Raising the glass ceiling: considering a career pathway for peer support workers - 2021

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Introduction

This thought piece will illuminate some initial ideas on developing a career pathway for peer support workers (PSWs), in line with aspirations set out in the NHS Long Term Plan. Commissioned by the Health Education England (HEE) Peer Support as part of the New Roles in Mental Health Working Group, this thought piece owes sincere thanks to a number of collaborating partners. These include:

- Implementing Recovery through Organisational Change (ImROC);
- Central and North West London NHS Foundation Trust;
- the Pan London Trust Peer Support Leads group;
- the London NHS Lived Experience Workforce Community of Practice;
- the Cellar Trust; and
- a number of independent Lived Experience Practitioners

all of whom have contributed to, and overseen, the development of the ideas included. The majority of people informing this piece of work have worked themselves as peer workers or lived experience practitioners, and/or led peer workers in their respective organisations or communities.

To protect the implementation of the peer support worker role from tokenistic practice, it is vital to create opportunities for progression that do not require assimilation into existing professions. This thought piece aims to give guidance on how best to do this, while also shedding light on the complex, ongoing debates for readers who are less familiar with the premise of the peer support approach. We hope this publication may inspire employers, peer support workers and non-peer support workers alike to create opportunities, which place individuals with highly developed skills in using their lived experiences professionally into positions of influence.

This thought piece will comment on an array of topics involved in considering safe, appropriate and best-practice-based learning in relation to the career development of peer workers. It also recognises that some of the recommendations will require adapting for local contexts.

But first… career framework or pathway?

In considering a career framework for peer support workers, examining the career frameworks of other health disciplines illuminates the substantial task at hand. Most of these frameworks relate to well-established, standardised roles in healthcare which link directly with educational qualifications and are registered with governing membership bodies who possess codes of conduct, ethics and registration requirements.

Unlike professionally registered roles in healthcare, peer support is based on the premise of valuing a foundation of experiential knowledge, as opposed to approaches grounded in theoretically learned expertise. In addition, the role of peer support workers has developed organically without affiliation to an accrediting or governing

body. It is both a potential pitfall and a diversifying and enriching strength that this has historically lacked standardisation, encouraging a huge diversity of peer support to develop.

Naturally, this has also led to variation in content, emphasis, structure, duration and quality of the training available to these roles. Since most peer support training programmes are not accredited or standardised, they do not directly translate to competency outcomes that can easily be mapped onto the NHS Knowledge and Skills Framework (NHS Employers, 2019) or likened to other training and progression routes. Though may soon change, with the introduction of the Health Education England Competence Framework for Mental Health Peer Support Workers, the competence framework is a much contested document in the eyes of much of the peer support community (Hart, 2020) and, at the time of writing, is in its earliest months of use.

The frequent lack of academic accreditation for peer support training serves to protect training accessibility for applicants who have often experienced a disproportionate level of disruption to educational attainment. However, it creates potential barriers for those seeking senior roles that generally require development and training that can be mapped onto existing training pathways. Certainly, no existing UK peer training programme currently registers peers for employment with direct parity with other health colleagues. Questions on appropriateness of creating training which might seek to fulfil this objective go to the heart of many debates about the development of peer support amongst the survivor and user communities, as well as in the broader mental health field (Recovery in the Bin, 2020).

It is not within the scope of this thought piece to create a full and exhaustive career *framework* for peer support workers as might exist for other professionals. However, it is a clearly stated recommendation that such a piece of work is commissioned and undertaken. This document presents a career *pathway*, describing important ideas to consider and examples of best practice.

Framing and setting the boundaries of the conversation

In order to develop what a career trajectory for PSWs might look like, we must first consider the difficult philosophical and conceptual debates that often surround the topic. Further complicating this debate, is the thorny issue of ‘ownership’. Clearly, the roots of peer support lie within the community of lived experience – with ‘service users’ and ‘survivors’ - not within statutory services or institutions.

As more peer support workers are incorporated into teams as NHS staff, with roles considered integral to service provision, complex debates on how heritage relates to ownership are invoked.

