take the medication."

while others referred to learning models such as the CHIME scheme (Leamy *et al.* 2011) and/or Bloom's taxonomy of learning objectives (n=3).

"I would use the CHIME scheme […] to create recovery tools."

Finally, some mentioned the praxis or application of their newly acquired knowledge as objectives (n=3).

"I would apply pooling activities and group discussions."

Session 3: participatory methodology.

After the third session, participants reported the consolidation of the contents of the previous session as main learnings: the learning models, Bloom's learning objectives taxonomy and the basic concepts of recovery (n=6).

"I learnt about recovery and how to transfer knowledge to students in a dynamic way."

Others learnt that recovery is an individual and unique process (n=4),

"[...] We were all able to analyze the path to recovery, both our own and that of our colleagues. This lets us better understand recovery and know that it is a path that does not have a single way, but that there are as many forms of recovery as people recovered from a mental disorder.

the importance of the recovery movement's history (n=3)

"To be aware of the relevance of the historical background of the recovery movement."

and/or expressed one or more factors that promote recovery: self-knowledge, hope, voluntariness and sharing experiences (n=5).

"[…] recovery emerges from hope, is self-driven, […] is supported by peers. It is promoted through relationships and social networks, […] it involves individual, family and community strengths and responsibilities."

Most acquired different tools to facilitate a session, such as knowing how to set good learning objectives and apply the CHIME model (Leamy *et al.* 2011) (n=9).

"[…] It gave me guides / tools to carry out a dynamic session in which, in addition to remembering and memorizing, we were all able to analyze the path of recovery, both ours and of our colleagues."

CHIME exercise

Connectedness

Most participants identified their personal relationships with their friends, their families and/or their couples as elements that promoted their recovery (n=14).

"To get back in touch with family and friends."

Half of them said that activism and peer support groups boosted the connectedness factor of their recovery (n=9).

"To get started as an activist; working with a team of people who have been diagnosed (like me)."

Others believed that their relationship with health professionals (psychiatrists, psychologists, and nurses) encouraged their recovery (n=2).

"[…] (the) doctor that listens to you, psychologist, nurse."

Hope and optimism about the future

Regarding this factor, participants considered that resuming old or adopting new activities and relationships promoted their recovery (n=5).

“To try to normalise my life, doing activities and having different relationships than I had.”

They also mentioned as factors that encouraged their recovery witnessing others’ recovery (n=3),

“"I'm not the only one". To meet people in Obertament [the Catalan anti-stigma campaign], people who were like me, (that) did not know anyone.”

relying on the recovery process itself (n=7),

“To have the mantra "everything happens", "I can be better", "I will get out", "I want to be well".”

and having an active attitude and being independent (n=3).

“To have dreams: being able to be self-sufficient.”

Identity

Some participants considered that personal growth and rebuilding their lives (by studying, working, or carrying out activities related to personal interests), helped them recover (n=8).

“To rebuild my life/future, to improve myself personally.”

Others highlighted instead feeling liberated from the diagnosis (n=8)

“To accept that the disease is not all of me (I am more than a mental disease).”or self-knowledge and self-esteem (n=2) as key factors for recovery.

“Self-love, inner strength to overcome obstacles and difficulties.”

Meaning in life

Regarding meaning in life, participants commented having a greater acceptance and understanding of their own situation (n=7)

“When I read for myself, I learnt about mental illness and talked to my friends about it”

promoted their recovery. From a spiritual point of view, they considered that self-knowledge, self-esteem and finding a meaning in life encouraged recovery (n=6).

"Finding a meaning in life […]."

In addition, some also highlighted as a recovery factor being able to see the disorder as an opportunity (n=5).

"To convert what I felt, which curtailed my development(illness: divorce, no children, loss of profession), into a stimulus to help others."

Empowerment

For most participants, autonomy, and empowerment promoted their recovery (n=13).

"Self-esteem and the desire to break with labels, show me that stigma is not absolute. And focus on what I am capable of achieving".

In addition, gaining more responsibility and commitment to work or volunteer, for instance, empowered some participants (n=5).

"Commitment to volunteering."

Others felt more empowered by being aware of their strengths and limits and setting acceptable goals (n=6).

"To meditate, fight, consider qualifications and assumable goals, apologize and forgive."

Session 4: Group dynamics.

Description

At this point of the course, once having explored the recovery concept and its related factors, the management of group dynamics were introduced. This session's importance was highlighted since group dynamics were the train-the-trainers basic tool.

Analysis of self-reported learning

In the fourth session some participants (n=3) highlighted Maslow's (1943) hierarchy of needs (including physiological, safety, belonging and love, social needs or esteem, and self-actualisation), their importance and reflections on the ultimate goal to reach self-actualisation.

> "The importance of the basic human needs and how having them covered allows us to advance towards self-actualisation […]."

Others acquired knowledge about emotional intelligence and the different ways of managing emotions (n=3).

> "[…] I learnt what emotional intelligence is, to know how to work things that happen depending on our emotional attitude and to name emotions, or a chain of emotions."

Finally, most participants learnt aspects related to group dynamics, such as the concept, the types and techniques, their usefulness and potential or the skills that a good facilitator should have (n=6).

> "Besides learning about new group dynamics, I learnt their importance and that they are not meant to pass the time. (I learnt) that they serve, for example, to get to know each other and ourselves better, to empathize, to assimilate concepts, to promote communication, to break the ice, […], etc. And that there are dynamics of various qualities, such as to introduce oneself, to study cases, to debate, etc. [...] We extracted conditions and aptitudes a good moderator must have, such as being empathic, communicative, knowing how to identify needs or particularities of the people in the group, knowing how to play, not judging, etc".

Session 5: Role Playing.

Description

In session 5, role playing was introduced as a tool to facilitate the learning of theoretical and applied contents. It was also discussed how it might help analysing and assessing one's self and others behaviours.

Analysis of self-reported learning

In this session participants reported learning to perform and participate in a role-playing activity (n=8);

"Staging, putting into practice a situation where an PSW and a user intervene, to see what issues arise or appear"

to search for alternatives and reflect during and after a role playing (n=3);

"[…] To analyze and draw conclusions together and thus widen and enrich our particular vision."

and to get closer and connect emotionally with observers while improving one's emotional management. (n=3).

"How to connect emotionally based on our own experience without falling into directivity, the expert's trap or frivolizing."

In addition, some participants reported learning some basic concepts of peer support, such as the characteristics the worker must have or that the support must be carried out in an empathic way (n=3).

