Peer Workers in NHS perinatal mental health services:

A values-based approach

mind
for better mental health

Contents

Acknowledgements

Our heartfelt thanks to the eight peer workers and eight clinicians who so generously gave up their time to share their expertise with us.

Thanks are also due to Cath Beard and Kathryn Grant, who helped us to recruit some of the clinicians. This piece was further informed by attendees at the MBU Shared Learning Day hosted by NHS England's Clinical Reference Group on 31 January 2020 and the Peer Support Day hosted by the Royal College of Psychiatrists' Quality Network for Perinatal Mental Health Services on 5 March.

We would also like to thank Louise Taylor, trainee clinical psychologist at the University of Southampton, who has shared insights from her research into peer supporters' emotional wellbeing, and her supervisor, Dr Pete Lawrence.

Finally, thanks to Liam Pywell and Suki Westmore at Mind, who have supported us through delivering this thought piece.

As a thought piece, the document is designed to be thought-provoking and offer perspectives on critical issues regarding Peer Support Workers and the wider health and social care system. HEE commissioned the document with the aim of making a helpful contribution to understanding, planning and expanding the presence of Peer Support Workers in health and care settings.

Author: Laura Wood
Contributors: Katy Chachou and Nisba Ahmed
Supported by: Suki Westmore and Liam Pywell (Mind)

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Introduction:

Perinatal Peer Support Principles

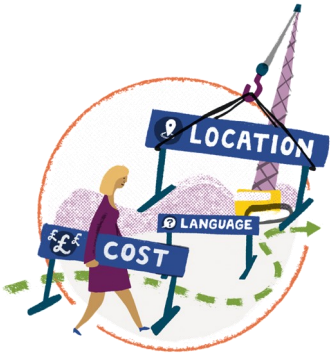
The Perinatal Peer Support Principles are a set of five values designed to give peer supporters the confidence to create and deliver peer support that meets the needs of women and families affected by mental health problems during pregnancy or the postnatal period.

The principles were co-designed by people with lived experience, perinatal 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. The project was funded by Comic Relief.

The principles constitute a framework of guidance for the implementation of values-based perinatal peer support roles in a variety of settings, including NHS perinatal mental health services. Since the launch of the principles in December 2019, peer support in these services has continued to expand and develop. Peer workers and peer support volunteers are increasingly being recruited to operate within these services and are becoming an integral part of the workforce. The principles offer guidance to ensure that this peer support is as beneficial as possible for everyone involved.

Download the perinatal peer support principles in full

https://maternalmentalhealthalliance.org/psp/



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Methodology

This thought piece has been co-produced by three mothers with lived experience of perinatal mental health difficulties, supported by staff from Mind and commissioned by Health Education England. We engaged in a series of discussions with peer workers and clinical staff within perinatal mental health services to understand how the peer support principles can be most usefully applied in the specified context. From these discussions, we offer some insights and recommendations to assure the quality and consistency of peer support in perinatal mental health services.

Initial discussions highlighted that perinatal peer workers are currently most well-established in inpatient settings, and due to the limited time and budget available, we intended to focus on peer workers in psychiatric mother and baby units (MBUs). We proposed to speak in depth with five peer workers currently based in MBUs and five senior members of staff in these units, in order to gather a range of perspectives around what both parties need to implement a values-based approach to peer support.

We exceeded our aim: we spoke with eight peer workers and eight members of clinical staff in both community and inpatient settings. This is testament to the enthusiasm and dedication of clinicians and peer workers in perinatal mental health services and their commitment to the values and benefits of peer support.

Two of the peer workers were also peer support co-ordinators, responsible for supervising other peer workers and developing peer support within the service. Three of the clinicians were consultant psychiatrists, one was a clinical lead overseeing several London boroughs, and the others were ward or service managers. We covered a broad geographical spread across the country, including a mixture of rural and urban areas, varying degrees of affluence, and perinatal teams serving different cultural communities.

We also hosted two workshops on peer support for perinatal peer workers and clinicians at the MBU Shared Learning Day hosted by NHS England's Clinical Reference Group on 31 January 2020 and the Peer Support Day hosted by the Royal College of Psychiatrists' Quality Network for Perinatal Mental Health Services on 5 March. Both events were attended by a mixture of clinical staff and peer workers and their conversations have further informed this thought piece.

Our initial discussions with peer workers also highlighted that some services were struggling to implement this values-based approach to perinatal peer support with regards to principle five. Principle five states that good perinatal peer support benefits everyone involved, including peer workers, and outlines what training and supervision peer workers need. Currently perinatal mental health services are not consistently providing training and supervision for peer workers which meets these quality standards.

For this reason, we resolved to focus upon how to ensure that peer workers receive the training and supervision that they need in order to safeguard their own emotional well-being and to provide excellent peer support to women and families. However, as our research progressed, other themes of equal significance emerged. As a result, the insights and recommendations offered by this thought piece are more equally spread across the five principles in turn.

