

So if we like the idea of peer workers, why aren't we seeing more?

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Abstract

The employment of peer support workers is widely encouraged in recovery-oriented mental health systems and services, providing a tangible example of how to translate recovery values and principles into actions. In Scotland, despite a long-term policy commitment to recovery approaches, the creation of peer worker roles has been slow and patchy. This paper describes findings from a study on the levers and barriers to the development of peer worker roles in two Scottish health board areas. Findings suggest that new evidence on effective implementation and cost effectiveness should be prioritised to support potentially complex role development in times of reduced resources. We argue that additional evidence on effectiveness is unlikely, by itself, to lead to country-wide employment of peer workers. We therefore suggest that a policy commitment to peer working would be reinforced by not only a strengthened evidence base but also strengthened accountability mechanisms. In the absence of such accountability, decision-makers and planners might reasonably continue to ask "why bother"?

Key words: Peer support; Recovery; Mental health policy; Role adoption; Workforce development

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Core tip: Recovery approaches are widely and increasingly promoted internationally in mental health policy and services. Peer support working is a new professional role in mental health services and provides a tangible example of recovery principles being applied within the context of these services. As a consequence, there is a great deal of interest in emerging evidence around this role, and whether/how evidence might support increased and more effective involvement of peer workers. Our editorial presents findings from research

in Scotland and on the basis of these, poses some "big questions" concerning what needs to happen to accelerate progress in not only the employment of peer workers but also in mental health services' recovery approaches more generally.

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INTRODUCTION

In this editorial, we report and discuss levers and barriers to local health boards' employment of peer workers to promote mental health service users' recovery drawing on findings from recent research in Scotland. We reflect on the implications of these findings not only for Scotland but also for other jurisdictions seeking to increase their mental health services' involvement of peer workers.

RECOVERY: AN INTERNATIONAL PERSPECTIVE

The integration of the concept of recovery into mental health policy has become increasingly widespread around the world^[1,2]. This development has been most notable in English-speaking countries although more recently recovery ideals and principles feature in mental health policies and practices more widely across Europe and in some parts of Asia^[3]. The renewed emphasis on recovery in modern mental health has been primarily driven through documented first person accounts of recovery from people in receipt of mental health services, initially in the United States but then more widely^[4,5]. These personal accounts indicate that recovery is generally interpreted in holistic terms. Furthermore recovery is often viewed as a process (or "journey"). People therefore can describe themselves as being "in recovery". These experiences and conceptualisations contrast with a narrower and more clinical understanding within mental health services of recovery as an outcome, characterised by a greater emphasis upon the cessation of symptoms than quality of life^[1].

The holistic and multi-faceted nature of recovery can present challenges in more precisely operationalising recovery. A systematic review of international literature identified connectedness, hope and optimism, identity, meaning and purpose and empowerment (creating the acronym CHIME) as central elements in personal recovery^[6]. In recognition of mental health services' needs for (increased) clarity on what constitutes recovery focused practice, another international study sought to identify and distil the key characteristics of

such practice. These were identified as: "promoting citizenship, organisational commitment, supporting personally defined recovery, and working relationship"^[7].

While there is increasing consensus on the practices and interventions of recovery focused service systems, the implications of adopting recovery focused approaches are significant and suggest substantial change to the culture and organisation of services^[8]. Promoting recovery requires appropriate, and in many cases, new skills, competencies and practices for mental health professionals. It also requires renegotiated roles for people in receipt of services, whereby their expertise, garnered through their live experience, is given enhanced recognition and self-management is encouraged^[9].

WHAT IS PEER WORKING?

Peer workers are people who have personal experience of mental health problems who are trained and employed to work in a formalised role in support of others in recovery. Peer workers are willing and able to share their personal experiences on an equal level that supports, empowers and brings hope to the people with whom they partner. The peer worker role involves: (1) Developing mutually empowering relationships; (2) Sharing personal experiences in a way that inspires hope; and (3) Offering hope and support as an equal^[10].