The notion that future ‘ownership’ or the ‘affiliation’ of peer support might transfer to the NHS, as a large national employers of peer support workers, can fuel high levels of concern amongst members of the survivor community. In her recent blog for NSUN,

Alison Faulkner discusses a ‘‘divided path’’ (Faulkner 2020) between peer support’s historical roots in the survivor community and recent adoption ‘‘by mental health services as a means of supporting people’’ (Faulkner, 2020). Great effort is often put into making the case for ensuring peer support is not ‘co-opted’ by the health institutions which, survivor activists might argue, have caused the harm that peer support workers are often supporting people to build lives beyond. This can often lead to the belief that peer support workers who can tolerate being ‘co-opted’ in this way have strayed so far from their heritage that their ‘compromised’ type of peer work is a ‘bastardisation’ of the approach. It can also lead to suggestions that these peer workers deserve estrangement and alienation from the broader peer support community external to statutory organisations. Faulkner, however, retains more optimism, closing her blog with the belief that ‘those two paths [can be brought] back together’ (Faulkner, 2020) if a ‘concerted effort’ is made, starting with ‘[Recognising] the value of peer support in all its diverse forms and in diverse communities.’ (Faulkner, 2020).

The varying ways in which peer support is undertaken in a variety of contexts opens up similar debates. Ideas of ‘purity’ in relation to this frequently arise, as opposed to an appreciation for the variety of roles and contexts. Forms of mental health-specific peer support can vary, depending on whether service providers are NHS or a voluntary, social and community enterprise (VSCE) organisation, and arguably more so when peer support is delivered in user-led organisations (ULOs) or at a grassroots level.

Even less rarely accepted than this difference between NHS and NHS-commissioned services and grassroots peer support is the notion that perhaps different forms of peer support are *required* in relation to these different contexts, or even essential. Perhaps an extension of Faulkner’s invitation to unite the paths is to also celebrate a broad spectrum of peer support within it.

Of course, in order to create unifying change, all peer support workers require education on the history of their vocation being firmly rooted in mental health activism and the survivor movement and its underpinning values and philosophy. This includes the importance of retaining strong links with their counterparts outside statutory environments, such as peer worker colleagues working within ULOs, VCSE and grassroots or activist projects. These links can help ensure that their ‘peerness’ (Silver, J., & Nemec, P. B. (2016) is consistently fostered and retained and less likely to erode their necessary difference from their traditionally trained colleagues.

Furthermore, attempting to apply the same model to all ‘versions’ of peer support requires compromise on behalf of the statutory sector peer support workers but also might incur great risks and losses if third sector or grassroots peer support felt pressure to comply with the operational practices necessary for peer support in statutory services. Framing these differences as a necessary and complementary spectrum of peer support can be of great value to all.

In Bill Moyer's model, 'The Four Roles of Social Activism from Doing Democracy: The MAP Model for Organizing Social Movements' (Moyer, 2001), he identifies the differing roles in social movements as follows in Figure 1:

