Five Principles of Perinatal Peer Support

What does good look like?

mind for better mental health

MQPin Foundation Transforming mental health research

MATERNAL MENTAL HEALTH ALLIANCE Awareness Education Action

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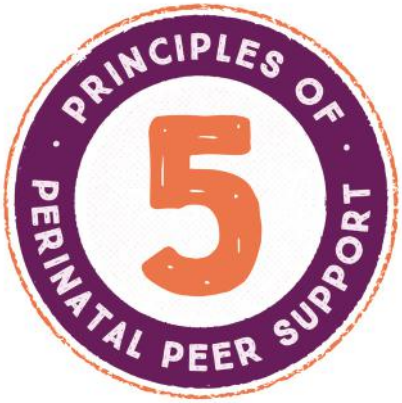


Introduction

The Perinatal Peer Support Principles were co-designed by people with lived experience, maternal mental health and maternity professionals, organisations facilitating peer support, Mind and the McPin Foundation.

Additional support, including testing and feedback, was provided by fellow Maternal Mental Health Alliance (MMHA) members and MMHA staff helped to coordinate the design and dissemination of the final principles.

You can learn more about the process and evidence at bit.ly/2Q7R4KK.

The Perinatal Peer Support Principles were designed to give peer supporters the confidence to create and deliver peer support that meets the needs of women and families affected by mental health problems during pregnancy or the postnatal period. Adherence to them should help ensure that peer support during this important time is safe, inclusive, informed, that it benefits everyone involved and remains distinct from - but closely connected to - clinical perinatal mental health services.

Our thanks to Comic Relief, whose funding made this project possible.

1 Good perinatal peer support **is safe and nurturing**

Good peer support fosters a culture of trust, non-judgement and empathy. It enables women to feel safe to share their experiences and difficult feelings should they wish to. This is facilitated by clear guidelines on how to discuss difficult topics safely, for example how much to share and in what way. Good peer support establishes clear ground rules and boundaries at the outset. These need to be revisited and renegotiated periodically as the peer relationship develops or group membership changes. Ground rules and boundaries should be developed within organisational policies but may be unique to each peer relationship as they are co-designed with peers.

Peer supporters and peer facilitators create a friendly and welcoming environment by being warm, demonstrating care and using positive language. Human relationships are crucial to peer support. Peer supporters and facilitators need to be free to share about themselves and have control over how much to share. Whilst the relationship should be nurturing, open and honest, peer supporters should guide conversations and ensure they are boundaried and safe. Therefore, peer supporters and group facilitators should be further along in their recovery. That does not mean that mums that have not been trained cannot offer peer support to each other in a group setting. However, this needs to be managed by a trained facilitator.

Group facilitators should encourage group members to think about their individual boundaries and how to maintain them in the group. This includes thinking about how much they are willing to share and hear, and whether they want to maintain contact with other group members outside of the peer support group.

A safe and welcoming environment is supported by robust safeguarding structures that ensure the safety of everyone involved including mums, babies and peer supporters.

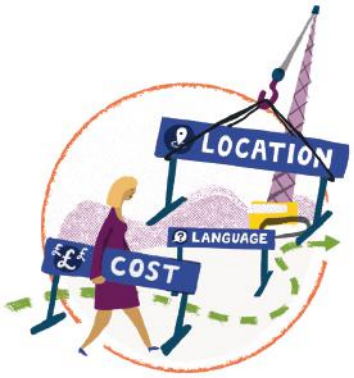
Peer support organisations need clear child and adult safeguarding policies and procedures, a safeguarding lead and clear reporting systems. These should be understood by staff, volunteers and project members/service users. If relevant, projects or services should also have lone working and home visiting policies and procedures in place. Peer supporters need to be trained in recognising and responding to potential safeguarding concerns. They should be supported to reflect on how to balance maintaining confidentiality and trust with acting to safeguard mums and babies.

Online peer support, whether a group-based forum or one to one messaging, should be facilitated through a moderated platform. Moderators should maintain safety by removing inappropriate and triggering posts and reaching out to platform users posing safeguarding concerns. In both face to face and online peer support, safety can be supported by positive relationships with clinical services. These can be useful in addressing safeguarding concerns and signposting of women who need additional support.

Reflective questions: principle 1

	Use the boxes below to note down how you have or are planning to achieve each principle. Think about how you will demonstrate how you have achieved each principle.	**What actions do I need to take?** If you have identified gaps or areas where you need to take action, what will this be?
a) What practical steps does your project take to create a welcoming environment?		
b) What are your safeguarding policies and procedures? Do you have a named lead? Do policies cover adult & child? Who could support you with developing this?		
c) How are ground rules and boundaries established and maintained within the project/service?		
d) If yours is an online service, what are the additional safety risks this might raise? For example, how is it moderated? What training have the moderators received? What are the limitations around using Twitter?		

2 Good perinatal peer support **is accessible and inclusive**



Good peer support takes proactive steps to ensure accessibility. An important part of this is the option of self-referral and limited waiting times. Practical steps that make it easier for women to attend face to face peer support include holding meetings in accessible locations with good transport links and at times suitable to peer support members. While some projects or services will find they need to provide childcare in order to increase accessibility, others may find that mums want the opportunity to attend a group with their children.

