The Cellar Trust

with-you

NHS
Sussex Partnership
NHS Foundation Trust

Peer support for people in crisis: Reflections for development of services

Contents

Introduction

This thought piece aims to bring together our existing knowledge and experience of peer-based approaches in crisis services. We include the experience of peer support for diverse communities and throughout we use stories of personal experience to illustrate a range of views on crisis settings and the potential for peer support. In the last section we develop this to offer our reflections on service development and delivery.

Our intended audience is anyone, organisation or individual, who wants to reflect on the use of peer support in crisis care. We, the authors, represent organisations from the voluntary sector (The Cellar Trust, Bradford), the statutory sector (Sussex Partnership NHS Foundation Trust) and from With-you Consultancy, who have worked with various agencies to co-design training and service development in this area.

We want to illustrate the breadth of potential for peer support in this setting which might include the peer support offered by people with shared characteristics that are separate from experiences of emotional distress, as well as highlighting the importance of support for our networks of supporters. There is no one service that every person in crisis might be directed to, any person in crisis is part of a community which itself experiences an aspect of that crisis and might themselves value peer support. So the topic of 'peer support in crisis services' is broader and more complex than might first be anticipated by such a narrow title.

We hope that this thought piece will encourage the reader to consider how they might support the development of peer support in any service that responds to crises, so that appropriate peer support is available to all who need it. However, every team is different, creating a range of settings and implementations, such that, while we can offer guidance and suggestions of benefits and challenges, it is not appropriate to impose any one way of working.

We have divided this paper into two sections:

- **Part one**: Background and general discussion to introduce the reader to our topic and key debates, and to offer some reflective points to encourage the reader to apply these ideas to their own practice.
- **Part two**: Learning from the introduction of peer support into crisis services, developed from our own practice in this field. Thoughts on developing crisis services that include peer support, with an emphasis on co-production between those with lived experience of distress and crisis and service providers.

Part one: Background and general introduction

Definition of 'peer support'

As a foundation to our discussions with teams nationally, and to support a shared understanding about the unique qualities of peer support, we have used the following definition which is widely used in the mental health peer support literature:

> **'Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful.'**
> Mead et al, 2001

We have found it beneficial for teams to explore any uncertainty about the role, particularly with this emphasis on mutuality and reciprocity, so that they can develop the role to meet their own service needs. More will be said later about challenges in implementation, but here we emphasise that peer support is not one implementation of a specific intervention, it is a way of thinking, a way of being and an interaction. This can take time for existing teams to understand.

For this thought piece, we use the definition used in the HEE Star materials:

> **'Peer support workers are individuals with personal prior experience of health and care services, equipping them with the knowledge and insights often helpful to supporting the recovery of others.'**
> (HEE, 2018)

Peer supporters are a growing part of the workforce, used across health and social care and beyond (NHSE, 2019). This document specifically focusses on peer support in mental health, where peer support workers are becoming established as an essential part of many teams, and specifically on services that offer crisis support.

What is a mental health crisis?

Defining a mental health crisis involves a variety of perspectives: one person may be overwhelmed by something that another person finds manageable. Consequently, people who use services and their carers suggest that perceptions of crisis are individual and it should be self-defined. However, the services they turn to for support may have strict definitions linked to safety or risk, or they may take a pragmatic approach that crisis is something that brings the person to the attention of crisis services, such as a relapse of an existing condition (Paton et al, 2016). Other services may not be specifically focussed on crisis, but they may be providing an essential support, either as alternatives or in the waiting periods between services, such as the informal online peer support described as the 'digital waiting room' (Tucker et al, 2019).

The document which shaped the Mental Health Crisis Service in the UK was the Mental Health Policy Implementation Guide (DH, 2001). Any consideration of definitions of crisis would be incomplete without some mention of the 'operational' definition of what presentation would be expected to trigger a response:

> **"Commonly adults (16 to 65 years old) with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorder) with an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation would be necessary."**
> (DH, 2001, p.11)

This view privileges severity and associated risk. A crisis may have many causes or triggers, and may be an abrupt disruption in someone's life or have developed over a longer time. For some people, the interruption caused by a crisis may later be viewed positively as an opportunity for review and change, while for many people the experience can feel wholly negative.

A personal experience of crisis: Grace Collins, Artist

With the power of hindsight, I identify my engagement with a variety of crisis services by locating their official names as I've heard them whispered. Accident and Emergency, Crisis Teams, IAPTs. At the time I would have called them services in the spaces between other services, punctuated by filling in the same questionnaire every two weeks.

I can't remember the face of the paramedic who shouted at me or the crisis team member who told me that maybe I should eat more fruit.

I vaguely remember (though if you asked me how tall she was I wouldn't be able to tell you) the lady who challenged me to meet her at the hospital. I remember my disappointment on arriving that she didn't beam with the same pride that I had on leaving the house alone.

I really remember how hot it was the summer my close circle of friends tried to talk to me about what I was going through on the back step of house parties. They didn't really know what to say and were too drunk to work it out. Friends who sent me letters in the post that included pictures of their pets but not the answers I wanted on how to pay my rent if I couldn't go to work. Friends who stumbled between smiling and avoiding eye contact, who tried their best while exhausting themselves with the worry that they weren't doing it right.

At the same time, in activist groups I joined at university, students' word-of-mouth mapped how to tackle the services available; when was best to call, who had a print-off of email addresses, how to score the right number on the questionnaire at the counselling service behind the laundry rooms.

We were aching to share these toolkits without the energy, time or health, to do so, with a frustration that surely it was someone else's job to help us? Someone who knew a bit better what they were doing, especially considering we still called our parents when a too-official form needed filling out.

With the power of hindsight, my experience of crisis services was propped up by a messy kind of peer support by young carers who would never have identified themselves as such. People who were desperate for me to tell them what I needed, while no-one knew that we were actually doing a really good job.

If I could return and offer something back to that situation, it would be the confidence and care that peer support can offer not only to the individual in crisis, but to the carers around them. I would tell my carers that I was not the only one who needed that care. I would tell a group of twenty-somethings that there was no secret to fixing it all, but eating very spicy Sri-Lankan curry in thirty-degree heat in a tiny concrete garden was definitely a valid form of community resilience.

A crisis may fundamentally be one person's experience, but it will also impact on others around them, as described in Grace's story. They may be drawn into a crisis, perhaps providing 24/7 care and support until the person finds other support. These family and friends may eventually identify as carers, but this is unlikely to occur for a first experience of distress, and consequently they may not be offered support for themselves. Similarly, they may not meet the criteria for support from crisis services in their own right, and services focussed on responding to crises may not be commissioned with the time or resources to support carers.

In this document, as authors, our preference is towards a broad view of self-definition of crisis. Consequently, the themes and learning in this document may be of relevance to a wider audience than those specifically defined in commissioning arrangements as 'crisis services'. We remind the reader that only around a quarter of suicides in the UK are by people in contact with mental health services (within 12 months of their suicide).

What are the policies that influence crisis care?

We have previously mentioned the importance of the Mental Health Policy Implementation Guide (2001) in defining 'crisis'. The NHS Long Term Plan (HMG, 2019) offers "a commitment to pursue the most ambitious transformation of mental health care England has ever known". This overarching document is the key current policy document across mental healthcare.