National Overview: Peer Support in NHS Perinatal Mental Health Services

Making a Difference

Clinicians and peer workers reported that peer support, where it is consistently available, is making a significant difference to mothers and families who use perinatal mental health services. Some of the benefits described were:

- instilling hope – interacting with others who have 'been there' assures mothers that they, too, can and will get better
- increasing engagement with services - clinicians report that when reluctant mothers are supported by peers to embrace therapeutic interventions, it can 'turn cases around'
- improving staff culture - clinicians report that having peer workers in staff environments helps them to ensure that care remains compassionate and patient-centred
- offering ideas and suggestions for self-care and managing mental health - these are more effective when informed by personal experience and reduce the need for clinical input
- combatting stigma and self-stigma, especially for mothers from cultural backgrounds in which perinatal mental illness is associated with significant shame
- reducing isolation
- enhancing mothers' understanding about what they are experiencing and why
- supporting mothers to form a narrative about what has happened and its impact on their identity, as peers explore together the complex questions that can arise during recovery
- improving mothers' perception of the quality of their care

> "I believe that peer support is one of the most vital elements in the recovery process in mental illness. Before I met [the peer support worker] I genuinely believed that I was the one person who would never get better. Hearing her story and getting to know her as a well person gave me the hope I desperately needed to trust in improvement. No doctor or other staff member could provide that for me."
>
> ***Mother who accessed peer support on an MBU***

The 'Postcode Lottery'

Mothers who use perinatal mental health services do not have equitable access to peer support and what is available depends mostly upon where they live. Peer support provision varies wildly across different community and inpatient teams. This situation looks likely to improve as more peer workers are recruited in response to the NHS Long Term Plan, but some concerning inconsistencies are emerging in terms of how peer workers are established and supported.

It has not been within the scope of this study to gather data on every team in the country, and the picture is complex because of the role of volunteers and informal arrangements, but our sample reveals that there are numerous different 'set ups' with regard to peer support.

Some peer workers are paid and others are volunteers; some are employed by the NHS, while others are brought in via sub-contracts to the third sector; some have permanent contracts and others are employed for anything from one year to five; some work alone and others in small teams; some exclusively deliver peer support and others are also responsible for public and patient involvement; some are paid significantly more than others.

The number of peer support 'hours' varies considerably, as does the training and support that peer workers receive. One service manager relies solely on an informal group of volunteers and so **'it often just doesn't happen'.**

Peer support is generally more successfully embedded in the newer services, where mothers with lived experience have been involved in designing and developing the service from the very beginning. A small number of peer support co-ordinators have also been recruited to oversee and develop peer support in certain areas. [1]This has a significant impact on peer workers' wellbeing and effectiveness, and subsequently enhances the benefits described above.

As a result of the variation in how, and by whom, peer workers are established and supported, peer workers' own wellbeing and the extent to which they can deliver good quality peer support also varies considerably. Peer workers and clinical staff have called for national standardisation, including a greater presence in the perinatal quality network standards hosted by the Royal College of Psychiatrists, to ensure that mothers have equitable access to peer support as part of their care. They have also suggested other measures to improve peer support within perinatal services on a national level: these are outlined at the end of this thought piece.

[1]These are also called 'peer support leads' or 'peer support facilitators'. Their role is described in more detail under principle four.

1 Good Perinatal Peer Support is Safe and Nurturing

The first of the perinatal peer support principles concerns balancing robust safeguarding structures with a friendly and welcoming environment that has human relationships at its centre. These are essentially two sides of the same coin: physical and emotional safety, being safe and feeling safe.

Safe Environments: 'Handovers' and Home Visits

Our conversations with peer workers and clinical staff emphasised the need for a comprehensive 'handover' as a critical element in safeguarding both peer workers and mothers using the service, especially in a ward environment. For example, when a peer worker arrives, she should be briefed on who's there, how everyone is doing, and any immediate risks or concerns. When she leaves, she should have the opportunity to raise any of her own concerns, both for patient safety and her own wellbeing. Peer workers have reported that a handover on departing helps them to 'leave work at work' and avoid a negative impact on their personal lives. Currently some peer workers consistently have handovers and others do not.

Some community teams have found it beneficial for peer workers to accompany clinical staff on home visits rather than to go alone: this can feel safer, particularly if the peer worker is new to the role or if it's the first time that she and the mother have met. Peer support does not need to be limited to the home or NHS premises and should be flexible to accommodate the needs and desires of its participants. Peer workers, particularly those employed by Action on Postpartum Psychosis (APP), offer one-to-one meet ups and run successful groups in cafes and other public venues.

Safe Conversations: Boundaries and Limits

Principle one states that, since human relationships are crucial to peer support, peer workers need to be free to share about themselves and have control over how much to share. Some services have struggled with this issue: one peer worker, on her first day, was told specifically which elements of her own experience she should emphasise and which she was forbidden to discuss. This made her feel, understandably, that her judgement was not trusted or respected by her colleagues, and she reports that it has inhibited her relationship with mothers on the ward and her ability to offer peer support: **'I may as well be a healthcare assistant.'**

Services need to trust the judgement of the people whom they recruit as peer workers, and peer workers should be able to maintain individual boundaries as an essential component of their training.[2]

[2]Peer workers' training will be discussed in more detail as part of principle five. This example demonstrates how, because there is no universal standard of training for perinatal peer workers, their NHS colleagues cannot be confident of the skills that they have.