Ideally, peer support should address the financial barriers women face in accessing peer support, for example by covering transport costs and not organising activities that will cost women money. Using accessible language women can relate to can also be important. This may include avoiding mental health terminology in favour of more neutral terms like emotional wellbeing.

Maintaining control over what peer support to engage in and when can contribute to accessibility. This includes a choice of different types of peer support including whether it takes place in person or online, in a one to one or group format, and in the form of structured discussions about mental health or informal chats and activities. Choice over how often to engage in peer support (e.g. not being required to attend every session) and to what extent (e.g. not having to share at every session) is also important.

The option of phone and online peer support can increase accessibility, especially in rural areas with fewer face to face options. However, this may not be appropriate for everyone as some women might struggle with literacy or have limited internet access.

It may be that a range of peer support options cannot be achieved within one project, service or organisation, especially when it comes to small projects based in the community. Therefore it is important for different peer support projects and services to work together collaboratively as the full range of peer support choices on offer will increase accessibility of peer support to individual mums.

What each project or service can and should do is to increase accessibility for the specific group of women it is aiming to support. From this perspective, increasing accessibility might mean defining membership more narrowly.

This is important for women who might be reluctant to attend general maternal mental health peer support. This includes women with less common maternal mental health experiences such as postpartum psychosis, perinatal OCD or birth trauma. It could also include women from minority ethnic backgrounds, refugee and migrant women, women with disabilities, lesbian and bisexual women, and women who have experienced homelessness, drug and alcohol misuse, or contact with the criminal justice system.

Projects or services will need to consider if there are any specific accessibility issues relevant for women that they support and respond accordingly (e.g. running sessions in languages other than English).

Reflective questions: principle 2

	Use the boxes below to note down how you have or are planning to achieve each principle. Think about how you will demonstrate how you have achieved each principle.	**What actions do I need to take?** If you have identified gaps or areas where you need to take action, what will this be?
a) What steps has your project taken to increase accessibility?		
b) Does your project offer a range of different peer support formats and activities? Have you developed links with other peer support projects in your area to increase women's access to a variety of peer support options?		
c) Have you considered the specific barriers women accessing your project may encounter? What will you do to address this?		

3 Good perinatal peer support **complements rather than replicates the work of clinical mental health services**

Good peer support builds on what makes it unique and distinct from clinical mental health services. It offers holistic support that goes beyond mental health. It works flexibly to adapt to the needs of the mum and her family. The work of peer support and clinical mental health services should complement each other. As the outcomes of peer support and clinical mental health services overlap only partially, women need to have access to both forms of support. Depending on the women's circumstances, including the severity of the mental health difficulties they are experiencing, one approach may be more suitable than the other.

However, the two should establish relationships of interdependence and equal recognition should be afforded to both approaches. Maintaining positive relationships with local clinical teams can enable peer support projects or services to support women better, for example via mutual referral. A relationship with clinical services can be particularly useful for peer-led groups running in the community. It facilitates access to appropriate channels for any safeguarding concerns and could provide an avenue for accessing clinical supervision for peer supporters. However, peer support should be able to accommodate the needs of women who prefer to avoid clinical mental health interventions because of previous negative experiences. Therefore, good peer support remains one step removed from clinical services.

Different models and degrees of collaboration with clinical services advance or hinder different aspects of peer support. Peer support projects or services need to make their own decisions regarding what is suitable for them.

Negotiating relationships with clinical services may be more challenging in certain contexts, for example when peer support is funded by the NHS or located within the NHS. In those contexts, encouraging meaningful peer leadership and involvement of mums in making decisions about what the peer support is aiming to achieve can ensure peer support maintains its distinct nature.

While there is likely to be some overlap with clinical mental health outcomes, peer support projects or services should define their own outcomes. These may include things like feeling heard and understood or dealing better with being unwell (rather than focusing solely on becoming well).

Not all peer support projects or services will identify the same set of outcomes as relevant to their work. This can vary depending on the focus and context of the peer support and may reflect cultural variation in mental health concepts. Outcomes should be developed in consultation with mums who can identify what feels relevant to them. This can include outcomes specific to individual women (for example, reconnecting with a family member with whom they have a fraught relationship) or outcomes that could be relevant to all women in the peer support (for example, normalising the experience of having mental health difficulties or living with a particular mental health diagnosis).

When consulting women, it is important to consider what language to use – for example, asking about what they would like to get out of peer support rather than what outcomes they would like to achieve.

Reflective questions: principle 3

	Use the boxes below to note down how you have or are planning to achieve each principle. Think about how you will demonstrate how you have achieved each principle.	**What actions do I need to take?** If you have identified gaps or areas where you need to take action, what will this be?
a) What is your relationship to clinical maternal mental health services? How does this contribute to the support you provide?		
b) How is what your project offers similar different to clinical services in your area?		
c) What are the outcomes your project is aiming to achieve? How did you decide these?		