The specific plans related to crisis care were based on the work of the Mental Health Crisis Care Concordat (2014) which suggested that principles of support for people in crisis should consist of:

- access to support before crisis point
- urgent and emergency access to crisis care
- quality of treatment and care when in crisis
- recovery and staying well/ preventing future crises

The NHS Long Term Plan (HMG, 2019) and the associated Implementation Framework (NHSE, 2019), built on this work to include commitments of:

- 24/7 Crisis Resolution Home Treatment functions
- 24/7 provision for children and young people
- a range of complementary and alternative crisis services to A&E and admission
- a programme for the ambulance service
- mental health liaison services within general hospitals
- specific funding for community crisis care services and mental health liaison services.

In March 2020, more than £200 million has been allocated to local areas to fund this transformation of urgent and emergency mental health care over the next two years. Overall the goal is to improve patient experience and free up resources by providing an alternative to A&E or inpatient admission. Funding will enable new or expanded crisis services such as safe havens, crisis cafes and crisis houses in every region. In some areas services will be co-designed with local communities such as young black men or older people and their carers to meet specific needs. Peer support roles are an integral part of many of these new and expanded services.

How to define crisis services

As we have seen, crisis services are diverse and expanding. An NHS webpage (2020) offers the following suggestions for public access to crisis support:

- A crisis line number provided by a health professional
- Details provided in an existing care plan
- Information provided by Mind
- The free to call service provided by the Samaritans
- A link for local crisis support services (mainly local Samaritans services)
- NHS 111
- Emergency GP appointments
- A&E or 999
- Social services
- Referrals to Crisis Resolution and Home Treatment teams, or to Crisis Houses.

Reflection Point: How would you personally define a crisis?

What definition of 'crisis' is used in your service or other local services?

However, people in crisis may choose their own access, or none. They may head for various voluntary sector organisations who may offer crisis support, including some specifically commissioned to provide mental health support, and also those working, perhaps 'below the radar', with specific populations or specific life events, including people who may be inaccurately described as 'harder to reach' by more traditional services (Newbigging et al, in press). Additionally, emergency services may respond to 'people in crisis', with the role of the police and fire services to be acknowledged, alongside ambulance services, such that the first mental health service for a person in crisis may be an inpatient or secure ward.

Some organisations may provide a range of different services including crisis services, such as those provided by the Cellar Trust in Yorkshire.

In our discussions here, we take 'crisis services' to be any service which responds to a person in crisis, a position shared by NHS England National Programme Lead, Bobby Pratap.

The Cellar Trust

The Cellar Trust supports people with mental health problems, across the Bradford district to move forward in their recovery and live independent, fulfilling lives. We exist because mental health problems exist and because they are complex. Our purpose is to support people when they face these challenges, and to empower them to move forward. We have three main strands of services, Crisis and Specialist Support, Employment Support and 'Being Well' (telephone wellbeing support).

Here is a description of the Crisis and Specialist Support strand:
Our crisis support service, known as Haven, offers a calm and friendly alternative to A&E for people in mental distress 365 days a year. It's available to people who live in Bradford, Airedale, Wharfedale or Craven. Haven is a non-clinical, supportive environment designed to help people in crisis stay safe, work through and understand their feelings, and then support them to access the support they need going forward. As crisis means different things to different people, clients don't need to be accessing secondary mental health services to access this support. Often, crisis will be when you feel unable to cope and need immediate support. Haven is available for people over the age of 16 and feel at the point of crisis (if they are under 16, they can still ring First Response for support).

In partnership with Airedale General Hospital and Bradford Teaching Hospitals, we are delivering peer support based in A&E departments. This will help to ensure that people can get the right support at the right time, as well as helping to raise awareness of alternatives to A&E.

Our part-time peer support workers deliver this ground breaking work and work as part of our Multi-Agency Support Team (MAST) – alongside psychiatric liaison nurses, personal support navigators, drug and alcohol workers, social workers and the wider urgent care team. The team assists people who attend A&E in emotional distress, providing one-to-one peer support within the hospital.

A personal experience of crisis: Sharif Mussa, Lived Experience Practitioner

When it comes to mental health awareness, openness, and attitudes towards mental health, I think as a black man I was short-changed in my knowledge. Growing up, questions like 'what is mental health?', 'how do you detect it?', or 'how do you assess it?' were myths, for I thought they were questions for the mentally ill patients, who were on psychiatric ward admissions or had done something terrible to land themselves there.

So, having had such views and stigma towards mental health, it's little wonder that I was unable to access and open up to services about how I was feeling from a very young age. Partly because of, it goes without saying, a system that's set up unfairly and does not serve its purpose when it comes to BME communities, and the negative views that my family and culture had taught me growing up. It's very hard to seek help or treatment for something you have no clue exists or is even affecting your potential in life. You begin to settle for the crap and internally start getting down and depressed about who you are to the point of destruction, where some men start to self-harm, abuse drugs and alcohol as ways of hiding and coping with the trauma.

For, ironically enough, that is the way we saw our elders cope and deal with their issues, (I often remember watching my uncles smoke and drink in disgust as a kid but then in my early 20s taking up both as coping mechanisms) not acknowledging that we are all different and that these things will affect us in completely different and sometimes opposite ways to what we have seen.

So, when we present to the Emergency Department in crisis it has often taken us a long journey just to get to presenting in the first place, and we are so desperate for help that we don't know what it looks like as we have never sought after any in the past. Everything else has failed, lots of crisis has gone unnoticed, and once we present we may present in distress unable to communicate, under the influence, trying to cope with trauma, as it's now too late and we've become dependent. And all these things work against us when we present as patients in the ED. This makes it easy for us to slip through the net and go undetected for years until unfortunately something terrible happens, and we end up detained, sectioned or imprisoned.

The needs of diverse groups in a crisis

With a broad understanding of the definition of crisis, it is clear that a wider range of different services need to be provided. People who are not familiar with mental health services may particularly welcome peer support in easily accessible community services. Young people may seek the shared understanding of their peers as people of similar age (Felton & Lambert, 2019). People from Black, Asian and minority ethnic (BAME) communities, for whom contact with services in a crisis, carries an increased risk of detention or criminal justice involvement, may value the shared language and acknowledgement of specific histories that can be offered in community-based peer support.

Peer support roles in crisis services

People have always looked for opinions and support from people who have had similar experiences; it's an organic activity we see all around us, from self-help groups, parenting networks to online reviews of products and services. Peer support in mental health is an extension of this: looking for people who have used a service or who have got through an experience of emotional distress to connect with and share. Informally, this has always happened, for example on wards where patients might help each other with the routine or offer suggestions of supportive community services. However, access to informal peer support may vary significantly across different settings: for example, in a study of a Home Treatment team, the lack of peer support for often isolated patients was noted in contrast to the informal peer support readily available in an inpatient setting (Carpenter & Tracy, 2015).

The development of peer support roles is an initiative to make use of the expertise offered through informal peer support and to extend this by offering structured employment, alongside support and skills development. Paid peer support workers are a relatively new development to the workforce throughout health and social care in the UK (Watson & Meddings, 2019). They have been introduced successfully in many teams, both in inpatient and in community mental health teams and recovery services (Gillard et al, 2014). In all these settings, the role of the peer support worker might focus on supporting the person to explore the impact of their experience and a way forward. Peer supporters have also been described as particularly helpful at times of transition, such as between CAMHS and adult services (Lambert et al, 2014).

