ImROC
Implementing Recovery through Organisational Change

Centre for Mental Health

Mental Health Network NHS CONFEDERATION

Briefing

7. Peer Support Workers: a practical guide to implementation

Julie Repper

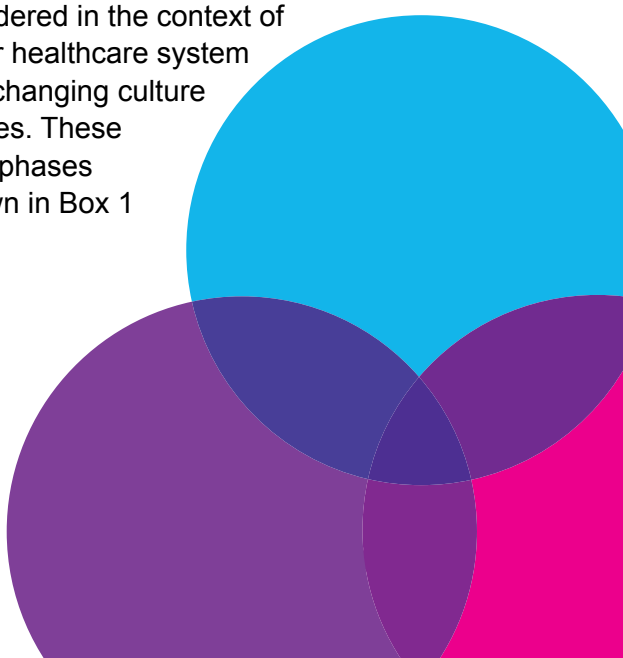
with contributions from **Becky Aldridge, Sharon Gilfoyle, Steve Gillard, Rachel Perkins** and **Jane Rennison**

INTRODUCTION

Our experience with the ImROC programme has led us to the conclusion that the widespread introduction of people with lived experience of mental health problems into the mental health workforce is probably the single most important factor contributing to changes towards more recovery-oriented services. In the first paper on this topic (Repper, 2013) we discussed the theoretical background, core principles and the range of potential benefits. In this paper we will discuss practical issues of implementation in more detail.

When developing peer worker posts, it is useful to think of four sequential phases. The first involves **preparation** – of the organisation as a whole, of the teams in which peers will be placed, and, perhaps most obviously, of the peers themselves. The second phase involves **recruitment** of peers to the posts that have been created or existing posts that have been modified for peer workers. Given the likelihood that peer applicants may have not worked for some time, nor been through an interview process with all of the formalities and checks that this brings, the whole process needs careful support. Thirdly, there is the safe and effective **employment** of peer workers in mental health organisations. Finally, the **ongoing development** of peer worker opportunities and contributions needs to be considered in the context of the wider healthcare system and the changing culture of services. These different phases are shown in Box 1 below.

.



Box 1: Developing peer worker posts: four phases

1. **Preparation**
   - Preparing the organisation
   - Preparing the teams
   - Defining roles
   - Common myths and misconceptions
   - Preparing the peer workers (training and work placement opportunities)
   - Developing job descriptions and person specifications
2. **Recruitment**
   - Advertising
   - Benefits advice
   - Applications
   - Interviews
   - Occupational health
   - CRB checks
   - Supporting people who are not offered posts
3. **Employing peer workers**
   - Selecting placements
   - Induction/orientation
   - Supervision and support
   - Maintaining wellbeing
4. **Ongoing development of the role**
   - Career pathways
   - Training opportunities
   - Wider system change

ACKNOWLEDGEMENTS

Advances in recovery-focused practice arise from collaborative partnerships between individuals and organisations. The ImROC briefing papers draw upon this work. Each paper in the series has been written by those members of the project team best placed to lead on the topic, together with contributions from other team members. In this case we particularly wish to acknowledge the contribution of those individuals who have been prepared so generously to share their materials and experience on this important topic. We particularly want to acknowledge the contribution of **Becky Aldridge** (Dorset Mental Health Forum), **Sharon Gilfoyle** (Cambridgeshire and Peterborough NHS Foundation Trust), **Liz Walker**, **Emma Watson** and **Marissa Lambert** (Nottinghamshire Healthcare NHS Trust) and **Jane Rennison** (Central and North West London NHS Foundation Trust).

PHASE 1 – PREPARATION

Preparing the organisation

The development of peer worker posts must begin with consideration of the context in which they will be employed. Although peer workers are, by definition, vulnerable to mental health problems, this does not necessarily mean that they have different needs to existing staff. Therefore, preparing an organisation for peer workers generally involves improving systems and supports so that they are more supportive for all staff.

The development of peer roles requires engagement and commitment from many different parts of the organisation. A project steering group will therefore need to be established and its membership should include representatives from the various parts of the organisation that will be affected, for example HR, management, professional groups, communications, etc. It is also important to include people who use the services, their family and friends, and members from relevant local partner organisations.

Once established, the project group then needs to develop a clear plan, within the identified financial resource, with specific actions, accountabilities and timescales. This will change as the project evolves, but clear planning from the start is essential to keep the project on track. It may be assisted by having some external monitoring of progress.

This group needs to work through a number of critical issues, beginning with the fundamental questions, *'Why do we want to employ peers?'* and *'What differences do we hope they will make?'*. For example, in Nottingham, the peer support service was developed in order to, *"improve the recovery orientation of mental health services and to improve the recovery outcomes of people using services, and where applicable, their carers. We envisage that service users will relate better to the mental health system as a whole by seeing it as an entity that is more accessible, approachable and relevant to their needs. We hope that by working alongside peer workers, current staff members will be inspired to work in a more recovery-focused manner and see the whole person in terms of their potential rather than as a presentation of distress, problems and diagnosis"*.

In the current climate, it is particularly important to be aware of the danger of creating peer support roles for the sole purpose of saving money, or simply to carry out tasks that other staff are unwilling to do.

To deliver on these ambitions requires commitment from the senior executive team. This vision needs to be communicated to relevant departments and teams through a variety of methods including information workshops, staff briefings, newsletters, etc. Potential peer workers must work in partnership in these exercises.

a. **Human Resources (HR)** – At the heart of establishing successful peer support worker progammmes will always be the support of HR departments (indeed, some of the most successful schemes have been led by HR professionals). Ensuring that HR colleagues understand the aims and philosophy of peer support and are in a position to offer their guidance regarding the recruitment, job descriptions, interviewing and supervision of peer support workers, is therefore essential. (Further detail about HR issues is provided in Phase 2 on recruitment).

b. **Workforce planning** – Predicting the future balance of traditional professionals and peer workers, in line with developments in practice, commissioning targets and financial constraints is a key challenge. The issue is not that peers could – or should – replace all professionals, but there is a question of balance to be addressed. Should the workforce comprise 10, 20, 30 or 50 per cent peer workers? Local services need to agree local targets and prepare to work towards them.

c. **Occupational health (OH)** – Occupational health services have a critical role to play in providing advice regarding appointments of new staff (peers) and return to work plans for peers who have periods of absence due to recurrence of illness. Although the same rules should apply to peer workers as to other staff, OH clinicians may be particularly anxious regarding fitness and 'return to work' issues when the person is known to have had mental health problems and is returning to work in a mental health service setting. They may be less familiar with the concept of 'reasonable adjustments' to the workplace as applied to people with mental health issues (see Perkins *et al*., 2009; Royal College of Psychiatrists, **http://www.rcpsych.ac.uk/usefulresources/workandmentalhealth.aspx**). Members of the project team will therefore have to ensure that OH colleagues are fully involved in the project from the outset and that their continuing engagement is secured. (Again, these issues will be discussed further later in the paper).