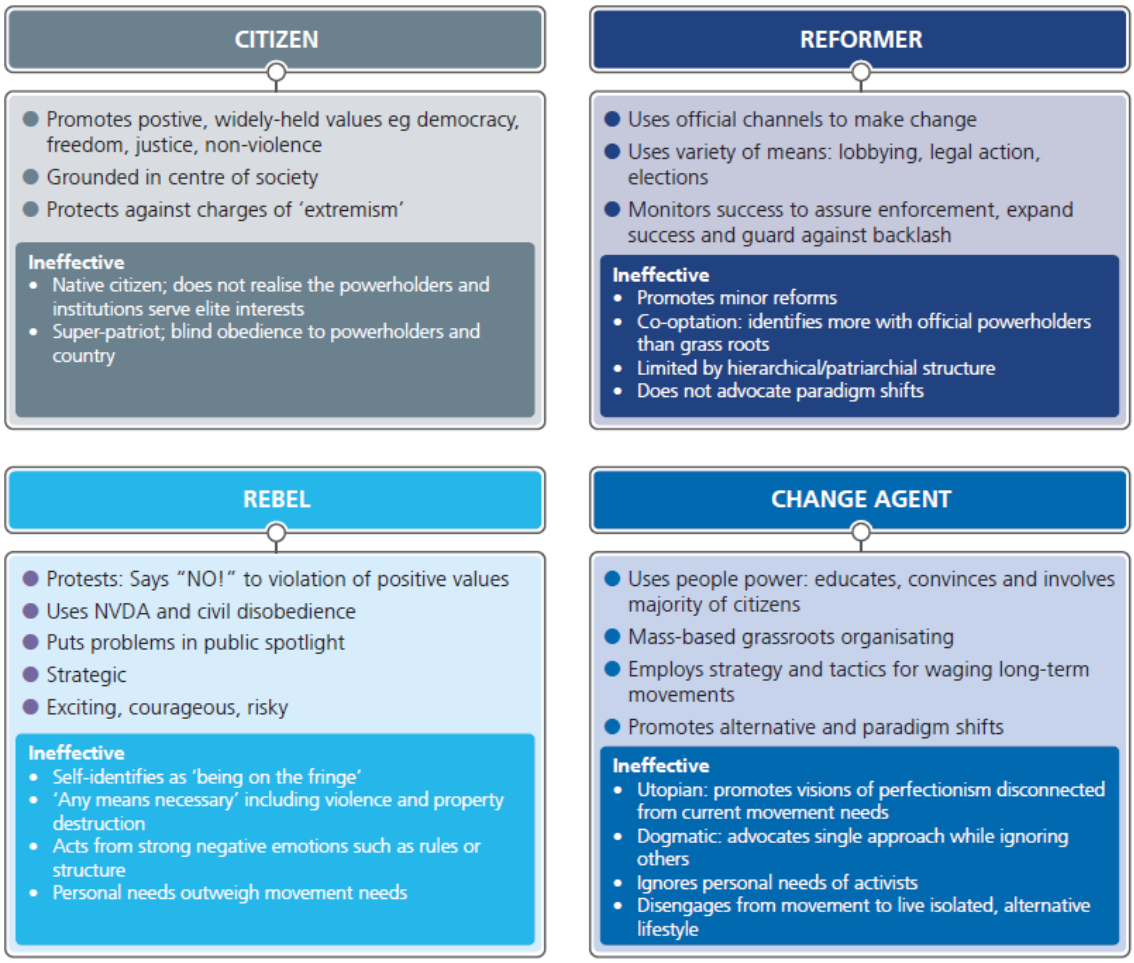


Figure 1

Moyer writes of all of these roles:

'both individual activists and movement organisations need to understand that social movements require all four roles and that participants and their organisations can choose which ones to play, depending on their own make-up and the needs of the movement. Moreover, they need to distinguish between effective and ineffective ways of playing these roles. Understanding a social movement's need to have all four roles played effectively can help reduce antagonism and promote cooperation among different groups of activists and organisations.' (Moyer, 2001).

If we set out with acceptance of peer support as a survivor movement-created endeavour, as well as an integral aspect of the survivor communities' resistance to and way of influencing contemporary mental health systems, we could re-create Moyer's diagram in relation to peer support as follows (Figure 2 overleaf):