Introducing new roles into mental health services, including the role of peer support workers, form a key part of HEE's New Roles in Mental Health National Programme, as part of transforming the workforce as set out in Stepping Forward and the Long Term Plan. We might anticipate that policy commitments for crisis services would require the involvement of peer supporters in a variety of settings.

However within these documents, we can only find mention of peer support in relation to the alternative services such as crisis houses or safe places (HMG, 2019, p.19; NHSE, 2019, p.31). The Long Term Plan however does include a specific commitment to funding peer support roles, detailing an indicative workforce profile for the alternative crisis services which specifically mentions peer support workers (p.33).

Against a background of community service transformation, NHS teams are in a good position to explore and innovate with new ways of working, and to share their learning and evaluation as they develop evidence-based practice. Specific crisis services are commissioned as a relatively short intervention to provide additional support, with referral to other services where needed for longer term support, creating an additional point of transition and consequent uncertainty. Research on peer support has concentrated on the offer within the statutory sector, particularly around these times of transition and including specific interventions (Johnson et al, 2018; Milton et al, 2017).

Reflection Point: What opportunities for peer support have you seen or do you think there are in relation to crisis services?

Sussex Partnership NHS Foundation Trust

Sussex Partnership NHS Foundation Trust's six Crisis Resolution and Home Treatment Teams (CRHTTs) took part in the long term 'Crisis Team Optimisation and Relapse Prevention' (CORE) study run by the University College London (UCL) which concluded in 2017. A key element of this study was exploring how peer support in crisis teams could add value, especially in providing support to patients as they make the transition from crisis teams to continuing care.

The focus was on promoting learning from the crisis to increase resilience, employing a strengths-based approach. The idea is that when the intensity of a person's experience is beginning to resolve a peer support worker can use their lived experience to support the person to explore what has been happening for them, to begin to identify what resources they have, what is available from their own network and what they might need from services to improve their resilience for the future.
As the original model suggests that peer supporters should work with the patient for up to 10 sessions, an additional benefit is that their involvement should lessen the impact from the drop off in support as the patient transitions back to mainstream support. Finally, the intention is that this work contributes to a comprehensive Crisis Plan for each patient which all parties, patients, families and staff can trust during any further crises.

Recent planning to optimise the delivery of crisis care in Sussex presented an ideal opportunity to review the skills mix within the various CRHTTs. The previous work carried out with UCL was influential in shaping the plan, particularly in introducing peer support workers into the teams. We were guided by the work of Johnson et al (2018) and Trachtenberg et al (2013) in our implementation. The need for team readiness sessions and attention to cultural change within teams as peer support roles are added cannot be underestimated (more on this in Part two).

In contrast, teams in the voluntary sector may be confident in their long term understanding of peer support and see this as a fundamental part of their offer. The expertise offered by lived experience may be central to their organisational values, and yet they may struggle with commissioning or their offer may go under the radar while statutory services and commissioning take a different lens to crisis support. Newbigging et al (in press) acknowledge this fundamental importance of peer support within a range of voluntary sector crisis services:

> **"The unifying themes across these different types of organisations is the importance of peer support" (p.145)**
> Newbigging et al

Crisis responders across a range of services might also need support for themselves and this can be facilitated using the peer support of colleagues. This following example is offered by a police officer to note the importance of opportunities for police officers to reflect with each other in peer support. This peer support is equally relevant for staff in all crisis services.

Peer support - a police perspective

I have been a frontline police officer in busy Northern towns for 17 years, in various roles and ranks. I have required peer support on far more occasions than I have received it, but when it has been available, it has made a huge difference to my wellbeing. Sometimes that has looked like a formal de-brief with a supervisor, but often it has simply been a colleague taking me to one side and asking 'Is everything ok?'. And then asking again.

We now have a formal, multi-faceted peer support/de-briefing model in my force, but my experience, training and instincts all lead me to strongly believe that peer support is simply having a measure of emotional intelligence and resilience.

We need emotional intelligence to recognise that people need to talk about difficult subjects and that those of us who work in crisis services become so thick-skinned that we can make the terrible mistake of confusing seeming ok, with being ok. It is necessary to make sure when you ask 'are you ok?' and the person says 'I'm fine' (which those of us in these roles always do), that you ask a second time and look for the hooks which suggest that it might not be true.

We need resilience to deal with what comes when someone does admit that they are not ok. It can be tiring and confusing, especially when you start providing support of this nature and you need to develop a set of strategies and resources to effectively deal with what comes your way. I suspect that this is why some (many) people shy away from doing it. I think that I am prouder of the support I have provided to colleagues than that I have provided to the public.

I have worked hard to embed peer support in my force, precisely because of the terrible impact not receiving it has had on me over the years. In my years of service, I have been to many incidents which have included personal danger to me as well as witnessing the intense distress of the person concerned. I am in no way unusual and the thing these incidents have in common is that immediately after the crisis had passed, no-one talked to me about them, I just went to deal with the next incident. The cumulative creep of not receiving support had a significant effect on my mental health, until I realised what was happening and did something about it.

Crisis service workers are constantly in a state of having to cope with the most horrific situations and those who do not build up a thick skin quickly crumble, or leave. That skin however, takes some skill to penetrate and this is precisely why peer support is so significant. My ability to empathise with a colleague, who knows I have stood where they stand, is a short-cut which no amount of training can ever replicate.

Counselling/psychotherapy/GP support and a multitude of other means absolutely have their place, but my repeated experience is that the need for those services can be mitigated by an early opportunity to talk things through with an effective peer supporter.

Part two: Developing peer support in crisis services

Having established the range of potential for peer support in crisis settings, including the diversity of the role itself as well as the broad definition of crisis, we will now consider some lessons learned in developing and implementing these roles and some successful examples of practice.

This thought piece covers both mainstream and alternative forms of service provision. Lessons learned in each sector can be vastly different, depending on a multitude of local factors. Overall, there is a need for further research into the efficacy and value of alternative provisions as well as peer support, wherever it is received by a person or family in crisis.

A rich range of case studies of alternatives to crisis care has already been produced by NHS England and NHS Improvement in 2019. It features a range of A&E alternatives that are open access or drop-in options. Some are called safe havens, crisis cafes or sanctuaries. There are also inpatient admission alternatives such as acute day services and home treatment team partnerships. The document states "none of the services featured have had external evaluation by NHS England / NHS Improvement (unless stated), but have been included as they are highly valued by the local system in which they operate." (NHS-E & NHS-I, 2019, p.2).

It can be difficult to measure and evaluate the outcomes of service provision or the peer support embedded within it. Services could look at data such as admission rates or re-referrals or number of relapse prevention plans completed, but it requires the involvement and voice of the service users to be heard to realise the meaning and complexity of the impact felt.

So many factors can be heard at work in the quotes below; the relief at being safe, the welcoming relationships, the lack of judgement, the feeling of being heard. One could assume that any or all of these factors allow a person to have the space and acceptance to reflect on what has happened and to feel strong enough to move forward.