d. **Finances/Management** – Where new posts are to be created, or existing posts redefined, there may be financial implications. Funding needs to be identified to cover basic salary and on-costs, recruitment, training, peer-led advice/supervision, relief cover, travel, administration and equipment costs. If comprehensive costs are not identified at the beginning of the project they will inevitably return to haunt the project team at a later date and may determine the extent of the success of integrating peer workers into the workforce.

e. **Involving staff 'learning and development units'** – The employment of peer workers may create new opportunities for learning and development departments to work collaboratively with peers in developing and delivering training to a variety of staff groups (and groups outside the organisation, e.g. police, GPs, etc.).

f. **Developing relationships with local social services departments and non-statutory partners** – Peer roles can usefully transgress the artificial boundaries often found between services, so any steering group is likely to need to include relevant partner organisations. For example, social services departments may provide funding for joint training; local peer-led or voluntary sector organisations might be involved in the preparation, training and supervision of peers. This is particularly important in the early stages of the project as user-run organisations may have considerable existing experience relating to the topic and may be able to provide advice, support and active collaboration regarding training and supervision. However, it may also give rise to conflicts (see Box 2).

g. **The role of commissioners** – At the moment the role of commissioners is still unclear. Broad policy is set by NHS England, but local clinical commissioning groups are likely to retain a considerable amount of autonomy over what services are sought and from whom. This offers opportunities as well as challenges. Similarly, as the health and wellbeing boards develop, there is likely to be room for influencing commissioning decisions at a local level.

Preparing the teams

If the introduction of peer workers is to be successful then the preparation of the teams in which they are to be placed is essential. The whole team must understand and own the process and it should form part of a broader, recovery-focused, transformation of services. In several pilot studies of peer workers, it has been reported that they are less likely to be successful or effective in teams that are not already working in a recovery-focused manner and not committed to engaging with peers as team members (McLean *et al*., 2009; Repper & Carter, 2010). Therefore, it is strongly recommended that teams in which peer workers are placed have already accessed training in recovery-focused practice and have a commitment to making the service more recovery-focused.

In practical terms, it is most helpful if the team is given an opportunity to work together, with

Box 2: Conflicting agendas in user-run groups and statutory providers

In Nottingham, external user-run groups have been vital in the development of peer worker posts within the trust. Making Waves (see **www.makingwaves.org**) co-produced the peer worker training and provided supervision for the first peer workers. However, this collaboration became difficult when the Trust's expectations of peer workers conflicted with the beliefs of Making Waves.

At the heart of the dispute was a difference of view regarding whether certain standard training elements (specifically 'control and restraint' training) which is mandatory for Trust staff, should be included in the role of peer support workers. The view in Nottingham was that peer workers should have a clear role in influencing the culture of the organisation by demonstrating recovery-focused practice, expressing their views and challenging poor practice (indeed their slogan has become 'Inspire to Influence'). In addition, if they do not wish to restrain a person or take part in the forced use of medication, they should be able to choose to take the role of supporting others in the area, and not necessarily become involved themselves. However, if it was an emergency and someone's safety was threatened, it could not be guaranteed that this might not be overridden. This seems a reasonable compromise and has encouraged the Trust to commit to a policy of 'No Force First' moving towards the abolition of unnecessary restraint. This difference of view regarding the role of peer support workers thus provoked a very helpful debate.

the peer support workers and other mental health practitioners, from teams which have successfully integrated peer worker roles within their team. Ideally, a day should be set aside to:

- consider the nature and role of peer support and how it differs from other roles in the team (see Box 3)
- meet, and hear the stories of, peer workers and mental health practitioners from other teams where they have been successfully introduced
- honestly discuss hopes, fears and concerns
- consider the different sorts of expertise within the team
- review peer worker job descriptions and person specifications to ensure that they embody the core principles of peer support
- develop a sense of collective ownership by coming together to think about the relative roles and responsibilities of peer workers and other team members in their own particular context
- provide reassurance from senior managers that there is a commitment to these developments from the top and that they will respond to questions and concerns.

This will need ongoing follow-up support. At the heart of these discussions should be an acknowledgement that all staff bring a different balance of contributions from three essential sets of skills and abilities:

a. their personal experience of life outside the mental health arena (skills, interests, culture, values, education etc.)

b. their personal experience of trauma, distress and mental health difficulties

c. professional/mental health training and experience.

The core role of a mental health professional is based on their professional expertise and this shapes their relationships. However, the core role of a peer support worker is based on their lived experience of mental health challenges and this informs a different kind of relationship.

Box 3: Defining the roles of peer workers, mental health practitioners and support staff

Peer support workers	Mental health practitioners	Non-peer support staff
• Primarily draw on lived experience of mental health problems • Provide emotional and practical support • Establish mutual and reciprocal relationships • Bridge the 'them' and 'us' divide • Be with people in their distress • Keep hopes and aspirations alive • Keep 'life beyond illness' alive • Support people plan their own recovery • Co-facilitate groups/ courses • Inspire others, offering 'images of possibility' • Listen to how people feel about their situation and about being a 'patient' • Contribute to maintaining safety • Influence recovery-focused practice within the team • Model appropriate disclosure	• Primarily draw on learned professional knowledge skills and expertise • Undertake assessment of problems • Diagnose/formulate difficulties • Provide clinical interventions, treatment and support • Understand different approaches to working with mental health • Provide information about diagnosis and treatment • Assess and manage risk from a professional perspective • Ensure safety of the team/ward • Ensure that legal responsibilities and professional accountabilities are covered • Complete agreed documentation • Deliver Key Performance Indicators • Manage ward/team • Provide staff supervision and performance monitoring • Build good team relationships • Establish team culture • Support recovery -focused practice	• Primarily draw on life experiences, acquired knowledge and skills • Maintain contacts with the world outside mental health • Bring in knowledge of local resources and opportunities in the community • Bring in knowledge of different cultures • Make information accessible – speaking in ordinary language • Provide practical support around personal care and tasks of everyday living • Help people do the things they want to do and maintain contact with the people they value • Bring in a range of personal interests and everyday skills – sports, hobbies, arts etc

Common myths and misconceptions about peer workers

When working in traditional mental health services, peer workers (paid or voluntary) often meet with various myths and misconceptions regarding their role. Indeed, a recent study of peers' experience found that the greatest difficulty reported was the lack of understanding of other workers about their role (McLean *et al*., 2009; Repper & Carter, 2010). Some of the most common myths are set out below.

Myth #1 – Peer support is just a way of saving money

As indicated earlier, this is where many of the debates about peer support workers generally begin. We have argued consistently that promoting recovery requires a great deal more than traditional therapeutic approaches. Providing hope, helping people make sense of their lives, finding meaning in what has happened, helping people take control over their destinies and manage the challenges of everyday life to pursue their aspirations: these do not require professional expertise and intervention. Those who have faced similar challenges are often far better equipped to support these endeavours. To extend the domain of professionals to work with all facets of life not only risks de-skilling everyone else, such as friends, families, carers, persuading them that all facets of our lives require the specialist expertise of professionals; but is also wasteful of the considerable resource involved in training and employing specialist professionals. Although traditional mental health practitioners have always provided more than the specialist treatments, this is what they are primarily employed to do. The use of peer support workers is simply an attempt to complement these 'professional' skills with 'life experience' so as to ensure that both are provided (hopefully in at least equal measure) to those who need them. It is therefore clearly *not* simply a case of 'saving money'; rather ensuring services optimise value for money, and the added value, of all staff groups.

Myth #2 – Peers will be too fragile, they are likely to 'break down' at work

People with lived experience of mental health challenges have long been employed in mental health services in a variety of positions from chief executive and consultant psychiatrist to support worker and secretary. (Recent surveys conducted in Devon and Nottingham showed that some 30 per cent of staff disclosed experiences of mental health challenges prior to appointment). Does this mean that all these workers are *'too fragile'* and *'likely to break down'*? The evidence actually suggests that, if provided with appropriate support, employees with mental health challenges may take less time off sick than those without (Perkins *et al*., 2000).