Principle one adds that, so that peer workers can guide conversations to ensure they are boundaried and safe, they should be further along in their own recovery. Different services, and the third sector organisations with whom they sometimes work in partnership, have very different views about how much time should have elapsed since a woman's own experience of perinatal mental illness before it becomes appropriate for her to take on a peer worker role. Recommendations varied from one to three years, while peer workers are being employed as soon as six months after discharge from the ward and one month after discharge from the community team.

Strong concerns emerged about a peer worker's experience being too recent and therefore 'too raw'. One peer support co-ordinator said that **'history tells us that it can go very wrong'.** These fears centred mainly around the peer workers' wellbeing: the content of any conversations she might have or events she might witness, the physical environment, or the burden of responsibility all might cause distress or even trigger a relapse. Alternatively, these fears might manifest in the attitudes of staff, who may be 'walking on eggshells' or struggling to view the peer worker as a colleague rather than a patient.

These are valid concerns, yet most people agreed that one cannot impose a timeline on recovery because it's individual. 'Recovery' is a subjective term and means different things to different people: one peer worker described herself as 'still in recovery'. One peer support co-ordinator pointed out that the same restrictions would not apply to a clinical staff member who had been signed off work with a mental health problem and so the time limits imposed by some services constitute discrimination.

While it's essential that a peer worker is ready to take on the role, there's no simple formula for ensuring this. Mothers who wish to take on a peer worker role need to be supported to self-identify the point in their recovery at which they are ready. For this reason, a careful recruitment and interview process is of vital importance. A peer support co-ordinator should lead this process if possible, and, if not, peer workers should be involved in a co-produced approach to recruitment and selection. Peer support co-ordinators suggested that the risk to peer workers' own wellbeing can also be mitigated by applicants' giving a presentation on their own recovery or experience, and by visits to the service in advance of beginning the role, to get new peer workers used to being in the environment.[3]

There might also be opportunities for people to undertake voluntary roles involving more 'light touch' peer support activities, such as helping to facilitate a coffee morning, before they are ready for the responsibility of an official peer worker position.

[3]The diversity of perinatal peer support will be discussed further as part of principle four. These 'light touch' approaches are also a valuable way to solidify training and increase confidence when a peer worker is new to the role.

2 Good Perinatal Peer Support is accessible and inclusive

Principle two stipulates the need for every service to take proactive steps to increase accessibility for the specific group of women it is aiming to support. It discusses various potential barriers that need to be considered, and stresses that different peer support projects and services should work together collaboratively as the full range of peer support choices on offer will increase accessibility of peer support to individual mothers.

Barriers to Accessing Peer Support

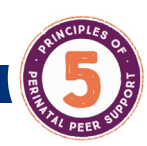
Many mothers cannot access peer support within perinatal services because their local service does not prioritise it. This means that there are not enough peer workers for enough hours to reach everyone who would benefit.

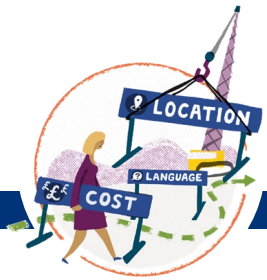
The peer workers and clinicians we spoke with also told us that accessibility for mothers can be affected when they are discharged from the MBU to the community perinatal team, or to a general adult community mental health team in an area where specialised perinatal care is not available. Geography and logistics can make continuity of peer support a challenge, and this is exacerbated when NHS staff do not understand and value peer support. Staff do not always inform peer workers when mothers are discharged or make appropriate referrals.[4]

Other barriers include location, cost, language, and childcare, as well as specific mental health conditions. A postnatal depression group, for example, may not be relevant or appropriate for someone suffering from perinatal OCD, and she might equally be reluctant to engage with more general perinatal mental health peer support. Similarly, mothers might be hindered from accessing peer support on account of different cultural backgrounds or life experiences.

Services must consider the needs of mothers from minority ethnic backgrounds, women with disabilities, LGBT+ families, and mothers affected by homelessness, drug and alcohol misuse, or contact with the criminal justice system. Sometimes increasing accessibility can mean defining membership more narrowly, which is why partnership working is important.

[4]The need for greater staff awareness about the role and value of peer support is discussed further under principle three.





Case Study 1: Lancashire and Cumbria

In Lancashire and Cumbria, APP provide peer support on a sub-contract from the Trust, where they offer peer support to women at the Ribblemere MBU and surrounding community teams. APP have a strong record of excellence in peer support, but also have a very specific remit. Postpartum psychosis affects 1-2 in 1000 women, and accounts for around 30% of perinatal hospital admissions. APP increase accessibility for women who do not have this diagnosis by offering peer support to all women on the ward, and supporting those with bipolar and psychosis following discharge into the community, through individual support, online support and café groups. Café groups are open to anyone affected by postpartum psychosis in the region. In this way, people may come through the project, train as volunteers and support others, whilst still being supported themselves.