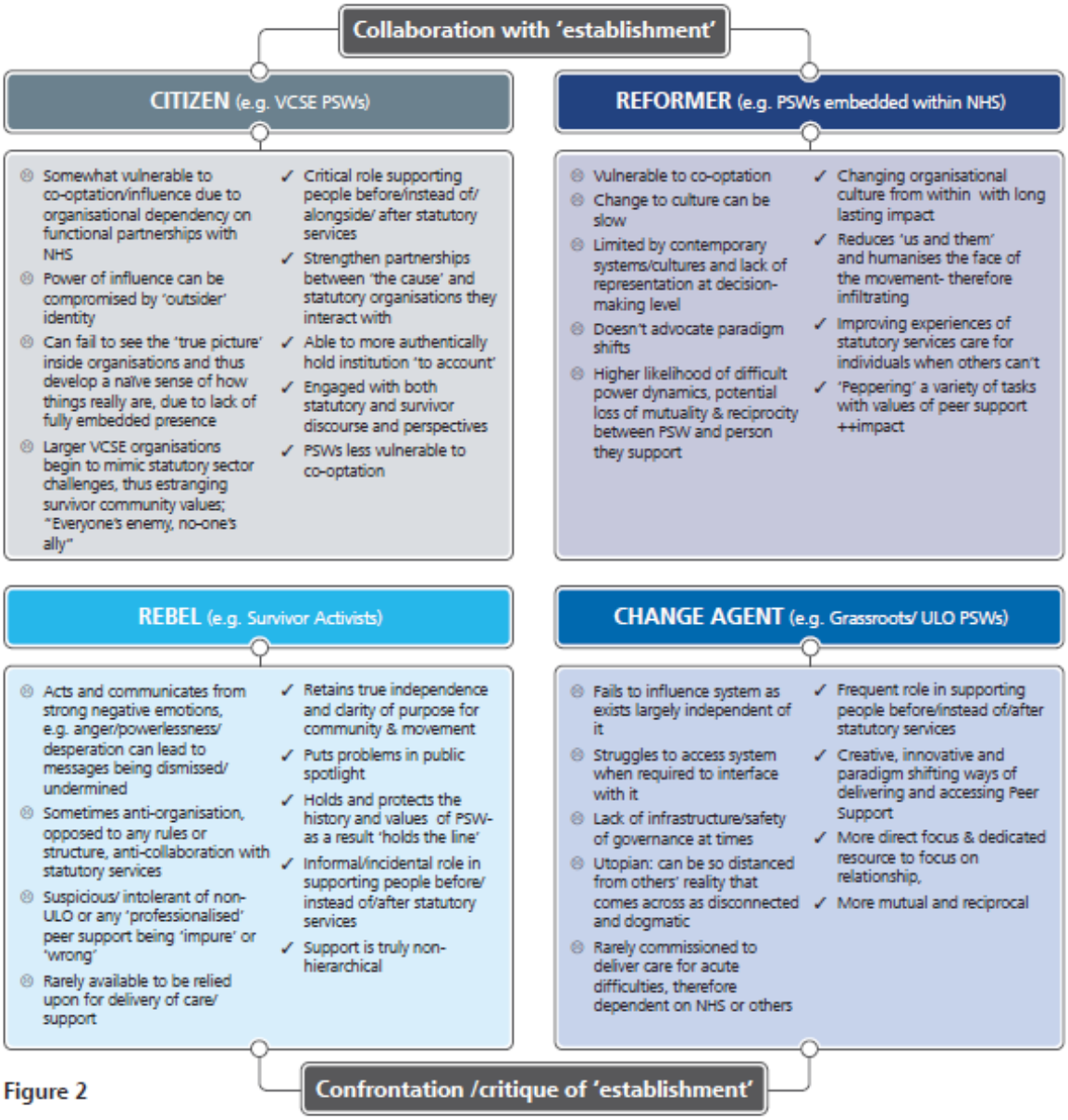


Figure 2

Despite these differences, there is a general consensus on the statement that peer support exists as a values-based, relational and trauma-informed endeavour, with the concepts of mutuality and reciprocity at the centre of the approach in most accepted definitions (Faulkner, 2020).

Understanding these debates relating to peer support, the power dynamics inherent in the differences, and the subsequent divisions and difficulties that they provoke, is integral to considering a career framework for peer support workers. Overlooking this discourse prevents us from holistically defining what peer support working is.

As the task of this thought piece is to respond to the NHS Long Term Plan's aspirations in relation to 'new roles' within mental health, it is therefore assumed that there is great need for non-professionalised peer support in some grassroots, ULO and other non-NHS and non-NHS commissioned contexts. However, the peer workforce being

described here will largely be working in NHS and NHS-commissioned environments. This thought piece will attempt to speak to a readership whose task is to implement the goals of the Long Term Plan, and respectfully acknowledges that other forms of peer support may need to critically adapt the ideas presented for their working contexts and roles.