"How to carry out mutual support based on empathy and not on sympathy."

Session 6: Accompaniment and mutual aid groups.

Description

The sixth session was based on the various forms of peer support, distinguishing accompaniment as defined by Watkins (2015) from mutual aid groups and focusing on the limits and the ethical code to be followed.

Analysis of self-reported learning

In this session participants reported learning concepts related to peer support (n=5),

> "The values of peer support. How to face the interviews with other "disease colleagues" using empathy and the mistakes that we shouldn't make."

such as recovery's values and principles, knowing how to help, the different ways to accompany and communication skills. They also learnt to identify and work with the workers' positive attitudes (n=3)

> "[…] knowing how to identify a correct and positive attitude, both the facilitator's and the peer support worker's, compared to a less constructive one."

and how to work in a team (n=3).

> "[…] to meet colleagues, […] to share, […] teamwork, etc."

Session 7: Rights.

Description

The focus of this session was to work and reflect around the tools available for respecting mental health users' rights, preferences, and wills. These tools include advance decisions and advance statements. Both tools pursue that the service users can express their wills and decide beforehand about their healthcare process. They differ in the fact that advance decisions are legally binding, while advance statements are not, although professionals have anyway the

moral obligation to fulfil them (Lynch *et al.* 2010). Some legal aspects, such as The Convention on the Rights of Persons with Disabilities and the legal framework in Catalonia and Spain were discussed.

Analysis of self-reported learning

In this session participants reported having learnt about rights and mental health (n=7),

> "To exercise social rights provides empowerment, self-esteem and promotes recovery. [...] The different rights that we, those affected by a mental disorder, have. Confidentiality of the clinical history. The directives and planning of advanced decisions […]."

highlighting their benefits and importance. In some cases, they referred to rights in general terms, while in others they specifically referred to confidentiality and anticipated wills. Most participants also reported the legal framework and conventions that define the rights of people with disabilities (n=7).

> "The legal framework that we have nowadays and the tools that it offers us:
>
> The Convention on the Rights of Persons with Disabilities (2006, UN).
>
> Law 21/2000, of December 29th, on the information rights related to the health and autonomy of the patient, and clinical documentation (Catalonia).
>
> Law 41/2002, of November 14th, basic regulation of patient autonomy and of rights and obligations in relation to information and clinical documentation (Spain) - The Document of Advance Directives and the Health Care Ethics Committees."

Some also underlined as a significant learning the discussion of real cases (n=2).

> "[…] I also found out about real cases of people with diagnoses."

Session 8: Language and communication.

Description

The aim of the eighth session was to learn appropriate language skills to establish respectful and mutual relationships with mental health service users. Another objective was to learn how to convey its importance, by mastering verbal and non-verbal communication tools, using active listening and recovery-oriented vocabulary.

Analysis of self-reported learning

In this session all participants mentioned as acquired knowledge topics related to communication (what are the types, levels, classes, elements, or axioms of communication and/or communication skills) (n=8).

> "Communication skills work: verbal, non-verbal. Practice on active listening. Recovery language application. We never stop communicating."
>
> In some cases, participants highlighted the values behind the peer support process (n=3).
>
> "The assertiveness of being able to send a message without occupying the other person's space so he/she doesn't feel attacked and thus being able to achieve common goals. Active listening, which is extremely important in order to understand and empathize with the other person, allows us to put ourselves in their shoes and share equality. And a lot of other things, that for me are basic and fundamental: respect for the other person, understanding and sharing, not occupying their emotional, social or physical space, and of course using language that gives confidence, security and hope to the companion."

Session 9: Risks and limits.

Description

In this session, we talked about ethical principles, sensitive issues, and risks. Contents included problematic relationships with service users, excess of involvement and measures to be taken when self-harm behaviours or suicide ideations are detected.

Analysis of self-reported learning

Participants reported having learnt that that accompaniment limits must be negotiable, clear and that they vary according to life experience (n=3).

> "You have to negotiate some limits in accompaniment. It is not a friendship; it is an intentional support. […] Our limits are conditioned by our life experience".

Session 10: Comparison of training models.

Description

In the tenth session, we compared the different training models from other countries, taking the model developed by the Scottish Recovery Network in collaboration with other five organisations (Christie *et al.* 2015) as reference. Other models commented were from Canada (Cyr *et al.* 2016), England (Mental Health Foundation), Germany (EX-IN, Experten durch Erfahrung in der Psychiatrie) and the US (Recovery University).

Analysis of self-reported learning

Some participants reported having learnt which aspects of the training should be included in the programme or which should be studied (n=2).

> "We saw that there are quite a few aspects of the training that need to be studied in depth […]."

A participant also learnt the basic themes of the Scottish model, as well as what the facilitator's role consists of (n=1).

> "[…] We discussed the Scottish model that encompasses all the basic themes: recovery, experience, peer support, the use of language and communication, risks and limits, and self-care. […] The peer support worker's position: they are next to providers or service users; either they are a kind of translator, or […] agents of change. […] We talked about mutual help between workers when we may feel overwhelmed. […] That peer-to-peer will be the worker's profession and that we will be within the health context and we will interact with professionals."

Discussion sessions

In the final sessions of the training course, we held a debate on various topics. Topics such as the organisation of the contents of the PSWs course and related issues were discussed. The main categories (families) extracted from the analysis were organisation and moderation; role, skills, functions, and values of PSWs; language; health system; and other topics. Each category was divided into various subcategories (codes), which are explained below (see table 3). It is worth noting that we analysed separately participants' and moderator's interventions, although the main categories and most of the subcategories matched. For more details, see supplementary tables 2 and 3.

Table 3.

Thematic exploration of the participants' and moderator's interventions in the debate sessions.