The challenges of providing and developing peer support in crisis services

There are many existing challenges to developing and providing recovery-oriented services and peer support in general, which can be found elsewhere in the literature (Davidson et al, 2006; Repper et al, 2013, Shepherd et al, 2008). Here we highlight some key challenges which are specifically relevant for peer support in a crisis service setting. All these challenges are also opportunities for growth within services and peer support.

1. **Nature of a crisis service:** A fundamental challenge of providing peer support in this setting is the nature of offering support in a crisis, which involves a prompt, and often time-limited, response and hearing personal stories of intense distress and pain. In addition, the environment of crisis services can be risk-averse and focused on 'working backwards from the coroner's court'. This combination, of acute emotional distress and a risk-focused environment, can be personally challenging for any worker, such as described earlier in the story of police work. It can be especially difficult for peer supporters whose training embodies a non-directive, strengths-based approach, and who may have experienced these services themselves. Another aspect is that crisis services are constantly working across transitions with other services, and a model of peer support that aims to hold hope and consistency across the transition can be a challenge to the focus of existing teams if they have targets to reach. It can also be a challenge to peer supporters who may feel their impact is constrained.

2. **The range of services involved in crisis care:** While the range of services involved is an opportunity for wider use of peer supporters, at this relatively early stage, we list it as a challenge because of the need to communicate this new way of working to a wider network of partners each of which is time-pressured and may not be as familiar with this agenda. This creates opportunities for shared learning and development, but can also be a barrier to effective, helpful and rapid responses to people in crisis. For example, ambulance services and call handlers are key to ensuring that people are made aware of peer-led crisis services rather than conveying people directly to urgent and emergency care.

3. **Commissioning of services from the voluntary sector:** While not specific to peer support, the short-term contracts available to the voluntary sector can be a challenge when establishing new ways of working. This has implications for instability of employment and the use of volunteers. The issue of whether peer supporters should be employed within the statutory sector, seconded into the statutory sector, or employed within a third sector organisation, is discussed elsewhere and is beyond our remit. However, while there are many advantages to commissioning from the voluntary sector, such as flexibility and agility as well as expertise, we include this here as a specific challenge, given the emphasis on the voluntary sector for provision of peer support in crisis care in the Long Term Plan.

4. **Team readiness for peer support:** The lack of understanding of the complexity of peer support creates a further challenge for teams who may be unclear about the responsibilities of a peer support worker. In crisis services, this challenge is heightened by short timescales, strict protocols and high perception of risk. Concerns include how already stretched teams could have workloads increased by managing the peer workforce and the perceived risks that are created by employing unqualified staff with lived experience of using mental health services. Many of these concerns may be unfounded or reflect a lack of understanding, but they all need to be aired safely to instil understanding and confidence. Finding time and space to do this can be hard when the everyday focus of teams is often on the current caseload and pressure, rather than on a longer term view of how peer supporters can enable people in crisis to self-manage and learn from their experience, thereby lessening demand in time.

5. **Additional support for wellbeing:** While employees have a responsibility to look after their own wellbeing rather than look to their employers, all staff in crisis services should be provided with support so that their emotional labour doesn't lead to burnout. Often, peer supporter workers are viewed as needing additional support to other staff, and their colleagues may feel an expectation to provide this support, which is then viewed as an additional duty to their existing workload. Peer supporters may see value in using their support skills to support each other. However, they may not be as familiar with the need for boundaries, including at what point they should inform their employer to prevent a situation reaching breaking point. Overall, organisations need to be confident in the capacity of their systems for support and wellbeing such as HR, occupational health and other forms of employee assistance.

6. **Pressures of working in a 24/7 setting:** Peer supporters in crisis services may be required to work rotas to provide cover for the service 24/7 and/or 365 days, which can feel unusual for staff in the voluntary sector who are more familiar with providing services for 9-5 weekday working hours. Balancing this contrasting use of time can be challenging for any new worker, but especially for peer supporter workers who are giving of themselves as part of their role, who may be returning to work. Clear protocols for out-of-hours and lone working are also required to ensure peer supporters feel safe and supported.

7. **Limitations for reasonable adjustments:** The need to provide services to a specific contract can also limit the flexibility to provide requested reasonable adjustments. Peer supporters may need reasonable adjustments such as a later start to the day or a limit to the number of clients, but these adjustments may not be possible with existing staffing. While all staff may require reasonable adjustments, this may disproportionately affect peer supporters who are employed for their lived experience of distress.

8. **Leadership and visibility of a new project:** Any change to existing services can be a challenge for team members, managers and leaders to communicate and enable acceptance of new roles and ways of working. Within crisis services, the pressures to react to demand and to manage difficult work as a team is already a challenge, so when changes are introduced, they can be seen to be disruptive to an already precarious balance. It is imperative that team leaders manage this change for the wellbeing and success of any new project, but particularly with a view to supporting the introduction of lived experience into a team with care.

9. **Time investment to develop new services:** Any new service takes time to design, develop and embed successfully and new peer support services are no different. Every step of development may take longer than anticipated. True co-production and co-design adds to the development time. As for any staff, recruitment needs to anticipate additional occupational health processes for considering potential employees who declare any disability. New employees need induction and mandatory training before being able to start their role. Any potential delays can impact on the success of time limited contracts, such as pilots commissioned in reaction to winter pressures, or contracts held by partners in the voluntary sector. Again, while all of these are general challenges for any new service, crisis services can be particularly influenced by time pressures. For example, staffing numbers and shift patterns can impact on how many staff can attend training and development events, which can delay the successful launch or embedding of a new role or service.

10. **Personal development opportunities:** Crisis services in the voluntary sector may be small with limited opportunity for progression such that peer supporters may move to roles within the NHS and/or non-crisis services, where there may be more regular hours as well as opportunities for progression. This turnover of staff has wider implications for investment in training opportunities and is also linked to the short-term contracts within this sector. Career pathways are a known challenge for all peer support workers, and the debate on how to ensure appropriate development opportunities goes on.

11. **Peer support for family and friend carers:** Carers, the family and friends who offer support, are often excluded from discussions of peer support on the assumption that it is only for people who use services. Consequently, carers peer support, the support offered by carers to other carers, is often delayed or not seen as a priority with services still suggesting they are not commissioned to provide support for families. A crisis is a clear opportunity to identify carers, but with limited time and working in an acute potentially short intervention, carers themselves may prioritise the person they support and not see themselves as a carer. There is an opportunity here for carers peer support and where it has been introduced it has been very welcome to carers.

12. **The culture of crisis services:** Particularly in the statutory sector, the team and organisational culture can be difficult for peer support workers. As previously mentioned, the speed and short duration of the service can feel difficult, creating pressure to 'move patients on'. The relationship between peers can be unhelpfully short and there can be anxiety from both sides about transitions to other services (if any). The culture of peer support is about growth, connection and hope and sometimes peers have reported that the language in team meetings or offices can be less positive, even labelling and judgmental at times. The jargon and acronyms used in team meetings can feel exclusive and overly process-oriented rather than people-focused. Teams that are inclusive and open to hearing the peer voice can gain some important feedback about patient perspective from a peer support worker, but few think about the impact of representing this voice on the individual.