The type of activities that peer workers undertake depends on the setting in which they are working but includes working one to one with people, running recovery education and mutual support groups and supporting people to use self-management tools.

For many years, people who experience mental health problems have described the importance and value of support from others who have had similar experiences and how it brings something different to that which is found in professional support relationships. Similarly, proponents of recovery consider that the employment of peer workers provides an opportunity to complement and enrich the provision of mental health services.

At the same time, robust evidence of the effectiveness of support provided by peers in comparison to non-peer equivalents is in its infancy internationally^[11] and extremely rare in the United Kingdom^[12].

RECOVERY AND PEER WORKING IN SCOTLAND

The mental health system in Scotland is underpinned by a raft of legislation, strategies, policies and targets that share a commitment to human rights, including participation and empowerment of those who use services. Thus, there is a legislative duty for local government (known as local authorities) to provide care and support services for people with a recognised

mental disorder who are not in hospital and to provide services to promote their wellbeing and inclusion. Similarly there are duties on Scotland's 14 regional health boards (*i.e.*, the National Health Service in Scotland) which are responsible for the protection and the improvement of their population's health, to provide care and treatment for people with mental health problems. Third sector organisations (both national and local) are recognised as key players in delivering mental health care and support, and their involvement is actively encouraged by the Scottish Government.

In the last decade there has been significant activity related to the promotion and support of mental health recovery in Scotland. Much of this activity has been linked to the work of the Scottish Recovery Network (SRN). During this time, recovery might reasonably be described as having moved from the margins of Scotland's mental health system to the mainstream. It has become part of the accepted discourse, seen as a predominant means of improving experiences and outcomes for people in receipt of mental health services in Scotland^[13]. Through this process Scotland has gained a reputation as a world leader in putting the principles and values of recovery into practice in mental health systems^[1].

Within this context, the development of peer worker roles has been consistently identified as tangible demonstration of the adoption of recovery principles and values in mental health policy and practice^[14,15]. SRN have been working since 2005 to promote peer working through the development of implementation and practice guidelines and nationally accredited training. This has been complemented by a Scottish Government policy commitment to the development of peer worker roles since 2006^[16]. This commitment is made explicit in the current Mental Health Strategy for Scotland which indicates a focus on increasing and embedding peer working across Scotland^[17].

It should be noted however that the recovery movement in Scotland is largely a "bottom-up" one insofar as decisions regarding recovery practices are taken at a local level. While the Scottish Government supports and endorses recovery, and indeed funds SRN to promote recovery values and practices, it is largely a matter for local areas to decide the degree to which they incorporate recovery principles, including peer working, into their service design and delivery.

MOVING PEER WORKER EMPLOYMENT FROM THE MARGINS TO THE MAINSTREAM

As outlined above, the employment of peer workers is encouraged in recovery-oriented services. It also provides a tangible example of how to translate recovery values and principles into actions (although, of course, it is not the only way that services can

realise recovery). Given the focus on recovery in Scotland and the endorsement of peer workers as a policy priority, our editorial reflects on the possible reasons for why progress has been patchy and asks - how do we move from simply having examples of peer support working across the country to widespread provision?

We consider how to achieve this shift by drawing on a recent piece of research in Scotland that we describe below. This research was intended to identify whether decision-makers in local areas have, or were perceived to have, any evidence needs that, if met, might increase the use of peer workers across the country. The findings point to not just what types of evidence decision makers might find useful, or even persuasive, but importantly, what else needs to happen for Scotland to see peer workers being employed across local health board areas.

OUR RESEARCH: EXPLORING ISSUES, INCLUDING BARRIERS, TO EMPLOYING PEER WORKERS

The research on which we draw was commissioned by SRN to help it understand the basis for local decisions regarding the introduction (or not) of peer workers. SRN was particularly interested in identifying whether/how it might engender their wider use through distilling and disseminating evidence to those who are responsible for making decisions locally regarding service design and redesign.