Family	**Participants' codes (P)**	**N(P)**	**Moderator's codes (M)**	**N(M)**
Organisation and moderation		57		47
	Course contents and distribution by sessions	29	Course contents and organisation	22
	General structure of the course	21	Dynamisation and moderation	25
	Role Playing	7		
Peer Support Worker's role, skills, functions, and values		74		77
	Role and functions	30	Role, functions and professional-user relationship	39
	Social skills, empathy	26	Social skills, empathy	15
	Emotional management, trauma, own limits	14	Emotional management, trauma	16
	Peer support values	4	Recovery process	2
			Critical thinking	5
Language		57		29
	Professional language, diagnosis, psychological distress	34	Professional language, diagnosis, psychological distress	29
	Psychopathological language	4		
	Recovery language	19		
Health system		40		40
	The sanitary system and its devices	18	The sanitary system and its devices	34
	Criticism of the health system	12	Use of power	6
	Professional-user relationship	10		

Types of help and support		18		19
	Associationism, state benefits, pensions	9	Associationism, state benefits, pensions	8
	Peer support between workers	5	Peer support between workers	8
	Child support	4	Child support	3
Other topics		70		54
	Rights	9	Rights	6
	Risks and limits	10	Risk, limits, and ethics	7
	Personal experience	20	Personal experience	7
	Stigma and self-stigma	11	Stigma	12
	Work rehabilitation	12	Work rehabilitation	9
	Dual pathology	8	Dual pathology	13

Final evaluation

In the last session of the course, participants were evaluated by two of the trainers. Each participant performed an oral presentation on a given topic, which was of their choice, in the form of a hypothetical lesson of a PSWs course. The trainers had an evaluation rubric to assess the exhibitions (see supplementary table 4).

All elements were graded out of 4 and were the following: temporal adjustment ($\bar{x}$ = 2.80), audio-visual material ($\bar{x}$ = 2.54), nonverbal language ($\bar{x}$ = 2.41), verbal language, content and subject mastery ($\bar{x}$ = 2.80) and answered questions properly ($\bar{x}$ = 3.50). The final scores' mean was 2.81 out of 4, which is 7.03 out of 10. We interpret these results positively and consider that participants acquired significant knowledge and tools to lead a PSW training course.

DISCUSSION

We aimed at highlighting strengths and weaknesses of the training course carried out, as a starting point for future peer support training in Catalonia further promoting the professionalisation of PSWs in this region. The course programme seems appropriate in

preparing people with lived experience of emotional suffering as facilitators of peer support training courses. On the contrary, the course had a relatively high dropout rate, which, although attempts were made to dampen it through weekly email communications and constant feedback, did lessen its potential multiplicative impact. Regarding the current analysis, the use of a qualitative approach allowed us to narratively illustrate the entire process, turning the present document into a useful tool for other organisations conducting similar trainings.

In the same way that previous research carried out with service users facilitating mental health professionals training (Fraser *et al.* 2017), the motivations to attend the course in our study included developing new skills and being able to make a difference in mental health practise. Participants hoped to help others, support the implementation of the PSW professional role and acquire tools for their future work. In our case, similarly to the training course carried out by Fraser et al. (2017), participants highlighted learning theories, teamwork and practical presentation as some of the most useful course content. Some felt that the course focused too much in theory and too little in practice and that the sessions were too intense due to the large amount of information provided. However, they highlighted that the content was appropriate and that the course was taught respectfully, encouraging learning. In addition, they valued positively the understanding, confidence, skills, and knowledge acquired. Moreover, participants considered as a significant learning the knowledge about pedagogy applied to recovery and the basic topics of peer support, but they also gave great importance to the practical aspects of the course. Through the practical exercises provided, such as the one implemented through the CHIME model (Leamy *et al.* 2011) and the final debates, they developed critical reasoning and generated a space for joint learning construction. In this way, the learning objectives set for each session were successfully achieved by most participants as was demonstrated by the excellent performance in the evaluation activities.

In the debate sessions, participants discussed topics related to the training course and to peer support in general. Regarding the course, and especially during the first debate session, they proposed the content and the sessions distribution that they believed the course should have. They also suggested more general aspects, such as the type of evaluation, the access requirements, and the pedagogical methodology to be followed. They concluded that the training should follow a participatory methodology, highlighting role playing as a tool to help better assimilating theoretical contents. Role playing is a playful activity in which participants must apply concepts and elements previously discussed (Hillbrand *et al.* 2008). It is usually a group proposal that involves the development of competencies such as teamwork, leadership, communication, responsibility, and tolerance, promoting meaningful learning. Similarly to the results of the study carried out by Hillbrand *et al.* (2008), participants stated that it is an opportunity to apply the concepts in a much more practical way and in a simulated scenario of their future professional practice, allowing them to associate more effectively theory and praxis.

Regarding peer support, participants discussed about the role, skills, functions, and values of PSWs. Participants considered that peer support workers must help service users to get what they want, connect them to the desired services, build trusting relationships, promote their empowerment and their self-esteem through their own experience (Jacobson *et al.* 2012). PSWs should also perform supervisions and communication tasks with the professional team aiming to build relationships with professionals and legitimize the PSW role.

One of the difficulties that course participants encountered was finding a clear definition of the PSWs' role (Gates and Akabas 2007). In the debate, it was concluded that PSWs must be intermediaries between mainstream professionals and the accompanied person. Among other things, their tasks are to accompany service users in their recovery process, understanding it as unique and personal, to solve their doubts and to help them understand professional

language. Thus, PSWs should have basic knowledge of psychological distress and know how to adapt to the context in which they find themselves. In the debate sessions here analysed, participants highlighted the importance of empathy as a tool to understand service users' suffering and pain (Ahmed *et al.* 2012), which is something that all participants have gone through regardless of their diagnosis.

Despite having lived similar experiences, PSWs are usually afraid of facing uncertain situations, especially when they involve severe traumatic events. However, service users identify benefits in peer support, including fear reduction, which leads them to feel capable of taking bigger control of their recovery process (Bradstreet and Pratt 2010). Our analysis identified emotional management, knowing one's limits and peer support as useful tools to face these situations. Given the importance of providing such support, participants proposed to guarantee a periodic meeting space for supervisions with and withouth other mental health professionals.

Another topic discussed in the debates was the use of professional language. On the one hand, participants raised the concern about promoting the pathologisation of service users and PSWs by using diagnostic language. On the other hand, according to previous research, teaching mainstream technical language to PSWs promotes their social integration in the work team (Gates and Akabas 2007). Therefore, participants considered necessary to understand the language used by mental health professionals, diagnoses and some basic psychopathology topics to be able to provide good quality peer support. In the present study, some participants considered that medical language must be previously known in order to change it to a recovery language from the inside (Bradstreet and Pratt 2010).

There was no consensus regarding the limits of accompaniment (Watkins 2015). Some participants considered that limits must be predetermined and that the relationship with the accompanied person must be restricted to the healthcare context, to prevent it from being

confused with friendship. Others expressed themselves more flexibly and believed that limits may vary depending on the situation, and the personal circumstances of service providers and users.