> **"If I want to challenge clinical language I tend to ask a question, usually about a person's strengths being presented as this humanises a person. Handovers can be traumatising, I go for short walk afterwards or do some grounding work."**
>
> Peer support worker

As is clear from the challenges described above, there are many considerations with embedding peer support in any service. Some of these that are relevant to crisis services in any setting are explored in more practical detail below:

HR considerations

Job descriptions and criteria for crisis roles:
Lived experience of mental health problems is an essential criterion for all peer support worker roles and 'experience of recovering a meaningful life' is at the core of these roles. (A 'meaningful life of course meaning different things to different people.) It is, however, also important that the individual is willing to 'use their own experience to help others'. In addition, for roles within crisis services, you might also look for peers who have also used crisis services or who have experienced acute distress.

Working within crisis services is emotionally demanding for all staff. It can be heightened for peer support workers due to similarities with their own experiences. It can be helpful to include a clear statement around the emotional effort required for the roles within crisis services for example:

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

This emphasis on emotional effort can be presented alongside information on the support available while establishing clear expectations in terms of individual's participation in supervision and training. This may vary depending on the organisation, for example, 'willing to undertake regular one to one clinical or peer supervision.'

The skills and experience required in the role, will depend on the nature of the service and the role that the peer support worker will play within it, for example:

- Level of independent working
- Need for shift working
- Environment operating in e.g. A&E, people's homes
- Other colleagues within the team, for example, a predominantly clinical team or other peer support workers
- Capacity within the organisation to develop peer support workers skills.

Recruiting the team manager or allocating supervisors
Insufficient skills or experience of managing staff and services, or a lack of understanding of peer support and the implications for HR policy, can be very problematic and have a knock-on effect on staff wellness, absence levels and retention for the whole team, including the team manager.

Consider the capacity for team managers and supervisors to support new peer support workers. Time needs to be taken to prepare staff for working with people in crisis and to understand the roles. Additional supervision can be advised for both the peer support workers and the team managers of crisis services to support their ability to deal with any vicarious trauma and to process the events of each day.

If services have shift patterns with frequent changes to staff on rotas, these skills should also be considered in terms of enabling good understanding and capacity in all staff with line management responsibility and/or those with responsibility for leading shifts.

Interviews
Alongside the assessment of skills and experience required to undertake the role, consider organisational values. Values-based interview questions can lend themselves to a more conversational interview, allowing individuals to draw on learning and experience from different aspects of their lives, not just those gained in a working environment.

Some questions should be considered to help draw out a candidate's strengths, skills and ability to cope with the emotional demand of roles within crisis services. For example:

- Can they express their journey?
- Can they describe how they have or would use it to support others?
- Is there self-reflection evident in their answer?
- Do they have a strong level of self-awareness about their own mental wellbeing and the things they have or can put in place to manage it?

LESSONS LEARNT

The Cellar Trust - 'recruiting the right peers for the right role'
It has been a journey for us to be able to use the application process as a tool to help us find the right peer support workers for our crisis services. We have learned that an excellent peer in one role may struggle in another role for many reasons, and so to help us and the applicants understand one another more, we introduced a two-interview process with applicants having a skills interview, followed by a values interview with a different panel of interviewers.

This is a time-consuming process and we are a small organisation but getting staff whose values align with our organisational values is of paramount importance to us. We do this with many of our roles now, not just peer roles. The values interview carries as much weight as the skills interview and has proven to be an essential part of our recruitment process.

Training

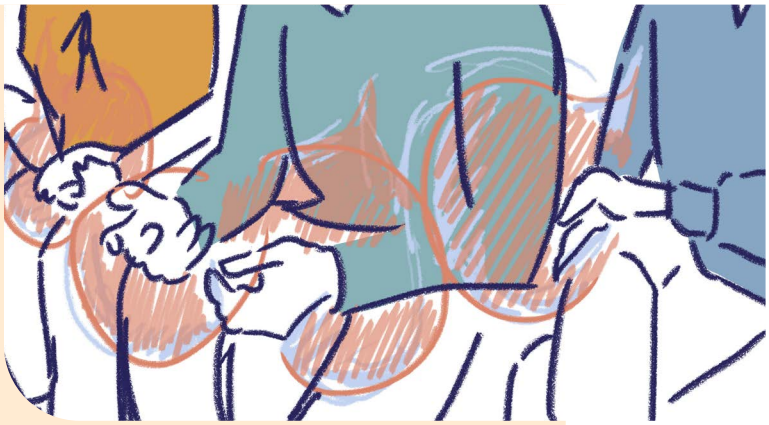
Peer support in crisis care is still relatively new, with a limited existing pool of previously experienced workers to recruit from, and it is essential that people appointed to these new roles will require some training. The need for training for all peer support workers has been established as part of the recognition of the variety of skills required for the role, with peer supporters themselves recognising the value of training (Burke et al, 2018).

Fundamental training for both peer supporters and teams has been discussed and described elsewhere (Machin, 2019). In addition, there may be additional sessions offered which relate to the peer support role in a specific service, such as an individual crisis care setting.

Training associated with peer support needs to go beyond individual peer support workers and be inclusive of the teams where they will be working, and potentially to wider networks, especially where this is a new way of working. Team development days are a key element of the training, enabling discussion and action planning which can be fed into the learning with the peer support workers, while at the same time creating an energy and enthusiasm to make the most of the potential of peer-based approaches. This overlap and integration are essential and works most successfully where the whole team are enabled to attend the session. In the example overleaf, With-you Consultancy worked with an NHS Trust

Learning from Barnet, Enfield & Haringey Mental Health NHS Trust Mental Health Liaison Service.

A new team of peer support workers were directly employed by the Mental Health Trust. They work within the North Middlesex University Hospital and have now developed a close working relationship with the Emergency Department staff. Preparation consisted of a team development day for the Liaison Service, as well as peer support training for the peer support workers.



The strong leadership enabled the whole team to come together for a one-day team development day where staff at all levels could express their anxieties, particularly about handling of risk, and consider how to integrate the peer support workers successfully into their team. Additionally, one member of the nursing staff attended and actively contributed to all days of the peer support training alongside the new recruits; several members of the team individually dropped in on the training to welcome their new colleagues; and leaders within the organisation attended to present certificates at the end of the course and share their ambition and commitment to a peer workforce.

During the training, the peer support workers were offered opportunities to see and feel the work environment, to ensure the learning exercises could be framed within the reality of the setting. A six-month follow up was arranged for the whole team including peer support workers, with the external facilitator, to celebrate their success, and reflect on progress and further development.

This commitment of resources and time established a strong foundation for this group of peer supporters who felt supported and welcomed by the team and organisation. Peer support workers acknowledged that they were introducing a new way of working into the team, and had anticipated some challenges. However, six months on, the whole team were clearly recognising the value, with comments from nursing staff emphasising the mutual respect and understanding that had changed practice, and shifting their perception of crisis with a recognition that it can happen for any one of us.

A suggestion for further development from this example is for the potential to include the wider team of Emergency Department staff beyond the initial team (Psychiatric Liaison) to establish and support closer working relationships. Their involvement from the start could have helped to explore the workflow together and support the integration of peer support across the wider setting.