Additionally, APP's online forum and messaging is universally available and accessible to those who prefer an online support, and telephone and Skype support is also offered. These steps improve accessibility for those with postpartum psychosis, but there are still mothers who are not able to access peer support appropriate to other perinatal mental health difficulties. APP have created a signposting directory of organisations for women with other diagnoses both whilst they are an inpatient and on discharge, but the project is hampered by not enough other organisations offering support to women with perinatal mental health conditions in the area.

Case Study 2: Birmingham

In Birmingham, peer workers from three separate third sector organisations work in partnership with the NHS team. APP have joined forces with Acacia, who support families affected by perinatal depression/anxiety, and Approachable Parenting, who support families from BAME communities. In this way, all mothers who use the perinatal service can access peer support specific to their needs. There are opportunities for a woman to be supported jointly, if, for example, she has postpartum psychosis and is from a BAME background, and the peer workers from the three organisations also run groups together. This co-working is managed by all three organisations and the NHS team so that each peer worker is trained, supervised, and supported by her host organisation and the NHS jointly – and they also have the opportunity to train and learn from each other.

A specific BAME organisation was included in the project after clinicians identified that BAME communities were significantly under-represented in terms of the families they were seeing. They did an analysis to demonstrate the need for better access for BAME families and used research which illustrates that those communities are more likely to engage with representatives from the third sector than the NHS directly to make a case for funding the project.[5]

Birmingham's peer support has been described as 'a gold standard model' but there may be capacity issues in scaling it up nationally, particularly given gaps in peer support provision in large areas of the country. There is a need for further research to demonstrate the value of peer support in perinatal services as this would help to ensure the funding required.

[5] *see the ENRICH study: https://www.ncbi.nlm.nih.gov/books/NBK373873/.*

Partners and Families

The NHS Long Term Plan stipulates that perinatal mental health services will become more family-orientated, with fathers able to access support as well as mothers. At the moment, perinatal peer support is mostly provided for and accessed by mothers, but some peer workers do support partners and families as part of their remit. One service has identified the need for a male peer worker to support fathers and partners specifically, especially since the clinical team are also almost entirely female, and the aim is to recruit one in future.

At another service, peer workers have set up a private, moderated Facebook group in which families using the service can connect with one another. Through this group, fathers have accessed craft-based peer support activities alongside their partners. Other suggestions to encourage families to participate in peer support have included a peer support display board, with photographs, personal stories, and a flyer, and a film about the MBU featuring a peer support worker who shares about her own experience. The latter is watched by families before mothers are admitted and subsequently the peer worker is recognised as a friendly face.

3 Good Perinatal Peer Support complements rather than replicates the work of clinical mental health services

Principle three describes how good perinatal peer support builds upon what makes it unique and distinct from clinical support. It should be holistic and flexible, adapting to the needs of individual families, and peer workers and mothers should decide together what outcomes they would like to achieve. In order for peer support within perinatal services to flourish, peer workers need positive relationships with clinicians in which both approaches are equally valued and respected.

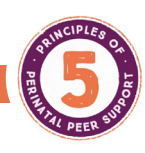
Different Models and Different Views

While principle three stresses that 'good peer support remains one step removed from clinical services', perspectives differ about the extent to which peer workers should integrate into NHS teams. Some services deliver peer support via sub-contracts to third sector providers while others employ peer workers directly through the NHS. These two different models have 'implications for peer workers' ability to act – and be perceived – as distinct from yet complementary to clinical care. Each has advantages and disadvantages in terms of its impact upon complementary peer support.

Some peer workers felt that being employed by the third sector rather than the NHS was a way of remaining true to the nature of peer support as distinct: 'being a step removed from the NHS is incredibly valuable'. One stressed that it was 'important to have that impartiality' and said that mothers were more likely to be open and honest with someone who wasn't wearing an NHS badge or lanyard.

Peer workers also benefit from opportunities for training and support from both organisations, and tend to be better paid by their host organisations than NHS peer workers. Women who are highly skilled and successful in previous careers report taking huge pay cuts to become NHS peer workers, and feel 'frustrated' and undervalued as a result.

On the other hand, one peer worker employed by the NHS described that as 'the best way'. She said that being an NHS employee made her feel 'on a level playing field' with other staff and that it was important to integrate fully into the team in order to have access to patient notes and be included in care planning. Third sector peer workers reported that a lack of integration into NHS teams made delivering peer support more logistically difficult: examples included the lack of an NHS email and not being able to share calendars with colleagues. They also said that NHS staff did not fully recognise them as team members and so would not always give them enough information about individual cases.




As such, both models present opportunities and challenges for delivering peer support that complements the support offered by clinical colleagues. Where peer workers are employed by the NHS, it's important that the distinct nature of their role and the support that they offer is honoured and upheld. Where peer workers are employed by the third sector, they must have the respect and co-operation of NHS staff in order to operate effectively within services. Peer support within clinical mental health services is inherently something of a paradox: it must be separate to remain true to the values of peer support, yet integrated to be part of what the service offers. For this reason, careful consideration is required when establishing peer support within perinatal mental health services in order to get that balance right.