Regarding health system knowledge, participants believed that it is the PSWs' responsibility to be aware of the structure of the mental health system to know the context in which they will be practicing. However, according to previous studies (Ahmed *et al.* 2012), many participants criticise the healthcare system in that it ignores users' real needs and discriminates them based on their diagnostic history. Several participants explained that they experienced situations where health professionals violated their rights and claimed that while the current national health system lacks psychotherapeutic resources it exercises an excessive use of medication and mechanical restraints. Consequently, it was considered as part of the peer support worker's role helping other service users claiming their rights.

CONCLUSION

The present analysis was intended to illustrate how a train-the-trainers activity can serve to introduce the model in a region where it has not yet been implemented. Despite being limited by its sample size, our analysis identified the participants' vision regarding their learnings and possible future needs. It questioned the role and functions of PSWs and promoted reflection on their training. More research is needed on mental health peer support training to ensure its quality.

RELEVANCE FOR CLINICAL PRACTICE

Our study illustrates the development of a train-the-trainers course in a context where people have very different levels of personal and clinical recovery, academic training, and social integration. This creates a diverse space that, far from being an obstacle, becomes an

opportunity for learning. The participatory development of the sessions and the selection of pedagogical elements allowed assimilation of contents as well as a mature discussion on the possibilities for real implementation of a professionalised mental health peer support project in a new region.

The sustainability of the future implementation project in the whole Catalan territory will depend on the capacity for synergies between survivor organisations, health service providers and the public administration. In this regard, policy makers involved in the implementation of the peer support professional role in Catalonia should consider evidence claiming for role clarification while maintaining coherence with the recovery model. Political instability and the current pandemic have posed severe obstacles to the implementation of this project, although some peer support training activities have been organised independently since the completion of the train-the-trainers course described here. These elements should be considered when implementing peer support training activities in the future.

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Supplementary table 1.

Learning acquired by participants after each training session: definitions, examples and frequencies.

Session	Categories	Definition	Example	N	%
Session 2: Pedagogy applied to recovery. Traditional model					
	Pedagogical concepts, differences between learning models	Learning of basic concepts about pedagogy and about the two learning models (traditional and inverted) and their differences.	I have learnt to name the different stages of learning […] (and) that (learning) is used in a pyramidal system […] that goes from memorization - understanding towards application - analysis - evaluation to creation. I have learnt that if we start from the top in this same model (creation), we get a learning model that starts from experience (the same pyramid but inverted) in which, in a collaborative way, what is created is evaluated and analyzed to identify errors and apply corrections, generating a learning and knowledge system that is finally understood and memorized (assumed).	7	53.85
	Bloom's Taxonomy	What is Bloom's Taxonomy, and which are its applications.	Bloom's Taxonomy, its application and how the traditional and inverted models work.	7	53.85

Session	Categories	Definition	Example	N	%
	Recovery concept	To understand the recovery concept.	Understanding the magnitude of the recovery concept.	3	23.08
Session 2 exercise: hypothetical objectives on the recovery philosophy					
	Improving health	Acquisition of healthier lifestyle habits.	[...] (to get) good sleeping, eating and exercise habits to be stable. To do some intellectual activity to exercise the brain, and for me, to take the medication.	2	14.29
	Empowerment	Aspects related to empowerment, such as accepting and being aware of the disease, hoping and trusting in one's environment, getting involved in one's process, changing one's attitude, improving one's relationship with the environment and fighting against stigma.	For me, recovery is to regain expectations for the future, even if they are not the same that I used to have. It is to hope again, train and empower yourself. To have a good relationship with the environment, either family, friends, neighbors or professionals […].	8	57.14
	Recovery	To understand the concept of recovery, its terminology, principles, and criticism.	To detect the main incentives of the philosophy of recovery in mental health […].	5	35.71
	Learning models and concepts	To refer to learning models, the CHIME scheme and/or Bloom's taxonomy.	I would use the CHIME scheme […] to create recovery tools.	3	21.43

Session	Categories	Definition	Example	N	%
	Application of knowledge.	To consider as an objective the praxis or application of what has been learnt.	I would apply pooling activities and group discussions.	3	21.43
Session 3: Pedagogy applied to recovery: inverse model					
	Session 2 content	To consolidate the contents of the previous session: learning models, Bloom's taxonomy and the basic concepts of recovery.	I learnt about recovery and how to reflect knowledge to students in a dynamic way.	6	42.85
	Recovery as a personal and unique process	To learn that recovery is an individual and unique process.	[...] We were all able to analyze the path to recovery, both our own and that of our colleagues. This lets us better understand recovery and know that it is a path that does not have a single way, but that there are as many forms of recovery as people recovered from a mental disorder.	4	28.57
	Values that favor recovery	One or more factors that promote recovery: self-knowledge, hope, voluntariness and / or sharing experiences.	[…] recovery emerges from hope, is self-driven, […] is supported by peers. It is promoted through relationships	5	35.71

Session	Categories	Definition	Example	N	%
			and social networks, […] it involves individual, family and community strengths and responsibilities.		
	History	Importance of the history of the recovery movement.	To be aware of the relevance of the historical background of the recovery movement.	3	21.43
	Tools for dynamizing sessions	Acquisition of different tools to dynamize a session, such as knowing how to set good learning objectives and apply the CHIME model.	[…] It gave me guides / tools to carry out a dynamic session in which, in addition to remembering and memorizing, we were all able to analyze the path of recovery, both ours and of our colleagues.	9	64.29
CHIME exercise					
	Connectedness				
	Close personal relationships	Identification of personal relationships with friends, family and / or one's couple as elements that promoted recovery.	To get back in touch with family and friends.	14	77.78
	Health professionals	To consider the relationship with health professionals (psychiatrists, psychologists and	[…] (the) doctor that listens to you, psychologist, nurse.	2	11.11

Session	Categories	Definition	Example	N	%
		nurses) as a factor that benefited their recovery.			
	Associations, Support Groups	Associations like *Obertament*, activism, and peer support groups contributed to the connectedness factor of participants' recovery.	To enter activism; working with a team of people who have been diagnosed (like me).	9	50
	Hope and optimism about the future				
	Normalizing life	To resume or adopt new activities and relationships that helped normalize life encouraged one's recovery.	To try to normalize my life, doing activities and having different relationships than I had.	5	29.41
	Trusting in one's recovery process	To trust in one's recovery process and to have hope of getting better helped participants in their recovery process.	To have the mantra "everything happens", "I can be better", "I will get out", "I want to be well".	7	41.18