4 Good perinatal peer support **provides opportunities for meaningful involvement of people with lived experience and peer leadership**

Good peer support involves people with relevant lived experience in its design and delivery. It is essential that all peer supporting is done by people with lived experience considered relevant in a particular peer support context. This on its own does not guarantee the quality of peer support but is necessary for the support to act as peer support rather than professional support or voluntary support delivered by non-peers. This is particularly important in one to one peer support but should also be considered in group facilitation.

What can be considered relevant lived experience may differ depending on the context of peer support. At a minimum, this includes experience of maternity and mental health difficulties or struggling with emotional wellbeing. In peer support aimed at women with a particular mental health diagnosis, from a particular demographic or with a particular experience, such as twin and multiple births, disability, migration, drug and alcohol use, or contact with the criminal justice system, relevant lived experience will be more narrowly defined. This will shape who can be considered a peer in a specific peer support context. This may change over time as the project or service develops and should be reflected upon periodically.

If an organisation setting up peer support does not have relevant experience among its staff and volunteers, it should consult people who do when developing the project or service. It should recruit staff and volunteers with relevant lived experience to deliver it.

It is important that people with lived experience have a leadership role where they have a voice and can influence the direction of the peer support. This includes involvement at project management level and representation on trustee boards. Peer leadership can take different forms depending on the focus of the peer support, and the size and structure of the organisation running or hosting the peer support.

Larger organisations with established structures might find it more difficult to promote people with lived experience into leadership positions, while smaller organisations and informal initiatives might have more flexibility in enabling peers to take the lead. While peers who have taken on additional responsibility need to be supported in their roles, this support can be offered by people who have both lived experience and professional skills.

If these roles cannot be filled by people who possess both relevant lived experience and professional skills, it is preferable to skill up people with lived experience to take on management positions rather than recruit trained professionals without lived experience. If this is not possible, peers should at a minimum be involved in the co-production and co-design of peer support projects and services as equal partners.

Reflective questions: principle 4

	Use the boxes below to note down how you have or are planning to achieve each principle. Think about how you will demonstrate how you have achieved each principle.	**What actions do I need to take?** If you have identified gaps or areas where you need to take action, what will this be?
a) Who has been involved in the design of your project? Who is responsible for decision making?		
b) What aspects of lived experience are important in the context of your project? How do these experiences inform the shape of your project?		
c) Which leadership positions within your project / organisation are held by peers? Do you have relevant lived experience representation in management positions and if applicable senior positions at trustee level?		

5 Good perinatal peer support **benefits everyone involved, including peer supporters**

Good peer support enables peer supporters to benefit from their involvement in peer support. People with lived experience in supporting roles, whether one to one supporters, group facilitators or online moderators, are not merely 'providers' of support. They should have the possibility of benefiting from peer relationships. While they may not benefit from their involvement in peer support in the same way as the mums they are supporting, peer support organisations should recognise that offering peer support has an impact on supporters' mental health and wellbeing.

Some of the benefits they might experience are increased confidence, a sense of purpose and feeling helpful. Peer support organisations should recognise this as valid outcomes of peer support. This will guard against over-professionalisation of peer support where peers in supporter and leadership roles fill the position of 'service providers' rather than that of people engaging in peer relationships.

Peer support organisations need to provide peer supporters with training that will support them in their role. This should address how to engage in peer support relationships including how to enable a safe and nurturing environment, listening skills, facilitation skills, communicating and negotiating boundaries, safeguarding, and when to share confidential information. This should also include training on maternity specific topics such as feeding and sleep, and training on a range of maternal mental health conditions and experiences that they may encounter such as postnatal depression, postpartum psychosis, perinatal OCD, baby loss, and birth trauma.

Peer supporters should be trained on understanding the remit and recognising the limits of their role and where to signpost women who are in crisis or in need of additional support. Where smaller organisations lack the capacity to provide training in house they may seek external support, for example through external training courses, engaging independent consultants or developing relationships with larger organisations.

Peer supporters need to be provided with regular opportunities to debrief and reflect and identify additional training and support needs. This can take the form of supervision meetings. In larger organisations this will form part of organisational management structures. Small peer-led initiatives without a formal organisational structure can develop relationships with larger organisations that might be able to provide them with supervision and support. If they are unable to access this support from larger organisations, peer supporters should debrief and reflect in pairs or in group reflection sessions.

Peer supporters should ideally also have access to clinical supervision. In larger organisations and NHS affiliated peer support, this could be provided in-house. Smaller initiatives could develop relationships with local clinical mental health services, such as a local perinatal mental health team or a hospital mother and baby unit, to provide them with clinical supervision.

Reflective questions: principle 5

	Use the boxes below to note down how you have or are planning to achieve each principle. Think about how you will demonstrate how you have achieved each principle.	**What actions do I need to take?** If you have identified gaps or areas where you need to take action, what will this be?
a) How does your project impact the mental health and wellbeing of peer supporters?		
b) What training do you provide for your peer supporters and peer facilitators? How is this training relevant for your specific peer support context?		
c) What training and support do you provide for peers progressing into leadership roles?		
d) What kind of supervision & clinical supervision do your peer supporters have access to? Who could you approach to support you with this?		

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Notes

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