> Peer support can help mothers with mental health difficulties in ways that are different from professional support, and many mothers found peer support to be effective in improving their mental health.
>
> Prof. Susan Ayers, City, University of London (See http://www.ogpnews.com/2020/02/research-shows-mum-to-mum-support-improves-mental-health-and-wellbeing/51289).

Different Outcomes

The distinct nature of peer support is reflected in its outcomes. Principle three stipulates that: '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).'

This poses a challenge in the NHS, in which an evidence base is essential for securing funding. Clinical tools, such as Health of the Nation Outcome Scale (HoNOS), are commonly used by NHS services to measure the effectiveness of interventions, but these are inappropriate for assessing the quality and usefulness of peer support. Subsequently, it can be difficult to persuade commissioners and clinicians alike of the value of peer support, when they have not seen it 'in action'.

The clinicians we spoke to testified to the difference that peer support can make – 'you suddenly see that spark' – and this is corroborated by the testimonies of the mothers who benefit. This evidence for the effectiveness of peer support can be difficult to capture.

Peer workers and mothers can co-produce their own outcomes to measure, but these will be unique to every peer relationship and not comparable on a larger scale. For this reason, services might consider adapting the self-defined 'goal-based outcomes' approach that is often used in CAMHS, but this should only be used where the peer worker and mother mutually agree that it would be helpful.[6] Generally qualitative data is likely to be more useful than quantitative in illustrating the difference that peer support makes.

[6]See https://www.corc.uk.net/media/1219/goalsandgbos-thirdedition.pdf.

As a result, some areas are struggling to provide peer support for mothers using their perinatal services. Commissioners have proposed hiring peer workers at very low pay grades, such as band 2, which do not reflect the responsibility of the role or the skills required; or they have tried to integrate peer support into occupational therapy, activity co-ordinator, or health and wellbeing assistant roles by hiring someone with lived experience.

Both proposed solutions reflect a fundamental misunderstanding of what peer support is and what it does. Some service managers have accepted these offers and others have rejected them, but either way mothers using these services do not have access to peer support that meets the standards outlined in the perinatal peer support principles. One service manager emphasised that embedding the principles into the quality network standards, so that commissioners were required to fund peer support adequately, would help to improve this situation.

A Supportive Culture

Principle three highlights the importance of positive working relationships between peer workers and clinical staff. These should be egalitarian and reciprocal: **'the two should establish relationships of interdependence and equal recognition should be afforded to both approaches.'**

Research into peer worker wellbeing more generally corroborates this: peer workers are only able to operate without a detrimental effect to their own mental health when structural support like training and supervision is underpinned by a supportive staff culture. For this to be possible, staff need to understand and value the peer worker's role[7]. Some clinical staff have embraced this approach, describing the arrival of peer workers as **'an incredible opportunity that brings really great things for lots of people'**. Others have found it more difficult to understand what a peer worker is and does, and how valuable their role can be.

Subsequently some peer workers describe a 'battle' in procuring resources for groups and activities as well as numerous other 'obstacles and hurdles' in providing peer support. For example, they have been offered unsuitable venues for groups, such as an office, and forbidden to pay for an alternative. They perceived that staff were unable or unwilling to support them in their role or to refer mothers for peer support in the first place. They felt 'belittled' and 'patronised' by clinical colleagues – **'like they look down on us'** – and said that, as a result, they didn't feel that they were making a difference to mothers, describing the situation as 'very frustrating' and 'really challenging'.

Some were prevented from engaging with mothers whom staff deemed 'too poorly for peer support'. Other peer workers had more positive experiences: one said that she felt staff on the ward understood the inherent power imbalance, because she had previously been a patient there, and actively sought to redress that. She described this as down to **'empathy and interpersonal skills... It's all about individual personalities.'**

[7]*Louise Taylor, trainee clinical psychologist at the University of Southampton, shared these insights from her research into peer supporters' emotional wellbeing.*

Peer workers and clinical staff alike have called for greater staff awareness about the role of peer support and its value, and they have specified that education on the subject is needed for the whole team working in perinatal services. One peer support co-ordinator has responded to this need by developing a short training session for staff, delivered in 45 minutes at the end of a team meeting, before a peer worker is introduced.

Peer workers have also suggested that their managers might benefit from attending an event like Peerfest, Mind's annual celebration of peer support, or from attending one of the peer support groups run within the service: 'If they saw what we're providing and talked to the mums, they would have a better understanding of what perinatal peer support is.'

4 Good Perinatal Peer Support provides opportunities for meaningful involvement of people with lived experience and peer leadership

Principle four explains how perinatal peer support should involve people with relevant lived experience in its design and delivery. This means that peer workers and mothers affected by perinatal mental health difficulties should lead decisions about how peer support happens within the service. This includes involvement at project management level and, wherever possible, mothers with lived experience should be skilled up to take on management positions. If this is not possible, they should be involved in the co-production and co-design of peer support work, as well as the service in which it takes place, and treated as equal partners throughout that process.