Myth #3 – Peers cannot be expected to conform to usual standards of confidentiality

Anyone working in a mental health service – from statutory to voluntary to peer-led will be required to observe formal rules relating to confidentiality. Peer workers are no different. Indeed, because of their lived experience, peer workers are often particularly sensitive to issues relating to confidentiality. Our experience is that issues of confidentiality have been more frequently raised by peer workers complaining about other staff breaching confidentiality by chatting about the clients with whom they work outside the workplace.

Myth #4 – There is no difference between peer support workers and other staff who have personal experience of mental health problems

Introducing peer workers into the workforce raises the issue of how best to support people in traditional roles who have their own lived experience of mental health issues. They sometimes report discrimination and exclusion (Disability Rights Commission, 2007) and if this occurs then it must be tackled under the requirements of the Equality Act (2010). Acknowledging the prevalence of 'lived experience' of mental distress in the existing workforce is not only 'healthy' in terms of recognising the reality of human experience as applied to those who are labelled 'staff' as well as those who are labelled 'service users'; it

can also enhance the quality of service delivery by encouraging traditional mental health staff to use this experience to inform their work. However, a psychologist, or a psychiatrist or a nurse with lived experience of mental health challenges remains a psychologist, psychiatrist or nurse, employed primarily to use their professional expertise rather than their life experience. The power imbalance, and professional boundaries (perceived and real), resulting from the formal status of their profession also remains a potential obstacle to establishing a relationship based on mutuality, reciprocity and a shared journey.

Myth #5 – The presence of peer support workers will make staff worried about 'saying the wrong thing'

Everyone, peer or professional has, at some time, said or done something that they later regret. Without the capacity for humility – and the courage to accept and accommodate feedback to reflect on our behaviour – any relationship, whether it is between partners, friends, or the providers of services, is likely to break down. Thus, the willingness to reflect and learn from our behaviour is a key process for improving the quality of interactions and most groups have some mechanisms (formal or informal) for reflecting on these problems as they arise. Opportunities for supervision and reflection on practice are therefore an essential and necessary aspect of good practice.

Myth #6 – The only way to be sure of getting a job these days is to say you have a mental health problem

Within mental health services many types of expertise are required: professional expertise, expertise resulting from experience outside the mental health arena, and the expertise of lived experience of mental health challenges, trauma and recovery. To date, pride of place in mental health services has been accorded to professional expertise at the expense of the other two. But formal treatment and therapy constitute only a part of the support we may all need in our journeys of recovery. Therefore, there is a continued need to break down barriers and actively value the expertise and insights that experience of mental distress brings. It is not the case that this is the only thing that is important, but it should be valued and not be a source of stigma and discrimination.

Box 4: Common myths and misconceptions about peer workers

Myth #1 – Peer support is just a way of saving money.

Myth #2 – Peers will be too fragile, they are likely to 'break down' at work.

Myth #3 – Peers cannot be expected to conform to usual standards of confidentiality.

Myth #4 – There is no difference between peer support workers and other staff who have personal experience of mental health problems.

Myth #5 – The presence of peer support workers will make staff worried about 'saying the wrong thing'.

Myth #6 – The only way to be sure of getting a job these days is to say you have a mental health problem.

Myth #7 – Peers get to do all the nice things – talking to patients, taking them out, going home with them – the rest of us have to do the boring admin and medication, handing out meals, making beds etc.

Myth #8 – Peers don't know the difference between friendships and working relationships.

Myth #9 – Peers will be subversive, they will be 'anti-psychiatry' and 'anti-medication'.

Myth #10 – Peers will take up so much time that traditional staff roles will be made much harder, not easier.

Myth #7 – Peers get to do all the nice things - talking to patients, taking them out, going home with them – the rest of us have to do the boring admin and medication, handing out meals, making beds etc

In any relationship, group or service there are tasks that have to be done. What distinguishes peer relationships is not what is done, but the nature of the relationship: 'peer to peer' rather than 'expert to non-expert'. Peer support can thus occur in the course of any activity whether it is making a bed, going for a walk or just sitting and talking. It is not the case of peers getting to do all the 'nice things', it is simply that peers may have greater opportunities to use their relationships productively. The key question this raises for staff is actually how to engage in the 'nasty things' while preserving as positive a relationship as possible.

Myth #8 – Peers don't know the difference between friendships and working relationships

As indicated in the first paper, there are many differences in the relationships between peer support workers and peers and those of friends, particularly in terms of self-disclosure, the degree of choice involved and the explicitness of 'rules' (conventions of behaviour). But formal rules don't obviate the need for judgement and sensitivity. Peer support worker relationships do involve more judgements than friendships – when and what to disclose, when and what 'rules' to obey, etc. The judgements need to be considered as part of the training of peer support workers and reinforced by reflection and supervision (individual and/or peer group).

Myth #9 – Peers will be subversive, they will be 'anti-psychiatry' and 'anti-medication'

The essence of peer support is not to prescribe what others should think, feel or do. Peers should not be telling people whether or not to take medication, or instruct them to use conventional services, complementary therapies, etc. Rather, peers should be aiming to help people explore different ways of understanding, ways of coping and growing that make sense to them. Such exploration may involve challenges to orthodox views, but orthodox views are nearly always limited by the attempt to generalise from the performance of a group to the experience of an individual (for example, in large scale treatment trials). Individual exploration is facilitated by the diverse narratives of others who have faced similar challenges.

Myth #10 – Peers will take up so much time that traditional staff roles will be made much harder, not easier

As indicated earlier, peer support workers may require additional employment support, particularly when the roles are being established. But these should not be different from any other worker. Peer workers may then make the jobs of other practitioners easier by relieving them of aspects of support that do not require their specialist professional expertise. This potential is clearly there if the roles are well defined and challenges properly addressed at the outset. If peer workers are simply 'thrown into the mix' then they will save neither time nor money.

Preparing potential peer workers: training and work placement opportunities

Supporting individuals to prepare for a peer worker role is essential and can be achieved through a number of routes. Peer support training, prior to employment, is considered an essential criteria in some organisations; whereas in others it is a requirement once a peer worker has commenced employment. Either way, when introducing peer worker roles in an organisation there must be clarity regarding peer support training opportunities for potential peer workers.

"The peer support training took me on a massive journey of discovery about myself and gave me an appreciation for my strengths. Through it I came to realise that all those scary places I had been during my time of being unwell were going to allow me to hold up a torch for others during their dark times and help them on their road to recovery – it wasn't wasted time". (Rand evaluation of CPFT peer workers)

Peer worker training has been developed and delivered in many different countries and settings: Working to Recovery in Scotland

(**www.workingtorecovery.co.uk**); Recovery Innovations in Arizona US (**www.recoveryinnovations.org**); Mental Health Kokua in Honolulu (**www.mentalhealthkokua.org**); University of Texas, US (**http://blogs.utexas.edu/mental-health-institute/**) and Institute of Mental Health Nottingham (**www.institutemh.org.uk**). It is interesting to see that a high degree of consistency exists across the content of courses, the style of teaching and intended learning outcomes. However, marked differences exist in the intensity ('depth') of the teaching and length of courses. For example, Recovery Innovations offers a four week full-time course, Working for Recovery offers a three-day training and Nottingham Institute for Mental Health offers a training of 11 days.