The research was carried out by one of the editorial authors (JG) who is an independent researcher and whom SRN contracted to deliver this research within that capacity.

RESEARCH

The research methods were qualitative and involved 19 one-to-one telephone interviews with local stakeholders and one focus group with a pre-existing national advisory group that has a remit for increasing and embedding service user involvement. The interviews were conducted with local decision makers in one of two (selected) Scottish health board areas. We used pseudonyms for these health boards in order to protect anonymity. One of these health boards ("Mags") was selected because of its known progress in using peer workers. The other health board area ("Cluny") was selected because it was known to have not (yet) employed people with lived experience to perform this role within their (statutory) mental health services. A total of 19 interviews were conducted: ten from Cluny and nine from Mags.

The research aimed to explore the views of individuals with responsibility (in the health board, local authority or third sector) for making decisions on the design or development of mental health services

Table 1 Details of interviewees' roles

Cluny		Mags	
NHS	General Manager for mental health Clinical lead and director for mental health OT service manager Lead for mental health nursing Strategic planning and commissioning manager (across NHS and Local Authority) Manager in service development/quality improvement Inpatient services manager	NHS	Performance manager Nurse with responsibility for practice improvement in mental health Associate director of nursing OT lead in mental health nursing Public mental health manager
Council	Head of Adult Social work	Council	Service manager Senior Social worker
Third Sector	Two managers in third sector mental health organisations	Third Sector	Two managers in third sector mental health organisations

NHS: National Health Service.

and recovery initiatives. The first point of contact in each local area was with an individual who was known to have a leadership role for mental health. These individuals were asked to identify colleagues who had a remit as described above. The researcher then contacted these individuals to request their participation, and also asked them whom they would identify as fulfilling the eligibility criteria. This process was repeated until no further individuals were identified.

Interviewees spanned a number of roles, all senior. These included people with roles in commissioning, mental health service planning and leadership (in psychiatry, nursing, occupational therapy and social work), governance, and service specification, management and supervision (For a breakdown of interviewees by role, please see Table 1).

In addition to these interviews, a focus group was run with a Scottish Government multi-disciplinary advisory group on peer support working. These focus group participants included individuals working for the Scottish Government, local health boards, and third sector organisations (including peer workers).

Ethical principles were practised in line with the guidelines of the Social Research Association and the Respect Guidelines^[18,19]. These included providing all participants with written information describing the purpose of the research, the focus of the interviews and their likely duration, their right to refuse to participate, details of how anonymity would be protected, and how findings would be used and reported.

The data analysis approach was informed by Framework - an approach devised for qualitative policy evaluation and used by the National Centre for Social Research^[20]. This involved developing an analytical framework that reflected the research questions and the content of the collected data, and which used descriptive headings under which data were summarised.

RESEARCH FINDINGS

What sorts of evidence needs were indicated?

In the main, Cluny interviewees (particularly those at

the most senior levels) acknowledged that they were not highly-informed about peer working. Nevertheless, even those who, by their own admission were less informed about peer working intuited what would be involved and talked of "theoretical benefits" for both the workers and for the individuals whom they would support. Thus they had an expectation that service users would appreciate talking to someone whom they felt was on a similar level to them, "had walked in their shoes" and, as a consequence, genuinely understood how they were feeling. There was therefore a general sense that the concept of peer support is a sound one, in principle at least, "The issue that we're talking about now is the sort of thing that even without the strongest evidence, it's worth considering because it's got a degree of face validity." (C.I1)

While there was an assumption that peer workers would be valued by patients, there was an identified need for evidence on the effectiveness of peer workers in achieving patient and service outcomes in comparison with the effectiveness of staff who perform other (more conventional) roles, *e.g.*, occupational therapists, nurses *etc.* This consideration was particularly acute in view of budgetary pressures.