Pre-employment steps for prospective peer support workers

It is imperative that early career peer support workers have not only their own lived perspective and experiential knowledge of the organisations and systems within which they are working, but training to safely operate within them. Work experience - paid or unpaid - can be necessary too, and some training programmes also include a work placement.[1] So, even for 'entry level posts', the need for established knowledge, skills and competencies, alongside values, principles and of course the qualifying lived experience, has already been established.

What should this entry route look like? In preparation for this thought piece, peer support workers at a co-production group agreed that short-term, less demanding contacts with services in a non-service user capacity can be useful. For many, this might take the form of service user involvement opportunities, such as contributing to quality improvement projects, service user experience feedback forums or participating in a co-production project group.

Peer support worker roles require both a sustained and well-established personal recovery in order to safely explore it with service users they are working with. Postholders are also required to hold a clear 'staff' identity; that is, a professional approach with responsibilities, and an ability to give more support than they receive in relationships with those whom they are employed to support. Problems can arise when postholders are unprepared for this shift away from a 'service user identity', where getting their own needs met is the main priority of the contact with services. In coming to a place of reconfiguring one's relationships and expectations in familiar contexts (and sometimes even the same site where one's treatment has been undertaken) there is often a process of re-negotiating and re-defining relationships, which can be referred to as 're-meeting'.

There are additional benefits, too, of giving potential peer support workers an opportunity to experience what goes on 'behind the curtain' of services, organisations and infrastructures, and the realities of why some aspects of the system operate in the way that they do. This can support people to make informed decisions about whether

[1] This model of training, which at times, as with IMROC's training, usually includes a placement, is known as 'train and place'- referring to the approach of training peer support workers before they are in post. Some organisations, and especially those who train in-house or via accredited courses which require written portfolios referring to practice or a case study from practice, will adopt a 'place and train' model to training their PSWs. There is literature discussing benefits and risks to both approaches and there is no general consensus on which is preferable. (Repper 2013).

these are contexts in which they would thrive. Experiences of services can be surprisingly disturbing or validating. Benefits can also include opportunities to develop routine, for fulfilment by contributing meaningfully to a workplace, and other benefits which are documented elsewhere (Pilkington, 2012).

Other routes for prospective peer workers may also include access as a student to resources such as a Recovery College, or similar, to develop understanding of their self-management and recovery, as well as a more in-depth familiarity with their own story, in preparation for sharing it with others. Furthermore, engagement in a Recovery College or similar resource - assuming retention to educational principles, (Repper & Perkins, 2017) allows a student to further 'rehearse' the role as an expert of their own experiences, in the company of others.

In addition, many third sector and NHS organisations incorporate the roles of both paid and voluntary peer support workers into services, with distinct roles and duties between paid and unpaid roles. Equally, short-term placements can be of great use. These can be either embedded in peer training or undertaken as non-lived experience specific placements in an employment support service, in roles such as a healthcare assistant or activity co-ordinator. These placements can be an effective way to give prospective peer support workers a 'taster' of what can be expected from settings where they may go on to work in.

As the peer workforce has grown, we are increasingly finding that those who have had a positive experience of peer support as a service user are attracted to the work, which is certainly a promising sign. Whatever the context, it seems to be of significant benefit for potential peer support workers to be motivated to undertake the role by a personal experience of the power of peer support. VCSE organisations provide opportunities to engage in schemes such as befriending or volunteering in spaces such as community cafes, which offer useful experience of supporting others and working in a health or care setting with low-level commitment.

Despite the rapid expansion soon expected in relation to the number of peer support roles available, historically roles have been scarce and thus recruitment processes highly competitive.

The NHS is considered an attractive employer by some, so job vacancies are often heavily oversubscribed with applications, with literally hundreds received in densely populated areas. As a result, employers are increasingly opting to recruit individuals who evidence 'pre-peer working' experiences, with the final (and often most valuable) of these being prior experience working as a peer support worker in a voluntary sector organisation or in a non-peer role elsewhere in health and social care.