All peer worker training should be a facilitative, experiential process which empowers students to learn from one another how to support recovery using an interactive format. Training should aim to build on students' strengths, offering constructive feedback, celebrating success, valuing difference and opportunities for everyone to learn, whatever their language, literacy, experiences or beliefs. The core skills required for peer support are active listening and problem solving; the core knowledge and understanding required are clarity about how to facilitate recovery and about the role and relationships of the peer worker. Thus, courses generally cover communication skills (particularly active listening); mutual problem solving/solution focused skills; wellness and personal recovery planning; managing challenging situations; valuing difference; code of conduct and ethical considerations; team working and managing personal information/telling your own story.

At the moment there are few empirical grounds to differentiate between these different training options, organisations are therefore advised to look into available training courses and determine whether they have the capacity to develop their own to meet their needs or to look elsewhere. Further information about the three best established training courses are given in boxes 5,6 and 7.

While this kind of basic introductory training in peer work is sufficient for safe practice, peer workers, like all other staff, will benefit from access to other training courses, mentorship schemes and workshops.

Developing job descriptions and person specifications

The final key area of preparation concerns the development of job descriptions and person specifications. Samples are given in Appendices II and III. These were developed

Box 5: Nottinghamshire Healthcare NHS Trust peer support worker training

The peer worker training developed in Nottingham has now run in 15 different organisations with almost 400 graduates to date. It is an 11 day experiential course that is co-produced and co-delivered and assessed by a reflective essay demonstrating learning and application of skills. Student feedback is very positive and the drop-out rate is low. Students find the course "*challenging*", a "*roller-coaster*" and "*transformational*". It is recommended that students are interviewed for the training to assess their readiness and resilience; also all students are asked to take their own recovery and wellness plan to the interview to demonstrate an understanding of recovery and what it means to them. All have to be willing to explicitly use their own experience of mental health problems in their practice as peer workers, and for those to be employed in Nottingham, all have to be willing to spend four days in practice during the course where their competency as peer mentors will be assessed by a placement mentor.

Further details are available from: marissa.lambert@nottshc.nhs.uk

Box 6: Cambridgeshire and Peterborough NHS Foundation Trust peer support worker training

Cambridgeshire and Peterborough Foundation Trust (CPFT) procured Recovery Innovations (RI) from the USA to deliver four cohorts of their peer specialist training. During this time RI also trained and accredited two peer educators to enable them to continue to deliver the training after the RI input had finished. The peer educators are now able to deliver training to all future training cohorts. The CPFT training is delivered full-time over four weeks. Students complete assessed role plays, a mid-term and final exam, and a reflective diary. Following successfully completing the training, students attend a graduation celebration to share their successes with their family and friends. In addition, students undertake a four-day work experience.

Further details are available from: sharon.gilfoyle@cpft.nhs.uk

Box 7: Central and North West London NHS Foundation Trust peer support worker training

Central and North West London (CNWL) NHS Foundation Trust benefited from the expertise of Nottingham who initially delivered it to two cohorts of students. The trust then worked in partnership with London South Bank University to co-produce this ten-day, level 4 accredited training programme, which is now established.

As the trust has adopted a 'recruit and train' model for peer support workers, all peer support workers and peer trainers are expected to successfully complete the training within six months of their appointment.

Undertaking the training when already in post provides a valuable opportunity for peer support workers to draw upon and bring their work situations and experiences from the clinical setting to the training. Students report this has enhanced the richness of the learning experience and promoted the transfer of skills and knowledge into the workplace.

Further details are available from: debbie.lane-stott@nhs.net

by CPFT and Nottinghamshire Healthcare, based on the available literature at the time, adapted for use in an English NHS context. They meet a number of different criteria:

- reflect all of the core principles of peer support
- allow flexibility for this new role to grow and develop
- accommodate individual skills, interests and development
- meet the organisational ambitions in relation to peer support
- include the specific circumstances of the team/locality in which they are based
- meet internal HR guidance
- meet equality legislation with regard to specification and definition of 'lived experience' as a requirement for the post.

A key question underlying the formulation of person specifications is what constitutes 'lived experience'? (i.e. whether all peer workers will have accessed secondary services, or whether peer workers might have used primary care or experienced challenges but avoided using services). This is for local discretion, but it is essential to work with HR to ensure that all aspects of the formal paperwork comply with the relevant legislation, in particular equality laws.

PHASE 2 – RECRUITMENT

All the preparation work may seem long and complicated – but if not done thoroughly then these new posts will not succeed and flourish. Assuming all the necessary preparation is undertaken, then the process of recruitment can begin.

Advertising

The project team needs to consider the options for advertising opportunities. If applicants are required to have completed peer worker training then obviously there will be an available pool of 'graduates' to approach. If the post is open to people who are willing to undertake peer training but have not already done so, then there will be a need to consider wider advertising. Prospective peer workers who are not in active contact with specialist mental health services are unlikely to read professional journals and may not access newspapers so other options for local publicity may need to be considered (for example, direct communication with local user groups). However, simply contacting local user groups may exclude many people who have experience of mental health problems, but have not chosen to join a local group. These processes of how and where to advertise need careful consideration by the local project team and a relevant strategy developed accordingly.

Whichever advertising strategy is adopted, local 'orientation sessions' may be a useful way of pre-selection (see BOX 8 below).

Benefits advice

If the organisation does not offer an orientation session, it is important to provide benefit advice for people or to signpost them to appropriate agencies (JobCentreplus, Citizens Advice). The benefits system is complex and highly individual, so it is important for people to get an expert, personal 'back to work' or 'better off' calculation to be clear about the financial benefits or challenges of being in paid employment. Many peer support workers may choose to be employed part-time or in some kind of 'job-share'.

Box 8: Cambridgeshire and Peterborough NHS Foundation Trust 'orientation sessions'

CPFT introduced 'orientation sessions' for prospective students/employees. This proved to be an excellent way of ensuring that people were fully aware of all the training and post requirements prior to making an application and attending an interview. The session gave an overview of the training content, the application form, CRB process, post availability and benefits advice. On all occasions the attrition rate for this session was 50 per cent. Initially this felt disappointing, but we soon learned that this is the first phase of self-selection for the training. The majority of people who did not attend, did not make contact again. If they were ill, we would simply re-book onto a future orientation. On the whole, the majority of people who attended the orientation subsequently then attended for an interview and were keen to start on the peer employment training. One student said, *"The orientation session was extremely comprehensive: it helped me think about the amount of work that was required and if this was the right time for me, it was also helpful to have the benefit issue highlighted, I got a back to work calculation done immediately"*.

Applications

Because of the nature of the likely applicants, it is necessary to consider how best to support them in the recruitment process. Some applicants may have been out of employment for some time and will lack the confidence and skills to apply. Applications can be particularly challenging for people who have spent periods of time in hospital, homeless, or in prison. The process usually assumes familiarity with IT, an ability to explain interruptions in employment and housing, and to answer questions about criminal history. All of these can be very off-putting for some people and may constitute a real barrier to the very people who could be the most helpful peers – those with most in common with the average person using services. Support for prospective applicants can be provided either within the organisation, or delivered by a partner agency specialising in employment support. For example, Central and North West London NHS Foundation Trust has a designated part-time 'senior peer support employment specialist' who is available to guide and support prospective applicants through the recruitment process, including navigating the benefit system, writing job descriptions, applying for post online and interview preparation.

For example, one of the challenges Cambridgeshire and Peterborough NHS Foundation Trust peer worker applicants faced was not having sufficient employment references. Often applicants had not worked previously, or had been unemployed for a long period of time and previous referees were difficult to trace. In these instances, the Trust decided to consider alternative sources, for example care coordinators, consultants, volunteer supervisors or teachers from educational facilities.

Interviews

Given the complex and sensitive nature of the role, applicants need to be interviewed to assess their communication skills, their understanding of recovery, and their ability to share constructively their own journey and what helps them to stay well. Interviews can be conducted on an individual or group basis. Each has advantages and disadvantages. A combined approach developed in Nottingham is illustrated in Box 9.