Session	Categories	Definition	Example	N	%
	Seeing others recover	The fact of seeing others recover has favored their recovery; to see and meet people who are going through the same situation.	"I'm not the only one". To meet people in *Obertament*, people who were like me, (that) did not know anyone.	3	17.65
	Active attitude and self-sufficiency	To have an active attitude and to be self-sufficient and happy has benefited participants' recovery.	To have dreams: being able to be self-sufficient.	3	17.65
Identity					
	Self-improvement	Participants consider that self-improvement and rebuilding their own life (by studying, working or carrying out activities related to personal interests), has helped them to recover.	To rebuild my life / future, to better myself personally.	8	44.44
	Getting released of diagnosis	To work self-stigma and to get rid of labels has encouraged participants' recovery.	To accept that the disease is not all of me (I am more than a mental disease).	8	44.44
	Self-knowledge and self-esteem	To identify self-knowledge and self-esteem as key elements related to the identity factor of recovery.	Self-love, inner strength to overcome obstacles and difficulties.	2	11.11

Session	Categories	Definition	Example	N	%
Meaning in life					
	Greater acceptance and understanding	To take responsibility of the recovery process, with greater acceptance and understanding of one's situation, is related to the meaning in life factor of recovery.	When I read for myself, I learnt about mental illness and talked to my friends about it.	7	38.89
	Self-knowledge and self-esteem	To consider, from a more spiritual point of view, that self-knowledge, self-esteem and seeing the meaning of life encourages recovery.	Finding a meaning in life […].	6	33.33
	The disorder as an opportunity	Being able to see the illness as an opportunity to help others or to learn is a recovery tool.	[…] To convert what I felt restricted my development (illness: divorce, no children, loss of profession) in a stimulus to help others.	5	27.78
Empowerment					
	Commitment	To strengthen oneself by acquiring more responsibility and committing to work or volunteering, for example.	Commitment to volunteering.	5	29.41

Session	Categories	Definition	Example	N	%
	Autonomy, empowerment	Autonomy, improvement, self-esteem and empowerment promote the strengthening factor of recovery.	Self-esteem and the desire to break with labels, show me that stigma is not absolute. And focus on what I am capable of achieving.	13	76.47
	Knowing one's strengths and limits	To feel more strengthened by knowing one's limits and strengths, as well as setting acceptable goals.	To meditate, fight, consider qualifications and assumable goals, apologize and forgive.	6	35.29
Session 4: Group dynamics					
	Basic needs	To learn, through Maslow's hierarchy of needs, what basic needs are, their importance and that the ultimate goal is to achieve self-actualization.	The importance of the basic needs of humanity and how having them covered allows us to advance towards self-realization […].	3	42.86
	Emotion management	To acquire knowledge about emotional intelligence and the different ways of managing emotions.	[…] I learnt what emotional intelligence is, to know how to work things that happen depending on our emotional attitude and to name emotions, or a chain of emotions.	3	42.86
	Group dynamics	To consider as acquired learning aspects related to group dynamics, such as the concept, types and techniques (71.43%), its usefulness and	Besides learning about new group dynamics, I learnt their importance and that they are not meant to pass the time. (I learnt) that they serve, for example, to get to	6	85.71

Session	Categories	Definition	Example	N	%
		potential (42.86%) or the aptitudes that a good dynamizer should have (42.86%).	know each other and ourselves better, to empathize, to assimilate concepts, to promote communication, to break the ice, to share experiences, to work as a team, to learn, etc. And that there are dynamics of various qualities, such as to introduce oneself, to study cases, to debate, to put oneself in the moment, etc. [...] We extracted conditions and aptitudes a good moderator must have, such as being empathic, communicative, knowing how to identify needs or particularities of the people in the group, knowing how to play, not judging, etc.		
Session 5: Role Playing					
	Execution	To perform and participate in a role playing.	Staging, putting into practice a situation where an PSW and a user intervene, to see what issues arise or appear.	8	61.54
	Reflection	To search for alternatives and reflect during and after a role playing.	[…] To analyze and draw conclusions together and thus widen and enrich our particular vision.	3	23.08

Session	Categories	Definition	Example	N	%
	Emotional connection	To learn to get closer and connect emotionally with observers and to improve one's emotional management.	How to connect emotionally based on our own experience without falling into directivity, the expert's trap or frivolizing.	3	23.08
	Peer support	To know basic concepts of peer support, such as the characteristics that the worker must have or that it must be done through empathy.	How to carry out mutual support based on empathy and not on sympathy.	3	23.08
Session 6: Accompaniment and mutual aid groups					
	Positive attitudes identification	To learn to work with emotions and identify positive attitudes of PSWs.	[…] knowing how to identify a correct and positive attitude, both the facilitator's and the worker's, compared to a less constructive one.	3	33.33
	Peer support	To reinforce and expand upon concepts related to peer support: the values and principles of recovery (33.33%) and knowing how to help, the diverse ways of accompanying and the communication skills (44.44%).	The values of peer support. How to face the interviews with other "disease colleagues" using empathy and the mistakes that we shouldn't make.	5	55.55

Session	Categories	Definition	Example	N	%
	Working in a team	To know how to work in a team, which promotes knowing more of your colleagues.	[…] to meet colleagues, […] to share, […] teamwork, etc.	3	33.33
Session 7: Rights					
	Mental health rights	To learn about mental health rights' characteristics, emphasizing their benefits and importance. In 30% of cases, participants refer to rights in general terms, while in another 30% the emphasis is placed on confidentiality and in 60% on advance directives.	To exercise social rights provides empowerment, self-esteem and promotes recovery. [...] The different rights that we, those affected by a mental disorder, have. Confidentiality of the clinical history. The directives and planning of advanced decisions. […]	7	70
	Legislation and conventions	To know the legal framework and conventions that define the rights of people with disabilities.	The legal framework that we have nowadays and the tools that it offers us: ▪ The Convention on the Rights of Persons with Disabilities (2006, UN) ▪ Law 21/2000, of December 29, on the information rights related to the health and autonomy of the patient, and clinical documentation (Catalonia).	7	70

Session	Categories	Definition	Example	N	%
			▪ Law 41/2002, of November 14, basic regulation of patient autonomy and of rights and obligations in relation to information and clinical documentation (Spain) - The Document of Advance Directives and the Health Care Ethics Committees.		
	Knowing real cases	To learn by knowing real cases.	[…] I also found out about real cases of people with diagnoses.	2	20
Session 8: Language and communication					
	Communication	To mention topics related to communication as acquired knowledge: 87.5% have learnt what are the types, levels, classes, elements or axioms of communication and 62.5% have deepened in communication skills, practiced active listening and known the language of recovery.	Communication skills work: verbal, non-verbal. Practice on active listening. Recovery language application. We never stop communicating.	8	100