Two years on, a proposed plan to redesign the service included a significant increase in numbers of peer support workers, suggested by nursing colleagues who valued the hands-on engagement of peer support workers who have been innovative in their own practice. However, there are now concerns that external priorities, such as that presented with the Covid-19 response, may cause the loss of momentum for this development. In these uncertain times, there is a greater need to raise the profile of the potential for peer support in these settings and continue to hold onto this aspiration.

Supervision and support

There are various approaches to supervision and support available to all staff in crisis services. However, models of supervision which incorporate the values of peer support itself and which enable reflection to hold to the uniqueness of peer support, may be particularly important for peer support workers.

Different layers of support might include line management focussing on performance and wellbeing in the role, and supervision to maintain and enhance the skills related to the role. This latter supervision aims to ensure that the peer support worker can reflect on and recognise the challenges and successes of their own role. Recognising the difficulty of maintaining this within a crisis service, this type of peer supervision may be provided by an external and independent organisation with expertise in using lived experience of distress.

Additional wraparound support might also be provided for all staff using team meetings and discussions on wellbeing planning. Opportunities to check in and check out are an extension of the training, to share and support each other, with any concerns. These can be offered online or by phone for remote working.

There is value in layering all these approaches to support the peer support workers in maintaining the uniqueness of their peer role. The focus of supervision may move towards managing risk because of the nature of the work setting, but by offering these different layers to focus on emotions, values, successes and challenges, the support structure is more balanced, minimising the potential for the focus to be solely on risk.

Peer supporters gain from opportunities for reflection because they are fluent in these skills at the core of their training and practice. This following piece illustrates the benefits and sharing that arises from taking a reflective approach to their role.

Retaining staff

Regardless of measures put in place to support individuals, there can be a finite 'life span' for peers, especially those working in crisis services.

Depending on the size and nature of the organisation, consider opportunities for peers to experience a range of different roles in other services, thus allowing them to develop new skills and deliver in other areas which may be less emotionally demanding. There are also benefits for the organisation in terms of shared skills and knowledge.

Creating a career structure for peer support is important for staff feeling valued, and to support retention. Continued learning for peer support workers within crisis services is also an important factor to consider for staff wellness, motivation and ultimately, retention.

Organisational culture that allows and promotes staff talking openly about other aspirations and subsequently supports them to work towards that should opportunities present can prevent the staff feeling they ought to leave.

LESSONS LEARNT

We have been fortunate enough to be able to start a reflective practice group with the peer support staff within our crisis service. This was started at the request of the team and is run by the team. The group has been well attended and is a space for joint reflection and open and honest discussions about practice with clients or about topics for which there is a difference of opinion, such as assessment of risk. We bought each team member a reflective practice journal, which they are encouraged to use throughout the month to note anything they wish to bring to the group. The group is facilitated by one of our senior peer support workers and has been a great space to discuss different approaches, reflect and learn together.

Emachi Eneje - Peer Mentor

I have been in a paid peer mentor role for almost three years. I support people who have been through a mental health crisis and are transitioning out of NHS psychiatric acute wards. I like to reflect on what I am doing in my role in order to develop my practice and to further the appreciation of peer support in my service. These reflections are important when working within an organisation whose funding depends on demonstrating the value provided. So, my reflections are often focused on the outcomes of peer mentoring. And, because I work alongside many other roles whose function within the mental health system is well defined, my reflections are also concerned with the unique contributions of peer mentoring to a person's recovery.

From my reflections I have identified a number of important contributions, encapsulated in the statements below, which peer support makes to the experiences people have of mental health services. I feel every service user should be able respond positively to each of these statements:

- I have been listened to and understood on my own terms.
- I have had a warm human experience of services.
- I have been engaged by services without the presence of power and authority.
- I have had the experience of being authentically validated by people who can relate to some or all of my experiences.
- I have been given time, not necessarily for any directed purpose, but time simply given to connecting with me. Time allowing me to express myself.

Many roles within mental health services contribute to these outcomes, however, peer support might uniquely be the only role a service user encounters that ticks all of these boxes – and ticks them most strongly. Every role can appreciate the importance of having such experiences of services, but being afforded the opportunity to deliver these outcomes is the privilege of peer support.

Delivering these outcomes assumes greater meaning when we consider people's experiences of services are not uniform. The harms caused by discrimination and inequalities that some carry with them effects every aspect their experience of services. From how such experiences that have shaped their perceptions and expectations has an impact on their faith in the system delivering them a good outcome to how their sense of self and belonging can cause disquiet in the most ordinary of everyday situations. Add to these feelings the burden of mental and emotional crisis.

For people in this position there is no better time to encounter another who will listen to them, provide a warm human experience, engage them without the use of power, validate their experiences, and give them the most precious thing anybody has – time – simply because as a person they are worthy of it. I believe that by providing people with the positive experiences that fall out from a well performed peer relationship it is possible to change people's relationship with services in positive ways. I think that is a profound and long-lasting impact that organisations employing peer support workers can deliver for the people they serve.

Embedding peer support in clinical teams

For an existing clinical team where new peer support roles are being created, there will be many operational, developmental and cultural issues to consider. Depending on the size and complexity of the service, 'team readiness' could be a one-day activity or a six-month programme. In essence it is the process whereby the whole team understand the rationale behind the introduction of peer support and how to safely and successfully maximise its benefits for the clients, their families, the team itself and the wider organisation.

For example, With-you Consultancy have provided a development package which includes:

The challenges:

- What does it mean for me? Different perspectives on peer support
- Myths of peer support
- Expectations – for staff, peer supporters, and service users and carers
- Potential conflicts (for example with existing pathways)

Introducing change against a background of constant change and pressure

- Creating the culture
- Communication about changes

Developing skills across the whole team

- Training – awareness of the role for peer support workers and the staff team
- How to sustain learning within the team
- Gaining from the perspective of people with lived experience

Ongoing support

- Beyond the introduction, how will we support development?
- Challenges at different points - signs of success and slippage
- Reviews, supervision, training and support for all staff

Discussions about peer support shine a spotlight on staff wellbeing in general, the staff's own involvement in the system in which they work and staff members own opportunities for peer support. Consequently there are many additional layers of complexity which need addressing beyond the introduction of a new group of workers.

LESSONS LEARNT

Sussex Partnership NHS Foundation Trust (SPFT)

When we received funding to create peer support roles in each of the six CRHTTs across West Sussex, East Sussex and Brighton and Hove, we knew this would be complex project. Some decisions were made early on by the Project Lead and Peer Support Lead, crucially that each team would recruit a minimum of two peer supporters (so none were alone in teams) and that all the teams would take part in a Team Readiness day at the start followed by another day of review and learning six months later. Based on their prior experience supporting training within the CORE project, we worked with With-you to deliver a training and development package for the teams and peer support workers.

As much as possible recruitment for the roles was managed centrally so that clear messages could be given about training, support and to build role clarity. The peer support worker training programme also involved at least one, often two, non-peer staff from each team. This was a powerful way of spreading the message, building relationships and deeper understanding of peer support. Some of the staff told us they found the training transformational for themselves in its focus on strengths, hope and growth.

In some teams there was more experience of peer support working and ability to take ownership and be innovative with the new resource than others. We realised that teams who were ready to embrace the peer support perspective (a strengths-based, collaborative one) were in a state of more natural readiness for any change and improvement. We made efforts to join up learning and successes across teams, through the team readiness follow up event and informally.