It is largely acknowledged that peer roles in these contexts can be better supported than those in statutory organisations. Sometimes this is due to the smaller size of these organisations leading to a more person-centred culture, or more inclusive of disabled people within local policies and/or practices (Lightfoot, 2018). However, in times of

relentless financial insecurity, these organisations can also find themselves at the mercy of short-term funding arrangements which translate to a lack of job security for peer support workers, including one year, fixed-term employment or zero hours contracts. Thus, working in a VCSE context can initially suit those who may require additional support in getting settled into working life, or are at earlier stages of recovery; but they may be less suitable for those who require a sense of permanency and longer term stability in order to thrive in their role.

Similarly, the professional boundaries of non-peer roles can allow for individuals in early recovery to gain working experience while still developing and forming their own recovery. They are likely to be less fraught with potential challenges linked with using the personal aspect of one's own identity at work without support, training, or supervision.

There can also be risks with these generic roles, however, of becoming socialised into non-recovery focused practice and traditional hierarchies of knowledge. Peer workers who unwittingly find themselves taking on these perspectives can often alienate their peer colleagues, who may be concerned by observing this non-recovery-focused practice and language from a supposed 'peer' ally who 'ought to know better'.

Another important role to consider is those of peer trainers within Recovery Colleges. Peer trainer roles share many of the competencies, politics and knowledge necessary for peer support working and are often located in dedicated Recovery College teams, who - much like VCSE organisations - can have more inclusive, wellbeing-focused cultures than 'frontline services'.

Additionally, many peer support workers are required to support, promote, and even undertake delivery of courses collaboratively with their local Recovery College. It is important to state that, however closely the two roles are linked, not all peer support workers would be effective or wish to undertake the roles of peer trainers, and vice versa. The diagram below (Figure 3) illustrates a peer support working pathway:

- 'Pre-peer working' elements are mapped in grey.
- Voluntary roles are mapped in dark blue.
- Roles which see individuals joining the paid job market are mapped in light blue.
- The peer trainer & VCSE roles have been mapped in terms of being a workplace where there generally is more support.