Session	Categories	Definition	Example	N	%
	Values of peer support	To reinforce the values of peer support: respect, assertiveness, empathy, no stigma and giving support from one's experience.	The assertiveness of being able to send a message without occupying the other person's space so he/she doesn't feel attacked and thus being able to achieve common goals. Active listening, which is extremely important in order to understand and empathize with the other person, allows us to put ourselves in their shoes and share equality. And a lot of other things, that for me are basic and fundamental: respect for the other person, understanding and sharing, not occupying their emotional, social or physical space, and of course using language that gives confidence, security and hope to the companion.	3	37.5
Session 9: The risk and the limits					
	Accompaniment limits	To understand that accompaniment limits must be negotiable, clear and that they vary according to life experience.	You have to negotiate some limits in the accompaniment. It is not a friendship; it is an intentional	3	60

Session	Categories	Definition	Example	N	%
			support. […] Our limits are conditioned by our life experience.		
Session 10: Comparison of training models					
	Topics to reinforce	To inform about the aspects of the training that should be included in the program or that should be studied in depth.	We saw that there are quite a few aspects of the training that need to be studied in depth […].	2	50
	The Scottish model and the facilitator's role	To learn basic issues of the Scottish model and what is the facilitator's role. To highlight the need to provide mutual help between workers and to professionalize this figure.	[…] We discussed the Scottish model that encompasses all the basic themes: recovery, experience, peer support, the use of language and communication, risks and limits, and self-care. […] The facilitators' position: they are next to psychiatrists or users; either they are a kind of translator, or […] agents of change. […] We talked about mutual help between workers when we may feel overwhelmed. […] That peer-to-peer will be the worker's profession and that we will be within the health context and we will interact with professionals.	1	25

Supplementary table 2.

Thematic exploration of participants' interventions in the debate sessions: definitions, examples and frequencies.

Family	Codes	Definition	Examples	N			
				S 1	S 2	S 3	Total
Organization of the Peer Support Workers course				49	7	1	57
	Course contents and distribution by sessions	To make reference on to how to divide the sessions of the course and what content should go in each session.	The second session would go into more detail about what is the philosophy of recovery and the history of recovery and of mutual support and also recovery as an individual experience. In other words, developing the concept of recovery in general.	27	2	0	29
	General structure of the course	General aspects of the course, such as the modules that will constitute it, the internships, the type of evaluation, who is it for and the pedagogical methodology it should follow.	We should have modules, apart from this course, some specific modules to learn everything that is related, for example, to labor reintegration, which is quite a thing, or rights, which is quite a thing…	15	5	1	21
	Role Playing	Comment regarding the importance and organization of role playing to complement the theoretical learning of the course.	The order that we provide allows us to reach some praxis that are role playing with acquired theoretical knowledge. To be able to put them into practice.	7	0	0	7

Family	Codes	Definition	Examples	N			
				S 1	S 2	S 3	Total
Peer Support Worker's role, skills, functions and values				16	20	38	74
	Role and functions	Description of the PSWs' role and functions.	Despite the fact that the patient can receive well a diagnosis, I believe that our function is also to make the patient or the accompanied person [...] see, to make them see that their life goes beyond that diagnosis.	14	11	5	30
	Social skills, empathy	Social skills that workers must have, making special emphasis on empathy as a tool to understand the suffering of the accompanied person.	To identify yourself with the other person [...], if you had an outbreak that you say, "I have gone to the other moon", you will understand yourself with the other person too. There's no need to put words.	1	1	24	26
	Emotional management, trauma, own limits	To know how to manage one's and the others' emotions, fears and traumas. To know the personal limits so as not to exceed them.	In mutual support for me it is essential to know whether to enter or not [...], when you meet a person [...] (who) has expressed his or her trauma, stop thinking about diagnosis. You see that this person has suffered a lot and what he or she needs on many occasions is to overcome trauma.	1	8	5	14

Family	Codes	Definition	Examples	N			
				S 1	S 2	S 3	Total
	Peer support values	Mention of values on which peer support is based, such as recovery, hope and self-experience.	Do not forget that it is done from your own experience and that it is done from recovery and hope.	0	0	4	4
Language				28	8	21	57
	Professional language, diagnosis, psychological distress	Comment related to the need to understand the language used by mental health professionals, the consequences of having a diagnosis and/or some psychological distress concepts.	To be able to say when we interact with professionals, let's understand what they are talking about first, [...]we listen, we understand them. That is basic. If we know their dictionary, we can listen and understand them, and reply to them when we want with their language, when we don't want with our language to crush theirs. But if we do not know, we cannot crush it. We will be smarter than them.	21	5	8	34
	Psychopathological language	To consider that by understanding or using the language of mental health professionals one is	I think it continues to pathologize [...] and not only the user, but us, the peer to peer himself, because they are speaking to us in that language.	3	1	0	4

Family	Codes	Definition	Examples	N			
				S 1	S 2	S 3	Total
		pathologizing or stigmatizing their own condition or that of those accompanied.					
	Recovery language	To make reference to the need to change the professional language towards a language based on recovery, depathologization and being accessible to patients.	The change of psychiatrizing language towards a recovery language [...] because if you do not put that, they stay with the idea that you are within their field [...]. In other words, we are going to study the language but to make a change towards recovery.	4	2	13	19
Sanitary system				7	13	20	40
	Sanitary system and its devices	Aspects related to the health system in general or to one of its specific devices.	You have to know the context in which you move. It will not be the same for the worker to go to the emergency room, to have a relationship with a mental health clinic or to be in an association.	2	10	6	18
	Criticism of the health system	Criticism of the way the health system functions, in relation to containment or over-medicalization, for example.	I know what I've seen. I have never seen a single containment where, not one, huh! where there was violence by the user rather than verbal. In the worst	2	0	10	12

Family	Codes	Definition	Examples	N			
				S 1	S 2	S 3	Total
			case, verbal. Verbal violence yes, but not physical. But in some cases, people who were asleep and lying in the hallways saying, "I won't take this pill" and they were contained. And it turns out that he was not supposed to take that pill and then the nurse apologized because the pill was wrong.				
	Professional-user relationship	Comment on the relationship and role of PSWs with other professionals and with users.	The relationship we will have with professionals, they must see us as a professional. And the relationship that we will have with equals, they must see us as an equal. So, we have both sides here.	3	3	4	10
Types of help and support				1	8	9	18
	Associationism, state benefits, pensions	Comment on the possibility of forming a professional association or another kind of association for PSWs and on their access to certain benefits and pensions.	But it is very interesting to form an association of TEAMs at the moment you start working, no?	0	4	5	9