Since interviews – whether for a place on the training course or for employment – can provoke great anxiety, applicants may benefit from support at various stages: to complete their application form, to plan for their interview, and in the waiting room on the day of the interview.

Box 9: Individual and group interviews

The number of applicants for peer worker training in Nottingham has risen from just ten people expressing an interest in 2010 to 195 applicants in 2011. This is due to the visibility of peer workers and the inspiration they give to people using the service – many of whom see peer work as something that they can do in spite of – not just because of – their mental health problems. Given the difficulty in shortlisting from such a large number, a group interview format is used with three applicants in each group. This mirrors the peer-to-peer relationship and allows relationship and communication skills to be observed. Each applicant is rated on relevant dimensions (communication skills, active listening skills, understanding of the role, recognition of considerations important in personal disclosure, relationships with others in the interview). Although only 18 of these applicants could be offered a place on the training, every single applicant was offered detailed feedback and at least one face to face meeting to discuss support to find an alternative way forward towards their goals.

Occupational health

As indicated earlier, the support of occupational health colleagues is central to the success of peer worker programmes. We need to ensure that applicants with a history of mental health problems are assessed in an appropriate and helpful manner and this approach should benefit all staff with mental health problems. Peer applicants need to be prepared for correspondence from occupational health and, hopefully, will find this helpful in examining the organisation's staff wellbeing plan. The plan should enable the peer worker to identify the sort of adjustments that are necessary to enable them work to their full potential. 'Reasonable adjustments' might include things like:

- specifying work hours to take account of particular problems with early mornings, rush hour traffic, or side-effects of medication
- offering support with aspects of the role that are particularly difficult due to the nature of their mental health challenges (for example, sealing envelopes may be difficult for people who feel compelled to check)
- increasing feedback to people who tend to repeatedly worry over possible mistakes ensuring that they are thoroughly debriefed at the end of each shift.

DBS issues

Peer support workers – like any other new employee – will need to have a Disclosure and Barring service (DBS) check, previously known as a Criminal Records Bureau (CRB) check. This will reveal any recorded crimes. The NHS is clear that it cannot employ people who have a serious criminal history and yet it is not unusual for applicants to peer posts to have a criminal history. The challenge for the service is to assess the risk involved in employing the person and make judgments about the likelihood of criminal acts being repeated. This has to be undertaken on a case-by-case basis and the decision needs to take into account the seriousness of the offence, when it occurred and its potential relevance to the role. Some decisions will be easy, some will not. Where the incidents are clearly related to periods of mental ill-health, it is easier to put safeguards in place to prevent re-occurrence. However, where the incidents are more serious, more frequent, or unrelated to periods of mental instability, then it may be more difficult to identify triggers and develop effective safety plans. The project team needs to be clear at the outset how these decisions will be taken and by whom.

Disclosure and Barring service checks can be very stressful for peer applicants and they often need support to complete the DBS form. This requires a full five year address history, plus paperwork to confirm current identity and address. This can be a real challenge for some people with mental health problems who have spent time out of work, or who do not own a passport or have a bank account. Some people will automatically assume that any criminal record will exclude them from peer support work, this is not necessarily the case and it may be helpful to clarify this at interview. Several services employing peer workers have now developed new processes for assessing criminal history. For example, CPFT has developed an 'objective assessment framework' which ensures that a comprehensive range of factors are taken into account when assessing risk. Nottinghamshire Healthcare NHS Trust has set up a panel including a peer worker, an HR representative, a general manager and the volunteer services manager to assess DBS returns and make a decision regarding whether or not to offer employment.

Supporting people who are not offered posts

Finally, it is important to consider how best to support unsuccessful candidates. Following an intensive training programme, then an unsuccessful interview, people will naturally feel despondent and their confidence will drop. It is helpful to offer them a face-to-face appointment to discuss the reasons for not appointing and to explore alternative options. For some this will take the form of further interview practice, for others a period working as a peer volunteer, or doing some courses in the recovery college might help.

PHASE 3 – EMPLOYMENT

Finally, once in employment, a number of elements need to be considered.

Matching peers with posts

Where there is a choice of peer worker posts, peers can be allocated according to their personal attributes, experiences and preferences. It is worth thinking more broadly than simply matching people in terms of their mental health problems. By placing a peer with a specific diagnosis on a unit that specialises in this particular set of difficulties, there is a danger of perpetuating a narrow diagnostic categorisation. Of at least as much value is the placement of a peer in a team that has identified a gap in certain skills or interests that the peer can fill (for example, membership of a particular age or ethnic group). Wherever possible, peers should be employed in groups of at least two per team, with some overlapping working hours. This will help prevent isolation, provide support and help create a greater impact on the team culture. There are specific challenges if the peer is employed in a team that is currently providing their mental health support or has done so in the recent past (see Box 10 below). However, if this is agreed, then arrangements need to be made for where the peer will be treated if they become unwell and all their notes/records need to be made inaccessible to other team members.

Induction/orientation

In terms of induction for new workers, it is helpful to allocate a staff mentor to each peer (possibly the team recovery champion) to organise this and to devise an induction plan. They will be able to provide information, support, and to give informal tips about routines and informal procedures ('*how we do things around here*'). Many peer workers who have not been employed for some years – and even those who have – can be daunted by the number of tasks involved in beginning to work in the NHS. As the peer support team coordinator reported on the first few weeks in Nottingham:

"Returning to work was a daunting issue in itself and it became clear that peers need tailored support during this period. Even though I described processes such as sickness reporting, how to apply for annual leave, using information systems (RIO), whereabouts sheets, client records, etc. many times; for some peers embedding this into their everyday working life proved very difficult. Even basic tasks like organising telephones and computer access and how to obtain diaries, keys, 'pigeon holes', etc. was time consuming and the team would have benefitted from a slow induction period to ensure that each peer was fully confident and familiar with these processes before they started working".

Box 10: Placing a peer in the team that currently provides their mental health support – experience in Nottingham

A peer was appointed to a post in the team currently providing her mental health support (early intervention). She put in a request to be placed in this team as she felt she could bring most benefit using her personal experience. Time was spent with the team talking through the issues involved. They felt she would, indeed, inspire both the staff and clients with the possibilities of recovery. The care coordinator also spoke to her about how she would find seeing her in a new role and discovering a different perspective on her character. Her records/notes were removed from the usual location and put in a different place to protect her and staff from inappropriate use. This then proved an effective and useful placement.

Supervision and support

Whether it is delivered on a group or individual basis, supervision and support is vital for peers – just as it is for other staff. Ideally, this should be provided through a combination of 'managerial' supervision (from the team leader or a care coordinator) and 'professional' supervision (from a senior peer or through contact with a group of peer workers). It is likely that in the early weeks of employment, peers, like any other new workers, will need reassurance, feedback and support to think things through, but that this will rapidly diminish over time. Individual and group supervision offer opportunities to model and practice the principles of mutuality: sharing strategies, challenges and successes, developing skills, knowledge and expertise in the group and creating confidence that difficulties are not unique and can be overcome.

The value of bringing all peer workers together for group supervision and mutual support cannot be over-estimated. Once together, peers become more confident about sharing their hopes, fears, their personal stories and challenges. As a group they gain strength and solidarity, they can support each other effectively and solve problems together. It is in this context that it is clear just how skilled, interesting and inspiring they are, how much they have in common, and how much diverse talent they bring as a group. Even when peers are working in separate parts of the service, it is helpful to provide opportunities for them to meet together from time to time so that they can continue to develop their identity and retain clarity about their distinctive features and unique roles.