Freedom of Choice

Peer workers should be free to choose what form(s) of peer support they provide so that it aligns with their own personal strengths and the needs and preferences of the individual mothers whom they support. This might mean offering one-to-one conversations, home visits, or supporting mothers to attend local play groups or appointments elsewhere, such as the Housing Association. It might mean facilitating groups, coffee mornings, film clubs, book clubs, trips out, nail painting and beauty treatments, baking, crafts, music, gardening, dance, brunches, or drop-in sessions.

One peer worker summarised this: 'It's about what that individual wants to do for that job." Unlike clinical support, peer support is primarily personal and relational, and as such it will reflect the personalities and interests of those involved. Peer workers should have opportunities to discuss and re-evaluate their plans as part of supervision.

Some peer workers praised the autonomy they have within the service - 'the managers let us make it our own' - But Others raised concerns about being used as occupational therapy assistants or support workers by staff who did not understand the distinct nature of peer support. Some peer workers felt 'micromanaged' and that they were being continually asked to work in ways that they found 'stressful', such as running large groups single-handedly or undertaking home visits when they had found that mothers using the service preferred groups or drop-in sessions: 'We have identified a massive need but our managers are not listening to us.'


Equally, others felt that they were just 'left to it' without enough guidance, that they didn't know what was expected of them and no one else seemed to know either. It is important that NHS staff work with peer workers to find the correct balance between autonomy and guidance: this will be unique to every individual peer worker and must be dictated by their needs.

Peer workers emphasised the need for clarification about their role. The quality network standards for community perinatal services specify that peer workers must have a defined role description, but there are concerns that this will interfere with the autonomy which is so crucial to good peer support. Therefore any role description must be worded with care to reflect the diversity of peer support and its peer-led nature, and it should either be written by the peer workers themselves or co-written with them. If they have yet to be recruited, it must be revised by them as part of their induction process so that they can make any changes necessary.

Career Progression

The role of peer support within perinatal services is rapidly developing, and this process must be led by peers themselves in order to remain true to the values of peer support. This is happening in some areas: where peer support co-ordinators have been recruited, they play a vital role in recruiting and supervising peer workers, designing and delivering training, ensuring accessibility, gathering and monitoring feedback and satisfaction measures, and leading quality improvement.

Peer support roles are attracting highly-skilled graduates and women who held positions of considerable responsibility in previous careers – one peer worker we spoke to used to rehabilitate child sex offenders – and NHS colleagues do not always seem to appreciate this: 'services need to recognise how capable these people are'. Research into peer workers' wellbeing has highlighted the importance of career progression.[8] Peer co-ordinator roles are a part of this, but peer workers need opportunities to gain new skills and knowledge more generally, and to explore other aspects of perinatal care if they wish to do so.

While it is important that peer workers have opportunities to contribute to other areas of the service, they should not be required to this as part of their role. Peer workers particularly voiced concerns about being 'shoehorned' into leading on service user involvement when this is not necessarily relevant to their skill set or interest: 'the NHS wants more than peer support from its peers'. It is important that service users are involved decisions about in the design and delivery of all aspects of care provided by perinatal services, and this currently operates more successfully in newer services – for example, mothers were involved in setting up the MBU at Dartford 'from scratch' – while it poses more of a challenge in services which were established without that input. However, this falls outside the remit of peer support and so peer workers should not be required to facilitate user involvement unless they wish to do so.

[8] *Louise Taylor, trainee clinical psychologist at the University of Southampton, shared these insights from her research into peer supporters' emotional wellbeing.*

5 Good Perinatal Peer Support benefits everyone involved, including peer supporters

Principle five explores the ways in which peer workers can benefit from their involvement in peer support. Peer workers are not 'providers' of support in the same way that clinicians are and should be able to benefit from peer relationships, although they may not benefit in the same way as the mothers they are supporting. Some benefits peer workers might experience are increased confidence, a sense of purpose, and feeling helpful. Perinatal mental health services must recognise that offering peer support has an impact on peer workers' own mental health and wellbeing, and take steps to ensure that the impact is a positive one. These steps must include providing adequate training and supervision.

> I find it incredibly rewarding and moving to personify that hope which can be the catalyst for change and healing. It is a privilege borne out of extreme desolation, a treacherous journey and a new way of light and hope.
>
> **Perinatal peer support worker**

A New Profession

Peer support originated within user groups and self-help spaces as mutual and reciprocal support between people who were facing similar challenges. The recent development of peer workers delivering support informed by their own lived experience within mental health services constitutes something of a departure from this. While it offers numerous benefits and opportunities, it also poses challenges, many of which are manifest in the issues already described in this thought piece.

The peer worker is further along in her own recovery and she is usually employed and paid – as such, she is not quite a 'peer' in the original sense, nor is she supported reciprocally by the mothers whom she supports.[9] For this reason, it's essential that she is well-supported by others.