Family	Codes	Definition	Examples	N			
				S 1	S 2	S 3	Total
	Peer support between workers	To remark the need for help among PSWs, either in the form of GAMs or of supervisions with other professionals.	Supposedly, there is a multi-professional supervision [...] of all professionals, and there is the PSW too.	1	4	0	5
	Child support	Specific comment on accompaniment and care for children.	Accompaniment is not being done, but mental health is being included in the classroom.	0	0	4	4
Other topics				9	19	42	70
	Rights	To refer to the rights that mental health users have and their violation.	What role can we find as PSWs before rights? For example, before contentions that are not justified at all?	2	0	7	9
	Risk and limits	Contribution regarding the risk and limits of the relationship with the accompanied person.	I think that there must be also predetermined limits, yes. There have to be things that, okay, you can go to have a coffee, but there is something that you cannot exceed.	0	9	1	10

Family	Codes	Definition	Examples	N			
				S 1	S 2	S 3	Total
	Personal experience	To consider first-person experiences as users of mental health services a tool for accompaniment.	We assume that whoever of us is going to accompany these people, has gone through these processes in first person. We already know a lot, well, we already know basically what we can find: depression, outbreak ... because we have been through it ourselves.	3	3	14	20
	Stigma and self-stigma	Aspects related to the stigma and self-stigma that exist in mental health patients, which lead to discrimination, abuse and hiding personal information about one's mental health condition.	95% of people with schizophrenia disorder don't say it. If the word wasn't stigmatizing, people would not hide it.	4	3	4	11
	Labor reintegration	To note the possibility of inserting oneself into the labour market having a mental health condition and the role of PSWs to help this happen.	As peers, in this case, we must accompany them towards the advisers [...]. There will be the occupational therapist, there will be foundations for protected work, [...] but we cannot know everything	0	4	8	12

Family	Codes	Definition	Examples	N			
				S 1	S 2	S 3	Total
			and perhaps our job is to accompany them to the specialist.				
	Dual pathology	To understand the concept of dual pathology as something that goes beyond substance use or to refer to which is the role of the PSW in this matter.	Socially, […] it has been divided into drugs and not drugs, but there are many people with addictive behavior who, depending on what ow how they consume […], it is no longer a drug. It's what we said (before) about compulsive shopping... There are fifty thousand things [...], food, sex... but instead, it is only associated with substances.	0	0	8	8

Supplementary table 3.

Thematic exploration of the moderator's interventions in the debate sessions: definitions, examples and frequencies.

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
Organization and moderation				13	22	12	47
	Course contents and organization	Aspects related to the contents and structure of the PSWs' training. General aspects of the course, such as the modules that will consitute it, the internships and role playing, the type of evaluation, who is it for and the pedagogical methodology it should follow.	But why are you going to make it difficult for them, when you can simply do it in a different order, and intersperse the theory with participatory activities, that don't always have to be role playing?	10	7	5	22
	Dynamization and moderation	Intervention made for dynamizing and moderating the debate. Introduction of topics, recapitulation of topics previously discussed and asking questions that promote reflection and debate.	The issue of professional role and deontological ethics, I believe that there is something that has to do with risk and limits, that are more or less related. What do you think? Do you remember when we did the risk and limits session?	3	15	7	25

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
Peer Support Worker's role, skills, functions and values				8	34	35	77
	Role, functions and professional-user relationship	Description of the PSWs' role and functions. Commentary on the relationship and role of PSWs with other professionals and users.	In addition, we have the subject of the professional-user relationship and who are we closest to, [...] because we are users ourselves, but suddenly we are going to be professionals and there is going to be a change of roles. There is an open debate about this [...] and I believe that, if we touch it, we must do it in the most critical way possible.	5	15	19	39
	Social skills, empathy	Social skills that workers must have, making special emphasis on empathy as a tool to understand the suffering of the accompanied person.	Speaking of social skills, which for example could be assertiveness, non-violent communication when imposing or negotiating our limits with other professionals and with the person accompanied, right? Somehow, all of these things [...] get mixed up a bit, right? If the PSW are capable of being assertive, they will be able to define their professional role both positively and through limits.	1	8	6	15

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
	Emotional management, trauma	To know how to manage one's and others' emotions, fears and traumas.	We have to be smarter than the other professionals who generate a lot of violence. Many times, a little understanding can make the person go down, especially if we are able to say "I am just like you", it is probably much more relaxing, much more reassuring than many other things, without minimizing suffering.	0	10	6	16
	Recovery process	To refer to recovery, understood as a personal, unique and non-linear process.	I could say "this is how it is done" [...], but I want us to reflect critically and keep in mind that we could reach many people with what we decide among the people who are here.	0	0	2	2
	Critical thinking	Invitation to think critically, reflecting on the things with which we agree and disagree.	Just because you have a bad day in depression doesn't mean you're getting more depressed. It is that life is like that and there are better days and there are worse days. That you are quitting smoking and one day you take a cigarette, does not mean that the next day you are going to smoke the	2	1	2	5

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
			whole pack, but that you have to tell people that quitting a consumption or leaving a mental state of suffering implies comings and goings. It should not be seen as a line going up or a line going down, they are comings and goings.				
Language				10	6	13	29
	Professional language, diagnosis, psychological distress	Comment related to the need to understand the language used by mental health professionals, the consequences of having a diagnosis and/or some psychological distress concepts.	If we are doing a course in which some people are going to be constantly listening to diagnoses, [...] without having told them absolutely nothing, what happens is that each person learns it in their own way. That has advantages and disadvantages, but [...] what is important, I think, is that people do not get there and find something very basic of their daily life that they have not heard about. Now, we don't have to teach them how to diagnose, we have to teach them how to communicate [...] with other professionals. To	10	6	13	29

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
			understand these professionals and to understand how to mediate between professionals and users.				
Sanitary system				7	17	16	40
	Sanitary system and its devices	Aspects related to the health system in general or to one of its specific devices.	The day hospital is a semi-hospitalization, which has a much stronger psychological-medical component. In other words, in a day hospital there is usually a more powerful medical condition and sometimes in a day center there are no specialist doctors or there is only one, and the level of intervention is much lower. You know, there are many more issues of social integration, ¡ varied activities, it can be almost like a social club, while the day hospital is a semi-hospitalization and the person let's say follows a treatment. You don't stay to sleep in either of them, that's why it's a day hospital. But it is considered semi-hospitalization.	1	17	16	34