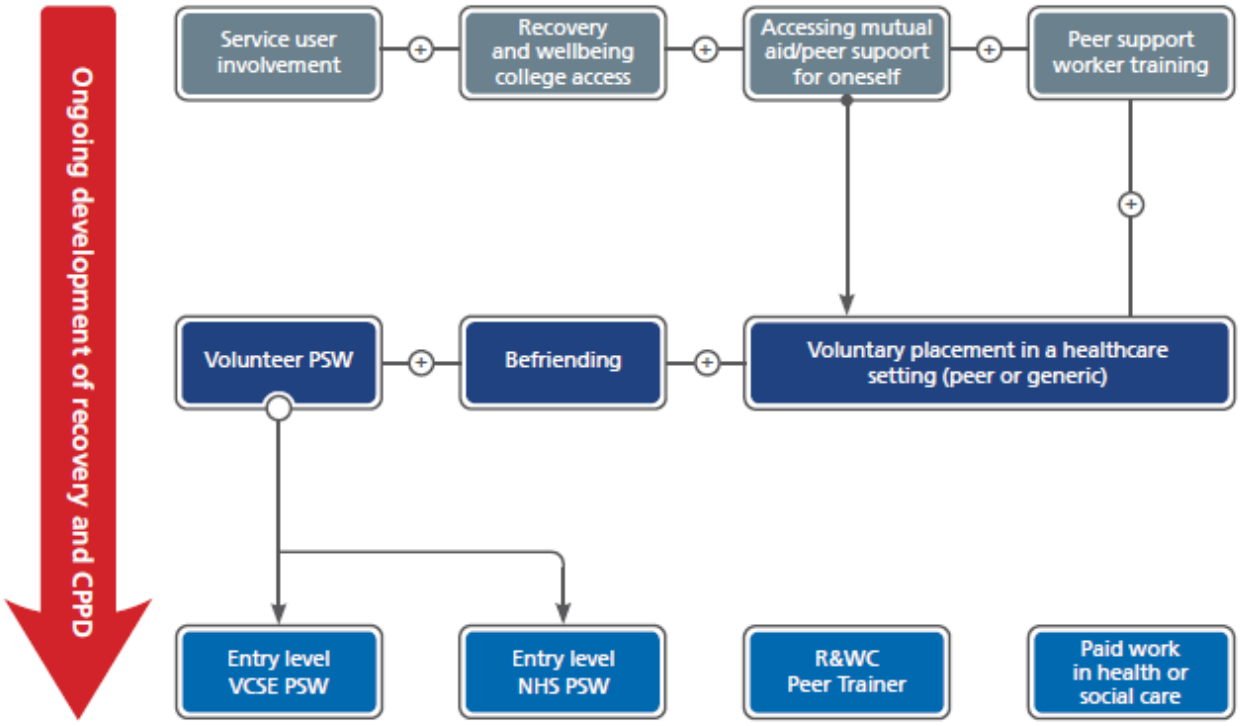


Figure 3

Requirements for entry-level posts

We are seeing these patterns emerge at entrance points into peer support at a critical time in the field, immediately before rapid upscaling of the workforce nationally. The above diagram has been developed on the basis of these experiences; it is not a prescriptive checklist for recruitment.

These patterns have emerged organically, based on the currently available routes that most have taken. But they are not necessarily the best or most well-designed routes in:

- Some well-established and brilliant peer support workers have successfully entered the field at the stage marked dark blue or even light blue.
- Engagement at the stage indicated in grey relies on local opportunities such as a Recovery College or peer support/mutual aid groups being accessible and suited to individuals' preferences.
- Equally, all these dark blue and grey stages often rely on the common assumption that someone looking to move into peer support work is in early recovery and perhaps not in employment.
- All the options indicated at these stages require ample time to volunteer or undertake training (usually unpaid). Increasingly, this is not always the case, especially with the success of the Individual Placement and Support into Employment model supporting people using services into work (www.ipsworks.org), and pressures from the welfare system on the amount of

time people are able to stay away from the job market while establishing their recovery.

- Therefore, it is especially important to emphasise that the dark blue and grey stages of movement into peer work can be useful but should not be used as an 'experience' checklist in person specifications to disqualify those looking to move into roles at the light blue (paid work).

Undoubtedly more important than journeying through all of these stages is the ongoing commitment to one's own recovery and continuing professional and personal development (CPPD). This is highlighted in the diagram above in a red arrow and importantly should not end at the point peer support workers secure a role.
To focus first on recovery; one of the most potentially grave and common mistakes in successful recruitment is underestimating how critical lived experience of recovery is for peer support workers to undertake and sustain their work.

As a result of hard-won learning, it is now more commonly understood that for peer support workers to safely explore what it means to develop a recovery with others, they need to have a clear sense of how this applies to them personally. Historically, many job descriptions have required peer support workers to have 'a lived experience of distress/mental health problems', without any mention of recovery. And yet considered critical to role is the ability to support others into recovery. How can it be appropriate or even possible for a peer support worker who has yet to discover how to sustain their own health and wellbeing to support others in this venture?
Importantly, requiring applicants to demonstrate and articulate self-defined personal recovery is not the same as a requirement of 'perfect health' for the duration of their time in post. Clearly this would be an unrealistic expectation of anyone in any role, with their own lived experience or not. Rather, it begins with defining recovery as, for example:

'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and / or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness' (Anthony, 1993).

In this definition of personal (as opposed to clinical) recovery, there is a sense of something being dynamically moved towards, and grown beyond, as opposed to concretely located within. Anthony's definition also emphasises the ownership of recovery sitting firmly with the individual, including key ingredients such as the development of 'meaning' and 'purpose', which *may* be aided by others at times but must be primarily defined, fostered and nurtured by the individual in order to come to fruition. This definition does not establish a binary recovery, which one is either in or out of, nor the notion of recovery as something that is arrived at. It does, however, allow for continued commitment towards recovery, flexing to the new challenges of life, cherished successes and all that lies in between.