The peer workers we spoke with described their role an emerging profession which is valuable but currently under-valued. They called for recognition as a professional body; for an annual forum with opportunities for networking and development; and for universal, accredited training: 'If we had this training and a network of support for peer support workers, then I feel we could do our job much better.'

[9]See Alison Faulkner's blog post for NSUN (National Survivor User Network), 'The Inconvenient Complications of Peer Support' parts 1 and 2: https://www.nsun.org.uk/Blog/the-inconvenient-complications-of-peer-support

Training

The perinatal peer support principles provide clear, evidence-based guidance about what training a peer worker needs: '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.'

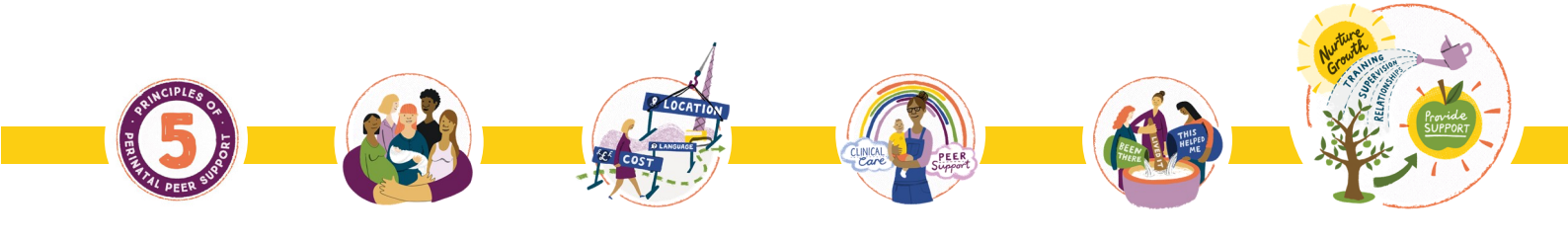
Most peer workers do not currently have access to this comprehensive training. In fact, many get no training at all. Some have generic induction training for NHS mental health staff, often delivered online and covering topics such as physical restraint and safeguarding, but it can take as long as year for access to be arranged. Some are joining clinical colleagues or those working in primary care on general perinatal mental health awareness training; others are accessing non-specific peer support training through the local NHS Trust. Generally peer workers reported low satisfaction with this training, describing it as 'very basic', 'patronising', and 'disappointing'. Peer workers also described actively seeking out training that was specific to perinatal peer support, only to be told that the NHS wouldn't pay for them to attend.

The perinatal peer support principles suggest that: '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.'

Where peer workers are recruited through the third sector, those organisations tend to provide their own training, which peer workers receive in addition to any NHS staff training. APP, for example, have developed training which includes peer support skills, scenario-based work on managing difficult situations, and how to access ongoing advice and support.

> 'I've learnt a lot about peer support and feel confident to deliver it. I had some great conversations with amazing, dedicated APP leaders and met lots of brave and fabulous women.'
>
> **feedback from someone who accessed APP's peer support training**

This is highly praised. APP are currently working towards offering this training to NHS peer workers, along with follow up support. They also have a peer support manual for volunteers who have experienced postpartum psychosis, and this is a valuable resource which could be adapted in future.



Another example of successful training for perinatal peer workers has been developed by a peer support co-ordinator, who identified the need for training for the peer workers in her area. This takes the form of NCFE peer support training with an extra two days added, including perinatal mental health difficulties, an exploration of what activities a peer worker might want to facilitate, creating an individualised timetable, challenges or pitfalls that perinatal peer workers might encounter, plans to protect peer workers' own mental health, making the most of supervision, and how to use patient notes on NHS IT systems.

Peer workers unanimously called for universal, accredited perinatal peer support training. It might be achieved by adapting accredited non-specific peer support training which is already available via numerous organisations. The process would need to be co-produced by a diverse group of people already involved in perinatal peer support and informed by the perinatal peer support principles.

A lot of work has already been done on developing perinatal peer support training by different people and organisations in different parts of the country: APP, the NCT's 'Parents in Mind' project, Mind's 'Mums Matter' project in Hertfordshire, and individual peer support co-ordinators in perinatal services, amongst others. It's important that we make the most of their expertise and avoid 'reinventing the wheel' wherever possible.

Supervision

Principle five states that: '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... Peer supporters should ideally also have to access clinical supervision.'

Recent research into peer workers' wellbeing also emphasises the importance of access to supervision but shows that provision varies considerably in different services[10]. Supervision provides an opportunity to share and exchange ideas and raise concerns, as well as guidance and reassurance. It increases peer workers' confidence and reduces anxiety, and peer workers feel valued and cared for when someone who is warm, trustworthy, and approachable asks about their wellbeing and takes any concerns seriously.

Perinatal peer workers described supervision meetings in which they were invited to talk about their plans, workload, concerns, and wellbeing as 'helpful' and most had positive experiences. The two exceptions both highlighted the fact that they felt their own wellbeing was not considered important:

> The supervision is all patient-related and role-focussed, about the programmes and activities we have on offer. There is no debrief for me or any discussion about my health and wellbeing. If this was part of the supervision, it would benefit me a lot.