"The question is - how could we afford this? How could we move towards it? What other posts would I have to cut in order to finance that kind of role? So what we always have to consider is not always just about the costing benefits of these peer support concepts, it's costing benefits of developing a peer support concept in combination with the cost benefits of making changes and probable reductions to something else within the services, in order to pay for it." (C.I1)

As a consequence, there was a view that evidence on cost-effectiveness and on cost-benefits would be compelling to decision makers in those health boards that have not gone down the route of employing peer workers. In fact, there was triangulated evidence across research participants from both of the health boards and from the Scottish Government focus group that in order to increase adoption of peer working, there was a need to build a costed argument (or

a "business case" as some called it) and for this to complement evidence on service users' perspectives.

"We're talking about commissioners here, we're talking about bean counters, we're talking about procurement teams, and senior executive management teams. ... If you could demonstrate by the introduction of a peer worker into an acute admission unit, that your average length of stay dropped by 7% over the course of the year following the introduction and there were no other attributable factors, then that would move people to introduce them, because they were getting a cost saving then." (M.I5)

In addition to unmet evidence needs regarding costed "arguments", the need for evidence on (successful) implementation also emerged. This need arose from identified challenges in establishing and/or delivering peer support services. Particular challenges were raised about how to ensure workers' compliance with professional requirements (such as patient confidentiality, information sharing with the wider multi-disciplinary team), maintenance of workers' wellbeing and risks to service continuity in the event of workers becoming unwell. In fact, there was a view that the significant challenges involved in establishing a service of this sort could lead to a "why bother?" attitude.

As a consequence, there were calls for information/evidence on how to go about employing peer workers and then how to ensure their ongoing and productive role within the multi-disciplinary team.

"There's not a lack of evidence around about its appropriateness and effectiveness... there is a lack about then "how do we go about making it happen?" (M.I4)

In view of the unmet needs reported above, focus group participants (*i.e.*, those in the Scottish Government advisory group) felt that a two-pronged approach would be advantageous: creating a business case (detailing aspects like cost-benefits, including the contribution of peer support working to other agendas such as person-centred care); and, partnering evidence on implementation with resources (such as job descriptions, employment contracts, supervision protocols, *etc.*) in order to make the establishment of a peer support service a less daunting prospect.

If decision makers had the "right" evidence, would we then see universal provision?

As previously explained, decisions about the inclusion of recovery values and practices in mental health service design and delivery are made at a local level in Scotland. Such devolved decision making on recovery issues is not a Scotland-specific phenomenon and is likely to be the case internationally. The question here therefore is - if decision makers were to be given the evidence that they say they are lacking, then would they go on to employ peer workers in their local areas?

The findings from this research indicated that this is unlikely, at least in Scotland just now. Rather, there are a number of other, and potentially stronger, drivers that can underpin decisions at a local level.

Insights from this research revealed that a key reason for Cluny having not introduced peer support working was because there was no requirement for it to do so.

"I think XXXX (civil servant) has pushed it a little bit, but clearly not very hard, otherwise...you know, normally when the Scottish Government say 'jump' the health board says 'how high?', and the last mental health review meeting that we've had in XXXXX (Cluny), they just were not interested in some of the softer stuff; it was all about meeting Health, Efficiency, Access, Treatment (HEAT) targets and stuff like that." (CI.2)

Interviewees-both in Cluny and Mags, were of the opinion that that if the Scottish Government went beyond simply asserting peer support working as a priority in policy documents and made local health boards more accountable for delivering on this, peer working would no longer be relegated to a position of "competing" with other priorities. Instead, local decision makers would be compelled to design their services accordingly.

"If there's a Government directive, then of course we have to work towards that." (C.I9)

"Until there's an ultimatum, I don't think people are going to just do it". (C.I4)

So, in the absence of any governmental requirement, why had Mags opted to introduce peer workers?