Peer support workers took initiatives themselves to communicate to the service and external bodies, like the CQC, about their role and impact. Most importantly, we quickly found that in feedback from patients and families, our new peer support workers were highly valued. They did not need to learn about the role and impact of peer support in advance to understand its benefits.

Based on this experience and learning, in statutory and clinical services, we would suggest team development approach relies on:

- clear descriptions of the peer support role and the training programme.
- understanding of which tasks lie outside of the role (e.g. clinical assessments)
- exploration of how peer support roles, with their focus on lived experience, complement other roles that have another primary focus (but where staff may have lived experience)
- understanding of why some roles may be outside usual shift patterns (peer support roles are often 'supernumerary' e.g. not part of clinical staffing numbers)
- clear answers to practical questions about level of responsibilities, lone working, who will manage the peer support workers and what other supervision and support they will need
- understanding of how to support a peer support worker who is struggling at work with mental health, and then the implication for any colleague who experiences distress
- agreement on how the peer support role will be used within the service, e.g. referrals and transitions to other services (a very important constraint or opportunity in crisis working).

VCS organisation operating a crisis service in partnership with statutory services

LESSONS LEARNT

The Cellar Trust

When we embarked on this journey to have a crisis service led by a VCS organisation but working in true partnership with the care trust and local authority we knew we would all learn a lot. We are still learning, overcoming obstacles and ironing out issues. Below we talk about some of our learning.

Communication:

A steering group gained buy in from high level colleagues and maintained momentum.

Our CEO, service and, or operational managers from both the mental health trusts and social care, police, service users, commissioners and ambulance services were all involved in the steering group. It was purposeful to involve all parties that might be involved when a person is in crisis. Without all parties at the table it would have been more difficult to ensure blockages were identified and systems, processes and solutions were found.

Through the steering group we were able to build strong, mutual relationships that all parties were committed to. The commitment from the people around the table in that group meant that the relationships formed were respectful of one another's skills and roles, recognising we all had something unique to offer within the remit of the crisis pathway. The power of those relationships should not be underestimated.

Within our steering group we had some key, solutions-focussed people who were not afraid to look in the 'too hard to do' box and find system solutions. There were awkward conversations and all parties remained open and honest about what was and what was not working.

We now recognise, that to have true co-production we would need to involve a wider group of service users and carers and we would suggest that co-production and the involvement of service users on the steering group, or via another forum, is essential to help navigate the clinical need and the client need and fuse the two into a service that will both help the client and be safe.

As with all services which have peer support workers, there needs to be an understanding of peer support. Without that any service will struggle to operate. If the clinical partners do not understand peer support and the remit of the roles it can cause frustration on all parts. For us, this matter is a continual campaign and key to the success of our crisis service. Without that understanding clinicians struggle to grasp the support being offered and the level of risk that can be handled.

Working outside of the medical model:

Clear contacts within other services are important to enable issues to be ironed out quickly. We have noticed that when issues continue for a time, staff can become frustrated that things do not work and stop trying, potentially preventing the success of the service.

Initially, we had the IHTT and social work duty managers co-located within our crisis service which had positive and negative consequences. Having a clinician on-site was great for managing risk, feeding back concerns and getting advice. Sometimes there were differences of opinion around decisions they made or conversations overheard that could be difficult for peer support workers to hear. We still have the IHTT manager and the duty social workers co-locate when capacity allows it and the relationship remains strong.

LESSONS LEARNT (cont.)

We had control over the environment and wanted it to be a warm, comfortable and relaxing environment. It is important not to underestimate the power of a non-medical environment, using warm and colourful furniture to brighten the rooms and show care and thoughtfulness over the décor. This can encourage clients to feel welcome and worthy. The service user on the steering group was very passionate about this, and they chose the furniture. We were very fortunate to have this donated by a local company who specialise in hard wearing, hospital furniture.

Managing risk without a clinical presence:
We need to escalate concerns often within our crisis services and as we work outside of the medical model it is a key element to ensure the services are safe.

On occasion, clinical or social care teams have different opinions from peer support workers on risk, whether that is assessing someone as not needing a clinical intervention and the peer support workers feeling additional support is required to keep that person safe, or whether it is the assumption that peer support workers should not see someone with certain risk factors. Again, communication is key.

We have made processes clear to manage risk with options to ensure that there is always somewhere to go to quickly for support, even if the final option is calling 999. For example, call the usual crisis number, call the duty manager for the crisis team, call the IHTT duty manager, call the service manager, email all of the above, or, dependant upon the level of urgency either await the usual end of shift call, or call 999.

While ensuring such services can work with the level of risk posed by a referral, is often considered, equal attention should be paid to ensure that risks are not avoided leaving services under-used because of assumptions about their capabilities to manage risk.

VCS employed peer support workers within A&E in partnership

For the last three winters we have been commissioned to provide some peer support workers to work with patients in the emergency departments at the two acute hospitals in our district. For this project we work in partnership with acute hospital and the care trust. Below we look at our learning:

HR / Operational considerations:
An A&E department is a complex and extremely fast-paced environment for peer support workers to work in. As VCS staff, they are working within the acute hospital trust, alongside colleagues from the mental health trust. There are a variety of policies and protocols to adhere to.

The acute hospitals issue honorary contracts to the peer support workers as they are employed by us. This adds a further layer of policies to take into consideration and can also make supervision more complex, as the peer support workers are working with people in crisis remotely, as part of a wider multidisciplinary team.

IT issues have been time consuming and frustrating, but we now have some solutions via tethering and some network providers being better than others.

Multi-disciplinary teams (MDT) in A&E:
Acute hospitals have an extremely diverse MDT and within the emergency department there will be the medical team and a psychiatric team, both of which peer support workers would need to work closely with.

It has been our experience that although hospital staff may or may not know anything about peer support, the daily pressure can result in teams readily embracing peer support. This does not mean that it is not important for peer support to be understood.

Emergency department teams, and indeed staff on wards where patients are distressed can see the help the role provides to patients and are often appreciative of support.

Within multi-disciplinary teams, where risk is shared across two NHS Trusts, there can also be a tendency to err on the side of caution. This is understandable. Nobody wants to go to coroner's court. Some clinicians can become risk averse or even risk avoidant, failing to understand the level of independence a peer support worker should have. This can result in limiting the people that peer support workers can see and prevent patients from receiving support that may be valuable. While it is of utmost importance to work safely, recognise the professionalism of peer workers and their ability to risk assess.

"... it was apparent immediately that although he (patient) had medical problems he was acutely distressed. He was a tall and at times aggressive and intimidating staff because he wanted to leave. She (peer support worker) was adamant it was her role to support, despite being advised not to by mental health team.... trying to de-escalate his aggressive/ anxious behaviour. I was impressed by her diligence in advocating and supporting him."
Advanced Nurse Practitioner

The peer support workers often relieve the A&E staff from being with distressed patients, releasing them to attend to other patients who also require their attention. This has proved difficult for us to quantify in a world where targets are mostly numbers driven but staff feedback has supported our argument.