[10] *Louise Taylor, trainee clinical psychologist at the University of Southampton, shared these insights from her research into peer supporters' emotional wellbeing.*

This reflects the fact that, for some services, there is a lack of clarity about the purpose of supervision for peer workers, in terms of what supervisory meetings or discussions should cover. Peer workers and clinicians agreed that peer workers' wellbeing should be a priority in supervision. One service manager believed that psychologists on the team should have input for this reason.

Our conversations highlighted the variety amongst the supervision that perinatal peer workers currently receive. This can be meetings with their line manager, such as a ward manager or team leader, clinical supervision, group supervision, reflective practice, or peer workers' supervising one another. Peer workers can also be supervised by occupational therapists, psychologists, senior nurses, or peer support co-ordinators. Supervisions can take place in a multi-disciplinary group, with other peer workers in the service or across the whole Trust, or indeed individually. Many perinatal peer workers have multiple supervision structures with any combination of the above. The frequency also varied: weekly, fortnightly, monthly, or quarterly, or just on an impromptu basis.

Monthly supervision meetings with line managers seemed to be the most common arrangement, but peer workers were vocal and emphatic about the benefits of peer-to-peer supervision. What they valued most was having time with other perinatal peer workers for reflection, sharing learning and ideas, and mutual accountability. Clinicians echoed this: one confessed that she had assumed that clinical supervision would be paramount but found that 'the support for one another is better'. This echoes the findings of recent research, which shows that peer workers need support from other peer support providers. [11]

Perinatal peer workers recognise this: one described arranging 'get-togethers at least once a week so we can support one another', and many have started or joined virtual groups for the same purpose, usually via Facebook or WhatsApp. As peer support has become professionalised, a new need has emerged: namely, peer support for peer supporters.

Peer support co-ordinators play an important role in developing and facilitating this peer-to-peer supervision. They can also act as a 'link' for concerns or information to be passed on to relevant parties. Where peer workers in perinatal services are employed by the third sector, these organisations provide a valuable parallel supervision structure so that peer workers benefit from multiple perspectives. NHS supervision helps them to be embedded in their team and the third sector provides the 'peer-to-peer' view which is informed both by lived experience and experience of delivering peer support. It was clear from our conversations that, however peer workers are employed, they need access to supervision both from NHS staff and other peer workers in order to thrive.

[11] *Louise Taylor, trainee clinical psychologist at the University of Southampton, shared these insights from her research into peer supporters' emotional wellbeing.*


Recommendations

Summary of Recommendations

In light of our conversations with perinatal peer workers and clinicians, we suggest the following measures in order to ensure the quality and consistency of peer support in perinatal mental health services. The perinatal peer support principles and accompanying self-reflective grid will be a valuable tool in implementing these, both for individual services and nationally. These can be downloaded at: https://maternalmentalhealthalliance.org/psp/

Key Recommendations

- Universal accredited training for perinatal peer workers. (See the section on principle 5)
- All staff working within perinatal services to receive a short additional training session on the role of a peer worker. (See sections on principles 1, 3, and 4)
- Dual support structures for peer workers which include supervision with both NHS colleagues and other perinatal peer workers. Clearer guidance should be co-produced with peer workers about how regularly and with whom they should access clinical or managerial supervision, and what that supervision should entail. (See sections on principles 4 and 5)
- Increased collaboration with third sector organisations delivering perinatal peer support to benefit from their expertise and increase accessibility for women and families. (See sections on principles 2 and 5)
- Detailed specifications about peer support embedded within the quality network standards for both community and inpatient perinatal mental health services. We have already initiated conversations about this with the Royal College of Psychiatrists. (See the national overview, and sections on principles 3 and 4)
- Increased opportunities for development and networking for perinatal peer workers across the country, including opportunities to meet peer workers in other teams face-to-face and share learning and best practice. (See principle 5)

Further Recommendations and Considerations

- A pay review for peer worker roles. We believe that no one responsible for peer support within a perinatal service should be paid at less than band 3. (See section on principle 3)
- More research to demonstrate the value of peer support within perinatal services to commissioners and other potential funders. (See sections on principles 2 and 3)
- More perinatal peer support co-ordinators. The aim should be for every perinatal service should have access to the expertise of a co-ordinator for development of peer support. (See national overview and sections on principles 1, 3, 4, and 5)
- As the Long Term Plan is implemented and services become more family-oriented, a wider range of peer support will be required, including for fathers and partners. (See section on principle 2)
- Peer workers in an MBU setting to have a 'handover' when they arrive and when they leave. (See section on principle 1)
- Recruitment and selection of peer workers to be led by a peer support co-ordinator, or co-produced with other peer workers. (See sections on principles 1 and 4)
- Peer workers to be supported to write their own role descriptions; alternatively these can be revised by peer workers after recruitment. (See section on principle 4)
- Recognition of peer workers as a professional body with the same rights and support as other professions. (See sections on principles 4 and 5)