There are some aspects of peer working that need particular attention. These are specific to the role and do not lend themselves to clear rules or black and white solutions. First, there is how to use personal experience. There is a stark difference between telling your own story in the classroom setting and using your experience whilst building a relationship with someone who you are supporting. Peers workers often need additional support in the early days to clarify their own boundaries and develop a personal account or narrative that feels safe. This entails working out what they want to share, what they feel safe about sharing, and what they do not want to share however tempting it might be in the moment. The second challenge for peers lies in their double role and identity as both a practitioner (staff) and a patient (service user). Peers may be accustomed to relating to mental health workers as the expert – or even the enemy – but not as a colleague with whom they can work as equals, in a relationship based on mutual respect. Similarly, they are more used to relating to service users as friends rather than peers, so it can be challenging for them to maintain the 'professional' boundaries that are appropriate in the workplace.

Other staff can also find this difficult. Too often the challenges reported by peer workers focus on the problem of gaining the respect of staff. In some instances, staff are reluctant to refer to peers, unclear about what peer workers offer, or lack confidence that peer workers can cope with people who might present complex challenges. Thorough preparation of the team can help engender clarity, ownership and pride, but peers should really only be placed in teams that are actively supporting recovery and are keen to integrate the peer support worker role to support this endeavour.

Maintaining wellbeing

All employees need support to remain well at work. Working with people who are experiencing disabling and distressing emotional problems can be upsetting and stressful; observing or helping in critical incidents can be particularly traumatising and distressing. The impact of these experiences can be amplified for peer workers if they

resonate with their own lived experiences. Their own anxiety might trigger recognisable symptoms and this can lead to fear of impending relapse and prompt them to take time off sick. But peer support workers who are employed in paid posts in statutory organisations work to the same policies, procedures and regulations as everyone else; this includes the sickness absence policy.

It is helpful for all staff to take their own wellbeing seriously and a wellbeing plan can support this process. By considering what they need to do to stay well, what sort of events make them stressed, anxious and potentially unwell, and how they can manage or minimise these situations, all staff can begin to develop their resilience, anticipate and manage stressful times and maintain their own wellbeing. For peers, as with all staff, it is helpful for managers to work with them to optimise their wellbeing; to make adjustments wherever possible to allow them to work to their full potential, to find solutions to aspects of work that they are finding stressful, to encourage them to seek support when they need it rather than trying to manage alone.

PHASE 4 – DEVELOPMENT OF PEER WORKER ROLES

Increasing peer employment opportunities

Given appropriate training, support, supervision and development opportunities, peer workers will be their own best advocates and become increasingly valued throughout services; posts will be created or converted and numbers will grow. Organisations are finding various ways of increasing employment opportunities for peer workers. For example:

- requiring all new services to include peer worker posts
- reviewing all vacancies to consider the possibility of creating a peer worker post (for example, replacing healthcare assistant post with a peer/healthcare assistant post – doing the same things in a different way)
- providing training for professionally qualified staff to use their personal experience of trauma/mental health problems in their work and thereby work as a professional/peer worker
- employing carer peer workers in dementia services (Central and North West London) and in adult mental health community services (Nottingham).

Alongside the development of new posts, potential peers themselves are creating demand for change. As people using services receive peer support, they recognise a possible career pathway for themselves, so numbers of applicants for peer worker training have grown exponentially. There are various ways of both supporting and developing these budding peers whilst they await opportunities to train or work as peer workers.

- They might attend various courses in the recovery college to help them consider steps back into work; using their own experience in work; recovery principles; problem solving skills; peer research skills; peer training courses.
- They might be interested in volunteering as a way into work or peer training when that becomes available.
- They could be offer supported internships in various departments within the organisation so that people who have used services can experience a structured, supervised work experience in a range of different areas.

Career progression

All peers in employment need support and encouragement to pursue their own personal and professional development. As they gain experience in post they will become clear about the sort of training they want to help them become more effective as peer workers. As they develop further they may decide to apply for professional training or to gain more specialist qualifications in project management; training, research or therapy skills. Whilst there may be specialist peer worker positions in peer supervision, peer management, peer training or peer research, these are unlikely to reach high bandings. Once peers are working as a team leader or a project manager, then their primary identity and role is likely to be developing beyond their lived experience, and whilst their personal experience of mental health problems will always have an influence on their work, it will not be their primary qualification.

Wider system change

The employment of peer workers drives forward changes across the whole organisation. As already described, it becomes necessary to review recruitment, occupational health and staff wellbeing processes in order to provide appropriate support for peer workers. And once in post, peers themselves will begin to challenge policies, procedures and language used. They see the world through different eyes and they need encouragement and support to remind others about how it feels on 'the other side of the drug trolley'. For example, peer workers employed in various organisations have:

- reviewed risk assessment documentation to develop a negotiated safety plan
- developed guidance for all staff on how to use their lived experience in clinical practice
- co-produced and co-delivered staff training
- developed guidance for outpatients to plan the questions they want to ask in appointments
- developed an *aide memoire* to guide questions about medication.

Such contributions are not to criticise and challenge existing practice, more to inspire and influence through modelling, suggesting and supporting others to find new ways of working.

NEXT STEPS

We are only at the beginning of a long journey. Although we have learnt a great deal about the employment of peer workers in a very short time, there are many more questions to answer. Perhaps the first step lies in demonstrating the difference that peer workers make – not just to those whom they support, but to the whole organisation. More research is needed to compare teams with peers workers with those without; to explore the experience of people receiving peer support; to understand how peer support makes the differences that it appears to, and to be clear about how to facilitate high quality peer support across the whole range of mental health services.

REFERENCES

Disability Rights Commission (2007) *Maintaining Standards: Promoting Equality, Professional regulation within nursing, teaching and social work and disabled people's access to these professions*. London: Disability Rights Commission.

Equality Act (2010) London: HMSO.

McLean, J., Biggs, H., Whitehead, I., Pratt, R. & Maxwell, M. (2009) *Evaluation of the Delivering for Mental Health Peer Support Worker Pilot Scheme*. Scotland: Scottish Government Social Research. Available at: **http://www.scotland.gov.uk/Publications/2009/11/13112054/0**

Perkins, R., Evenson, E. & Davidson, B. (2000) *The Pathfinder User Employment Programme*. London: South West London and St George's Mental Health NHS Trust.

Perkins, R., Farmer, P. & Litchfield, P. (2009) *Realising Ambitions: Better Employment Support For People With A Mental Health Condition*. Norwich: TSO.

Repper, J. (2013) *Peer Support Workers: Theory and Practice*. London: Centre for Mental Health and NHS Confederation Mental Health Network.

Repper, J. & Carter, T. (2010) *Using personal experience to support others with similar difficulties: A review of the literature on peer support in mental health services*. London: Together/University of Nottingham/NSUN.

APPENDICES – SAMPLE DOCUMENTS

I. Advert for recruitment

II. Job description

III. Sample person specification

IV. Framework for CRB assessment

V. Ethical Code of Conduct

I. ADVERT FOR RECRUITMENT

Job Title	Peer Support Worker
Location	Mental Health Intensive Care Unit
Job Type	Permanent
Pay Band	Band 2
Number of Hours	37.5 or part thereof
Introduction	Opportunities have arisen for people with lived experience of significant mental distress that have passed Nottinghamshire Healthcare Trust's peer support training programme. The role both encompasses the duties of Health support worker and will additionally enable the PSWs to use their specific expertise to be a valuable resource to both staff and patients within an inpatient setting at Highbury Hospital. The role will enable the PSW to draw on their lived experience of mental health challenges to help shape a culture that supports and infuses the concept of recovery in everything we do whilst modelling recovery in individual relationships with people on the unit. The posts will be specifically based on Willows Unit MHICU which caters for a patient group that are experiencing degrees of mental distress that compromise their ability to safely control their behaviours.
Information about the Trust/ Department	Nottinghamshire Healthcare is one of the country's leading mental health and learning disability service providers, employing over 6000 staff to provide these services over more than 100 sites. The Willows MHICU is a ten-bed unit based at Highbury Hospital in Bulwell. It compromises eight male and two female beds.
Key details of the post	The post holder will work under supervision of qualified nurses providing planned support care and interventions with access to peer supervision within the peer support service.
Details of the essential criteria	You will have had significant lived experience of mental distress and have attended and passed Nottinghamshire Healthcare NHS Trust's peer worker programme.
Contact details for informal discussion	For further information please contact XXXXX Ward Manager.