"He (peer support worker) managed to make a very depressed crying patient, with social housing and numerous issues smile and feel positive about what was available to him."
Consultant & Associate Dean

Patients who do not have a medical need can be directed to other, more appropriate options, such as safer spaces to divert people away from attending A&E in the first place. People with a medical need may also be informed about those other services and supported in a kind way, encouraged to seek help before requiring medical attention should they feel distressed again.

"...It was nice to have a peer support worker there who understood how I was feeling"
Friends & Family Feedback, A&E Department

In addition, the peer support workers have created a more open conversation within the hospital about mental health, with staff having open conversations about their own mental health.

Our closing thoughts

Developing crisis services using a co-production approach

There is a lot to consider in developing peer support services in crisis settings. Out of all the strategic and operational concerns however, perhaps the most important questions to ask may be: **How are you involving people with lived experience of distress and crisis?**

Only by involving people and families who have experienced crisis in a way that allows them to understand and be heard, will you design a service that genuinely meets their needs. The 4Pi Involvement Framework, developed by NSUN, encourages people to think of involvement in terms of principles, purpose, presence, process and impact (4Pi).

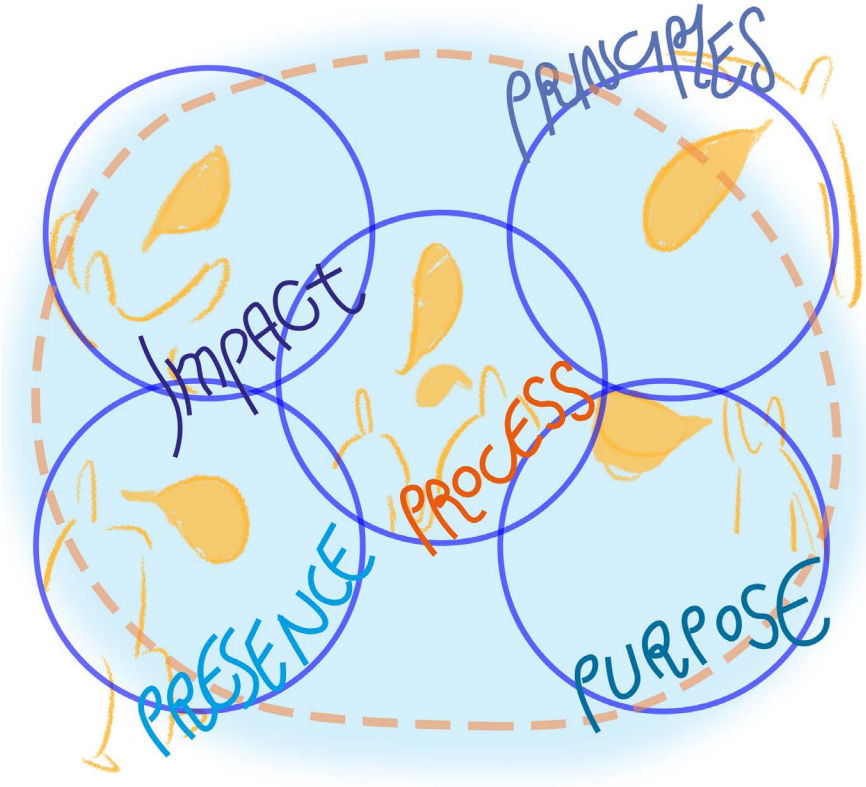
The 4Pi allows you to think about the whole project and who is involved, why, how and when and what impact the involvement has. It is useful for thinking of all partners; including existing staff, patients, families, commissioners, service leads, and other agencies. It also helps you to think about all stages of a project from conception, through development to delivery, review and evaluation.

Lastly it challenges us to think about how we relate to, and engage with communities. For example, how will you communicate your service to people who may need to use it? How will you listen to their experience and ideas for improvement?

How will you collect ongoing data and feedback that is meaningful, non-intrusive and reflects the local community and their experience?

These questions are of course not specific to crisis services but because of the diversity of people involved, the intensity of the experience and the rapid response required, they are extremely important elements to consider. Our message to those readers looking to develop peer support in crisis services is this: listen to those in distress and listen to their peers who now work with them - it is here you will find your answers.

We hope that the reader has gained more perspective and understanding of the value of peer support roles in crisis services. This thought-piece ends with words from a Lived Experience Practitioner, Sharif Mussa, who sums up many of the points made in this piece in a more meaningful and thoughtful way than we, the authors, could ever do.



A personal experience of crisis: Sharif Mussa, Lived Experience Practitioner

In my role as a peer I often see black men on admission after serious attempts to self-harm or end their lives declare to medics and psychiatrists that they are perfectly okay to return back to their trauma. They have no idea of how to express their feelings and open up about their trauma, out of fear of judgement and being incarcerated, and when we get talking and they manage to open up we find solutions to socially-related issues. Like unrealistic expectations and pressures placed upon us by our families and society. Like secret drug, alcohol, and gambling addictions, that we simply don't know how to disclose to our families.

Firstly, our crisis services should immerse themselves in the community. In hubs, such as churches, mosques, synagogues, to offer help and better reach these 'hard to reach' groups. Our views and perception of mental health services are often based on what we have seen in movies, it's not a real account of what PTSD, depression, anxiety and mental illness is actually like. We have no perception of recovery therefore, as we think it's something that is unachievable. So, when we present to the people who we think should or ought to have the answers, often they are unsure or don't have the knowledge to help us better understand what crisis is. Conversations about crisis and what it actually looks like should be happening much earlier in life, so that as we develop as adults we have a better understanding of our own stigma around mental health. Because we can't fix something if we don't know it is the problem.

Equally crisis services need to embrace the spirit of peer working, by employing more professionals with lived experience of caring for or having experienced mental health difficulties themselves. And I don't think this is too much to ask for because mental health is something that affects us all, whether as professionals or as service users. Because when we eventually present in crisis there has to be an element of the recovery principles embedded in the peer movement. Principles such as building relationships based on mutual respect and understanding, a strengths-based approach, and compassion are paramount and essential in positive recovery.

In my experience these elements were simply not there. Some crisis services especially in drug and alcohol rehabilitation often had a criterion to meet for them to be able to support me that weren't based on who I was as individual, or what I thought. By having service users feel like there is an 'us and them' culture we prove their negative perceptions with the fuel they need to keep them stuck in their revolving crisis or crises.

Conversations around mental health and crisis need to reach these hard to reach groups in places where we find it comfortable to express our true selves, such as the barbershop or hairdressers, places of worship, gyms, pubs, social gathering and family functions. What this may look like in practice is perhaps another conversation, but it would be practical to start this approach in our grass roots and social institutions. For instance, there is a voluntary organisation in mental health called 'masked men in the community' that I work in which goes out to places where BME men hang out and aims to raise awareness around mental health illness, how to cope with diagnosis, etc.

We currently have a model that acknowledges crisis but has little emphasis on what recovery is or what it takes. This I feel is at the disadvantage of us as a society for when we do present in crisis it could be our first time ever. Therefore, it's important that we are not discouraged by a lack of hope and language that is not understandable. Crisis services must focus on the real goal which is positive recovery.

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“If I could return and offer something back to that situation, it would be the confidence and care that peer support can offer not only to the individual in crisis, but to the carers around them.”

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