Mags interviewees described how the local decision was taken because peer support was seen to be wholly consistent with the health board's and strategic partners' recovery principles and practices. Furthermore, despite the relative lack of evidence on successful implementation, in Scotland at least, Mags' interviewees talked of taking a "leap in the dark"- a leap that they were willing to take because their health board area was a forward thinking and enterprising one that was not limited by the highly risk averse attitudes and judgements that were considered to be typical elsewhere. In other words, Mags' decision cannot be explained purely in terms of evidence-based considerations. Better evidence, while desirable, was not a pre-requisite for Mags' decision: employing peer workers was seen as an evolutionary development-a logical, highly acceptable and obvious next step that was consistent with its value-base. Mags' decision was a hearts and minds affair.

DISCUSSION

Our research was based on the assumption that providing better evidence to those responsible for making decisions on service design and delivery at a local level would encourage wider-scale adoption of peer workers. Certainly there was some support for the notion that a basket of evidence might be useful, and therefore that SRN might usefully review, distil and disseminate evidence in a manner that targets key decision-makers and tailors this evidence to their particular requirements. Thus, a sound and reasoned cost-benefit analysis that pointed to both improved

patient and service outcomes over existing or more conventional models and staff teams would provide the information that was likely to go some way to meeting the needs of decision-makers with responsibilities for budget allocation. In the same way, SRN might target those with a role in commissioning and service governance with tailored evidence on what works well in terms of establishing a service, attending to issues such as maintenance of workers' wellbeing, procedures to ensure adherence to confidentiality codes *etc.*

Participants in this research spoke about making decisions in the context of contracting and pressurised budgets and services. Furthermore, the Scottish experience and the feedback from the participants involved in the research project described in this paper clearly suggest that the development of peer worker roles is complex and challenging for those who have made a commitment and potentially daunting for those who have yet to commit. Clearly the question of "why bother" has to be emphatically answered and there are indications here that people would value specific evidence (and associated outputs such as job descriptions and templates) to help them navigate and effectively address the challenges of establishing and sustaining the peer worker role. Indeed this, along with evidence on the cost benefit of role creation, was more strongly emphasised than a need to demonstrate the effectiveness of peer workers. These needs suggest areas - perhaps even priorities - for future research and evaluation. They might also helpfully redirect energies from well-intentioned research on peer worker effectiveness (that casts them themselves as the intervention) rather than focusing on the effectiveness of the things they do. While we should certainly test the effectiveness of peer worker led interventions and support, we would argue that to treat peer workers as an "intervention", and a homogenous one at that, is unlikely to be helpful. We would argue in line with realist principles^[21], that the key issue is not whether or not peer workers should play part of our (recovery focused) services but rather to identify the circumstances that make the involvement of peer workers more (and less) valued and effective. We consider that such insights are consistent with use-led research and thereby have the potential to be of value in shaping (real-life) decisions about service design.

The development of recovery approaches in Scotland has been notable internationally in that the main driver for systems change has come from outwith the statutory sector. While SRN is funded by the Scottish Government, it is based in the voluntary sector and acts more as a facilitator and bridge builder across groups and sectors than as an enforcer of policy. This facilitative approach has been broadly welcomed by stakeholders^[22] yet it undoubtedly has its limits when it comes to encouraging the type of fundamental service redesign which the genuine application of recovery principles and values would suggest.

We did, though, note earlier that there has been

a clear policy commitment to the adoption of peer working for some time in Scotland so support and encouragement from the top level has been consistent. We would however argue that given the perceived and real challenges in developing peer worker roles, to effectively challenge the "why bother" question we need more than one-off commitments, which, according to decision makers in one area of our study, did not feature highly on the list of policy priorities at local or national level. This suggests that to move beyond the current impasse, peer working must shift from being perceived as a "nice but not essential" feature of mental health service policy and provision to genuinely being a core and consistent one.

Furthermore, in the absence of mental health services being held to account on this issue, the "why bother" question has some credence, with or without evidence.

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