II. JOB DESCRIPTION

Job Title: Peer Support Worker (PSW)

Reports to (post title): Ward Manager / Team Leader

Role Purpose: The role of peer support worker has been developed specifically for people who have lived experience of mental distress. Through sharing wisdom from their own experiences, peer support workers will inspire hope and belief that recovery is possible in others.

As an integral and highly valued member of the multi-disciplinary team, the PSW will provide formalised peer support and practical assistance to service users in order for them to regain control over their lives and their own unique recovery process. Within a relationship of mutuality and information sharing, they will promote choice, self-determination and opportunities for the fulfilment of socially valued roles and connection to local communities.

The PSW will act as a recovery champion within the team and an ambassador of recovery for the Trust with external agencies and partner organisations. There is also an expectation that PSWs will be involved in the ongoing development of peer roles in the Trust including the peer support training programme and evaluation.

Role Context: The postholder will be required to work as part of a multidisciplinary team.

KEY ACCOUNTABILITIES	PERFORMANCE MEASURES
Working Practice	
To establish supportive and respectful relationships with people using mental health services.	Appropriate professional standards are met.
To help people identify their own recovery goals.	Recovery benchmarking will demonstrate improvements.
To support service users to identify and overcome fears within a relationship of empathy and trust.	
To share ideas about ways of achieving Recovery goals, drawing on personal experiences and a range of coping, self-help and self-management techniques.	
To assist others to create their own Recovery plans and develop advance directives.	
To model personal responsibility, self-awareness, self-belief, self-advocacy and hopefulness.	
To sign-post to various resources, opportunities and activities within the Trust and in communities to promote choice and informed decision making.	
To accompany service users to appointments/meetings/activities of their choice and performing a range of practical tasks, aligned to recovery goals.	

II. JOB DESCRIPTION continued

KEY ACCOUNTABILITIES	PERFORMANCE MEASURES
To support the team in promoting a recovery orientated environment by identifying recovery-focused activities and imparting information and education as required. To be actively involved in the continued development of the PSW training programme and in the ongoing evaluation of the PSW role. To abide by the PSW Code of Conduct, so that the central focus of work, inspiring recovery, is not compromised in any way. To act as an ambassador for the Trust with external agencies and partner organisations. To undertake any other duties which may reasonably be regarded as within the nature of the duties and responsibilities/grade of the post as defined, subject to the proviso that normally any changes of a permanent nature shall be incorporated into the job description in specific terms.	
Education and Development Attend and complete agreed induction programme. If not completed to attend the Trust's peer support worker training programme. To identify personal developmental needs in conjunction with Line Manager and recovery-focused supervision. Work to standards which equate to NVQ Level 3 Care Standards, undertaking further training as necessary. To participate in mandatory training as required. Participate in regular supervision including recovery-focused supervision. Maintain a working knowledge of current trends in mental health, recovery and peer support by reading books, journals and accessing peer support networks.	Personal development and training targets are met. Participation in Personal Development Appraisals.
Health and Safety To work within Health and Safety Policies in accordance with Nottinghamshire Healthcare NHS Trust, Nottinghamshire Social Services Department, Nottingham City Social Services Department, as applicable.	Health and Safety Practices are adhered to.

II. JOB DESCRIPTION continued

KEY ACCOUNTABILITIES	PERFORMANCE MEASURES
Policies and Procedures The duties and responsibilities of the post will be undertaken in accordance with the Policies and Procedures of Nottinghamshire Healthcare NHS Trust and Nottinghamshire Social Services Department, Nottingham City Social Services Department as applicable.	Policies and Procedures are adhered to.
Risk To assist in risk assessments with multi-disciplinary staff, highlighting any changes in service users presentation relevant to their safety plan and feed back accordingly	Risk Assessments and safety plans are implemented efficiently and effectively.
DIMENSIONS	
As a core member of the multidisciplinary team, the PSW will work alongside an agreed number of service users on a 1:1 and/or group basis. The PSW will take a lead role in embedding recovery values within the service setting in which they work with other Trust recovery champions. Reporting directly to the Team Leader/Ward manager and under the professional supervision of the Peer Support Worker Lead, the PSW will be responsible for the delivery of peer support interventions as agreed within the peer relationship	
SKILLS, KNOWLEDGE AND EXPERIENCE	
• To have lived experience of mental health problems • To have experience of recovering a meaningful life • To have experience of being in a supportive and enabling role • To be computer literate in Microsoft office • Ability to share personal story of recovery in a professional manner • Ability to assist people to develop recovery plans • Ability and willingness to reflect on work practice and be open to constructive feedback • Ability to work in an enabling and creative way • Willingness to support people with a range of needs to meet their recovery goals • Ability to manage stress and to plan and prioritise workload • Ability to carry out practical tasks • Ability to maintain a healthy home/work life balance • High level of self-awareness – ability to critically appraise own performance	

II. JOB DESCRIPTION continued

SKILLS, KNOWLEDGE AND EXPERIENCE

- Critical thinker
- Understanding and practical knowledge of recovery
- Understanding of the issues and concerns of mental health service users
- Knowledge and commitment to service users rights
- Understanding of the impact of stigma and discrimination
- Knowledge of Mental Health Legislation
- Knowledge of local policies in respect of safeguarding children and the protection of vulnerable adults
- Able to organise and plan own work activities
- NVQ 3 or equivalent level of knowledge training and experience

COMMUNICATION AND RELATIONSHIP SKILLS

- Excellent written, verbal and non-verbal communication skills.
- To communicate effectively with a range of service users, carers, professionals and agencies
- Receiving highly complex and sensitive information. Persuasive and reassurance skills required
- Ability to develop and maintain sound working relationships with all members of the multi-disciplinary teams
- To be aware of professional roles within the therapeutic relationship
- Willingness to use the Trust IT systems
- Professional in appearance and behaviour
- Able to manage conflict and to help others to do so
- Good team-working skills

PHYSICAL EFFORT

In frequent requirement for movement and handling of service users and objects. May need to travel within service area, as required. Use of breakaway techniques may be required.

EMOTIONAL EFFORT

The role is emotionally demanding due to the nature of distress experienced by service users and the workers own lived experience. Issues may be encountered which may be emotionally distressing for the workers involved.

II. JOB DESCRIPTION continued

WORKING CONDITIONS

- Frequent exposure to potentially aggressive behaviour from patients, carers and relatives, and occasional actual aggression from patients.
- The postholder will occasionally become exposed to communicable diseases.
- The postholder will occasionally come into contact with body fluids and foul linen.