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
	Use of power	Comment on the use of power that is exercised within the health system towards users.	When people who can diagnose do so, they are exerting power, yes? A power over a person. Sometimes that person wants that power to be exercised, he is desperate, he wants to know it, and sometimes, that power is exercised and the person is not happy, is not satisfied, but feels attacked, or feels that his identity has been canceled.	6	0	0	6
Types of help and support				0	10	9	19
	Associationism, state benefits, pensions	Comment on the possibility of forming a professional association or another kind of organization for PSWs and on their access to certain benefits and pensions.	There is an important issue: the government has to authorize the creation of each professional association and when a professional association is created, it is compulsory to be a member/be registered in order to practice within that profession.	0	3	5	8
	Peer support between workers	To remark the need for help among PSWs, either in the form of GAMs or of supervisions with other professionals.	Without ignoring the supervision of other professionals, which in many places is mandatory [...], I saw that in Germany the PSW was in those meetings and it was very	0	7	1	8

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
			good because he also gave his opinion and facilitated the change, but it should also be mandatory that at least once a month there were supervisions among PSWs.				
	Child support	Specific comment on accompaniment and care for children.	But mentoring, right? For example, a child who has a very severe mental disorder and can talk to a person who has overcome it so that fear is removed a little, is not bad.	0	0	3	3
Other topics				0	10	44	54
	Rights	To refer to the rights that mental health users have and their violation.	Advance directives, advance decisions... Advance directives in a document with legal validity and the other is simply a working document between the professional and the user, okay? There is one that is simply a working tool to try to make things more appropriate to the person.	0	1	5	6
	Risk, limits and ethics	Contribution regarding the risk and limits of the relationship with the accompanied person and deontological ethics.	There are limits that have to do with the professional role, some of which we have to put on professionals (psychiatrists, psychologists, nurses) and others on the	0	5	2	7

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
			accompanied person, right? And this somehow defines our relationships in the professional context and in the context of accompaniment, right? In other words, sometimes limits also define in some way, because at least they make clear what we aren't, what we cannot do.				
	Personal experience	To refer to first-person experiences as users, family members or mental health professionals, presenting them as a tool for accompaniment.	So, somehow, we can be afraid of new situations. We may also have to lean on each other, right? In other words, people who have or have had the experience of being in these places, both as users or as professionals or as family members, [...] we can accompany a companion so they can have a better time in those first approximations which are a little bit harder. It is also true that you never know that an advice or a life story of a person who has never been admitted (at a hospital) can help a person who has been admitted or who is currently admitted.	0	2	5	7

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
	Stigma	Aspects related to the stigma and prejudice that exist in mental health patients, which leads to discrimination, abuse and medical malpractice.	Many times, things happen in primary care that, when you have a diagnosis, they do not look into [...], to the point that there was a case of a person who had a heart attack and they believed that it was part of his delirium. Until they realized that maybe something was going on and the ambulance had to come.	0	0	12	12
	Labor reintegration	To note the possibility of inserting oneself into the labour market having a mental health condition and the role of PSWs to help this happen.	We are not going to adapt the position, but we can probably accompany them, we can tell them how it went for us when we tried to do it, that sometimes we were better than other times, that failing once does not mean that we will always fail… Or maybe it does, and you have to take it more easily. That it depends, that there are no blacks and whites.	0	1	8	9
	Dual pathology	To understand the concept of dual pathology as something that goes beyond	Will can be infused in many ways. At the level of accompaniment [...], what gives you the experience of having managed to get out? [...] It gives you tricks; it gives	0	1	12	13

Family	Codes	Definition	Examples	N			
				S1	S2	S3	Total
		substance use or to refer to which is the role of the PSW in this matter.	you a testimony, right? Exactly the same as in mental health. [...] It has the peculiarity that there is always a substance, a behavior that is not within the person, a bit like stress and anxiety, right?				

Supplementary table 4.

Evaluation rubric to assess the oral exhibitions of the facilitator's training course.

	1	2	3	4
Temporal adjustment	It is necessary to interrupt the presentation due to excessive time (it exceeds 15') or the presentation lasts less than 6'.	The exhibition takes 2 minutes more or less than the established time (less than 8 'or more than 14').	The exhibition takes the established time (10-12'), but he or she is not able to adapt to possible setbacks.	He or she adjusts to the established time (10-12') and adapts to possible setbacks.
Audiovisual material	The material used is inadequate either in content, organization of information, originality and / or volume.	The material is confusing and makes it difficult to follow the explanation instead of facilitating it. The material is excessively extensive or scarce, but adequate in content.	The material is generally organized and clear, but it is too long or too short. The images are related to the topic, but do not facilitate the explanation. There is some information or slide that seems to be out of place.	The material makes it easy to follow the explanation. It is adequate in terms of quantity (e.g. number of slides), content and originality (not copied). It is error free and organized. Images are appropriate.
Nonverbal languge	The exhibition is made simply by reading the audio-visual material. The tone of voice and posture are inadequate and make it difficult for the audience to follow the explanation.	He or she frequently resorts to literal reading of parts of audio-visual material. Sometimes the tone of voice and / or position makes it difficult for the audience to follow the explanation.	The tone and posture are adequate. He or she does a large part of the exhibition without the need to resort to audio-visual material.	He or she makes the exhibition with ease and mastery of the subject, addressing the audience. He or she does not need the audio-visual material for the explanation, although he or she uses it to clarify and facilitate the understanding of the explanation to the public. Both tone of voice and position are adequate.
Verbal language, content and subject mastery	The explanation is disorganized, ideas are repeated, or important concepts are omitted. It is not possible to follow the common thread nor extract the main idea. He or she does not dominate the subject.	The explanation is organized but insufficient. Part of the content remains unexplained and this makes it difficult to understand the main idea. He or she has difficulties with some parts of the subject.	The explanation is organized and quite complete. Some content is missing or left over, but in general the main ideas and the common thread are clear. He or she dominates the subject remarkably.	The explanation is very well organized and complete. The common thread of the content is easily followed, and the audience is able to understand the main ideas easily. He or she masters the subject excellently.
Answers questions properly	He or she is not capable of answering questions on the exposed topic.	He or she is able to answer only some of the questions made on the subject.	He or she answers most of the questions that are asked on the subject.	He or she answers all questions, adding new ideas or examples if necessary, to make himself or herself clear.