ORGANISATION

- Executive Director-Adult Mental Health
- General Manager
- Service Manager
- Modern Matron
- Ward Manager
- Clinical Team Leader
- Staff Nurse
- This Post

SIGNATURES

After reviewing the questionnaire please sign to confirm agreement

Post holder: Date:

Line Manager: Date:

Next level Manager: Date:

III. PERSON SPECIFICATION (BAND 2)

Attribute	Essential	Weight	Desirable	Weight	How identified
Physical Characterisitcs	Good health record				
Qualifications/ Professional	Good level of secondary education Completion or willingness to complete the Accredited Peer Support Worker Training Completion of own Wellness Recovery Action Plan (WRAP)	10	Level of educational attainment to NVQ 3/AS Level or equivalent Mental Health related qualification ie. Certificate in Community Mental Health or equivalent Willingness to undertake further training in line with the development of peer support	8	Application form
Experience	Lived experience of mental health problems Experience of recovering a meaningful life Experience of being in a supportive and enabling role Independent living	10	Psychiatric hospital admission Experience of working in the public sector Experience of working in a team Experience of training, teaching, coaching/mentoring others Experience of using a range of self-management or recovery tools and techniques Experience of working across different organisational boundaries	8	Application Form Interview

III. PERSON SPECIFICATION (BAND 2) continued

Attribute	Essential	Weight	Desirable	Weight	How identified
Aptitudes / Skills	Excellent written, verbal and non-verbal communication skills. Willingness to use the Trust IT systems Able to relate to a wide range of people Professional in appearance and behaviour Able to manage conflict and to help others to do so Ability to maintain a healthy home/work life balance High level of self-awareness – ability to critically appraise own performance Ability to demonstrate critical thinking Good team-working skills Ability to share personal story of recovery in a professional manner Ability to assist people to develop recovery plans Willingness to reflect on work practice and be open to constructive feedback Ability to work in an enabling and creative way Willingness to support people with a range of needs to meet their recovery goals Ability to manage stress and to plan and prioritise workload Ability to carry out practical tasks	10	Computer literate in Microsoft Office Presentation skills		Application form Interview

III. PERSON SPECIFICATION (BAND 2) continued

Attribute	Essential	Weight	Desirable	Weight	How identified
Dispositional Attributes	Range of life experiences Good team worker Ability to use initiative Reliable Flexible Resourceful Good organisational skills including time management Supportive to other colleagues Able to demonstrate a patient, non-judgmental, respectful and compassionate attitude	10			Interview
Contractual Requirements	Must be able to travel to a range of locations by own or by public transport	10			Application Form Interview

IV. FRAMEWORK FOR DBS ASSESSMENT

This framework should not be completed until the attached guidance notes have been read.

Attribute	Essential	Weight	Desirable	Weight	How identified
Qualifications: Academic / Craft / Professional	Relevant lived experience of significant emotional / mental distress Completed and passed Nott's Healthcare Peer Support Training Programme	10 10		5	Application form
Further training	Shows aptitude and desire to complete further training	10	MVA	5	Application form Interview
Work Experience	Ability to demonstrate has reflected on challenges involved in working on Mental Health ward Has developed an awareness through reflection / experience of how their personal attributes will apply to role	10	Ability to demonstrate transferable skills Knowledge of: Developments in Mental Health Policies and procedures. Team/MDT working. Issues around Acute Care	5	Application form Interview

IV. FRAMEWORK FOR DBS ASSESSMENT continued

This framework should not be completed until the attached guidance notes have been read.

Attribute	Essential	Weight	Desirable	Weight	How identified
Aptitudes / Skills	Effective communication skills including literacy. Effective team working Positive attitude towards people Knowledge of key concepts of recovery model	10	Awareness of needs of distressed people Awareness of how to use self to meet needs of distressed individuals Computer literate	5	Interview
Dispositional Attributes	Flexible/adaptable. Caring/diplomacy. Ability to work with people displaying anger/distress. Ability to identify own stress and awareness of how to manage this Motivated and Self aware	5			Interview
Interests (including leisure)	Evidence of awareness of need for healthy work life balance	5		5	Interview
Contractual Requirements	Day/night rotation. Ability to work over a 24 hour rota (Hours to reflect need of the service, including unsocial hours, bank holidays.) Good attendance				

V. ETHICAL CODE OF CONDUCT

*"Ethical issues are moral-value issues suggesting that some ways of acting are bad, good, wrong, or right. Related differences of opinion are at the heart of different points of view about the 'best way to live,' the most moral way to behave toward others, and how to structure society. They require ongoing debates by their very nature**.

The following principles will guide Peer Support Workers (PSWs) in their various roles, relationships and responsibilities. However, given the nature of ethical issues, it is recommended that dilemmas that arise in practice are discussed in detail in supervision.

1. The primary responsibility of PSWs is to help individuals achieve their goals guided by the principles of Recovery:
   - Inspiring Hope
   - Facilitating Opportunity
   - Handing back control of difficulties, the way they are treated and their lives as a whole.
2. PSWs will also conduct themselves in a manner that fosters their own recovery.
3. PSWs will share stories of their own recovery as appropriate, in particular the factors that promote their recovery.
4. PSWs will, at all times, respect the rights and dignity of those they serve.
5. PSWs will never intimidate, threaten, harass, use undue influence, physical force, or verbal abuse, or make unwarranted promises of benefits to the individuals they serve.
6. PSWs will not practice, condone, facilitate, or collaborate in any form of discrimination on the basis of ethnicity, race, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other preference or personal characteristic, condition, or state.
7. PSWs will always recommend that the people with whom they work make their own decisions in all matters when dealing with other professionals. PSWs may advocate on their behalf, but always with the goal of handing back control.
8. PSWs will respect the privacy and confidentiality of those they serve.
9. PSWs will not work when under the influence of drugs and alcohol
10. PSWs will work towards full integration of the people with whom they work into the communities of their choice and will promote the inherent value of those individuals to those communities.
11. PSWs will not enter into personal relationships or commitments that conflict with the interests of those they serve.
12. PSWs will never engage in sexual/intimate activities with the consumers they serve.

This code of conduct was developed by peer workers on the Nottingham PSW training in 2010.

*Gambrill, E. (2006) *Social work practice: A critical thinker's guide*. Oxford: Oxford University Press.

Peer Support Workers: a practical guide to implementation

This briefing paper has been produced for the Implementing Recovery through Organisational Change programme, a joint initiative from the Centre for Mental Health and the NHS Confederation's Mental Health Network.

The pilot phase of ImROC ran from 2011-12 and was supported by the Department of Health, together with contributions from the participating services. The continuing work of ImROC is endorsed by the Department of Health and managed and supported by the Centre for Mental Health and Mental Health Network.

For more information on the current work of ImROC, please visit **www.imroc.org**.

ImROC, c/o Mental Health Network, NHS Confederation, 50 Broadway, London, SW1H 0DB
Tel: 020 7799 6666
imroc@nhsconfed.org
www.imroc.org

Centre for Mental Health

Centre for Mental Health is an independent national mental health charity. We aim to inspire hope, opportunity and a fair chance in life for people of all ages with or at risk of mental ill health. We act as a bridge between the worlds of research, policy and service provision and believe strongly in the importance of high-quality evidence and analysis. We encourage innovation and advocate for change in policy and practice through focused research, development and training. We work collaboratively with others to promote more positive attitudes in society towards mental health conditions and those who live with them.

Maya House, 134-138 Borough High Street,
London SE1 1LB

Tel: 020 7827 8300
contact@centreformentalhealth.org.uk
www.centreformentalhealth.org.uk
@CentreforMH

Charity registration no. 1091156. A company limited by guarantee registered in England and Wales no. 4373019.

Mental Health Network NHS CONFEDERATION

The NHS Confederation's Mental Health Network (MHN) is the voice for mental health and learning disability service providers to the NHS in England. It represents providers from across the statutory, for-profit and voluntary sectors. The MHN works with Government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of its members and to influence policy on their behalf.

50 Broadway,
London SW1H 0DB

Tel: 020 7799 6666
mentalhealthnetwork@nhsconfed.org
www.nhsconfed.org/mhn
@NHSConfed_MHN

Charity registration no. 1090329.

Published October 2013