The notion of continued commitment to recovery as a professional competency and requirement is somewhat controversial within the peer support community. Much

debate centres on the language of recovery overall, with rejections and critiques of the construct of ‘Recovery’. Survivor group Recovery in The Bin states as the first of its 10 key principles:
‘The Recovery approach started with noble principles but has been co-opted by neoliberal ideology and now mostly operates as cover for coercion, victim blaming, disability denial and removal of services’ (Recovery in the Bin, 2014). They continue… ‘Unrecovered is a valid self-definition. We reject co-opted ‘Recovery’ that has been redefined and taken over by market forces with humiliating treatment techniques and homogenising outcome measurements’ (Recovery in the Bin, 2014).

There are also criticisms that over-emphasis on peer support workers needing to appear ‘well’ and ‘recovered’ is discriminatory, as this emphasis is not required of other professional groups.

On the other hand, many other professional bodies require that their membership take personal responsibility for their own health and wellbeing in order to operate effectively within post. The Nursing and Midwifery Council’s Code of Professional Standards states its membership’s responsibility to ‘maintain the level of health you need to carry out your professional role’ (Nursing and Midwifery Council, 2015). Occupational therapists are required to ‘inform [their] employer/appropriate authority and the Health and Care Professions Council about any health or personal conditions that may affect [their] ability to perform [their] job competently and safely […and…] limit or stop working if [their] performance or judgement is affected by [their] health.’ (College of Occupational Therapists, 2015).

Additionally, the Health & Care Professional Council stipulates that:
‘Someone may be unwell or may have a health condition which they manage appropriately but they may still be able to practise their profession safely […] Our standards of conduct, performance and ethics says: ‘You must make changes to how you practise, or stop practising, if your physical or mental health may affect your performance or judgement, or put others at risk for any other reason.’ You have a professional responsibility to maintain and manage your own fitness to practise.’ (Health & Care Professional Council, 2017).

There does, therefore, appear to be a uniform responsibility placed on workers from all other professional backgrounds to ensure their mental health and wellbeing is managed appropriately in terms of ‘fitness to practise’. However, none of these professions appear to emphasise the relational way of working to the extent that peer support does. Arguably the professional group closest in terms of the emphasis on the relationship and ‘therapeutic use of self’ are counsellors and psychotherapists.

In the British Association for Counselling and Psychotherapy’s Ethical Framework for Counselling Professions (British Association for Counselling and Psychotherapy, 2018) the expectation for managing what is loosely defined as ‘wellbeing and psychological health’ is more extensive:

‘We will take responsibility for our own wellbeing as essential to sustaining good practice with our clients by:

a. taking precautions to protect our own physical safety
b. monitoring and maintaining our own psychological and physical health, particularly that we are sufficiently resilient and resourceful to undertake our work in ways that satisfy professional standards
c. seeking professional support and services as the need arises
d. keeping a healthy balance between our work and other aspects of life.’

Considering these significant expectations placed on colleagues from other disciplinary backgrounds, it seems a reasonable request for the peer support workforce to commit to managing their health and wellbeing so that they are able to sustain their roles. However, how to capture or measure this at recruitment can be difficult and certainly anxiety provoking for managers. Clearly it is inappropriate to interrogate or call into question how truly ‘recovered’ someone is at interview. Decision making on fitness to practise needs to sit firmly within occupational health assessments.
In gaining a sense of both, occupational health providers and peer support leads/ recruiting managers must collaborate closely, and be guided by local human resources policies, so as to comply with the Equalities Act 2010 and be non-punitive and compassionate. This is discussed more fully in the Thought Piece ‘Preparing Organisations for Peer Support: Creating a Culture and Context in which peer support workers thrive’ (Repper 2020).

Asking applicants to present their recovery story at interview can provide useful information for recruiting managers. Ensuring a marking criterion based on how someone openly relates to their recovery narrative and how they frame the context (and thus avoid ‘prescribing’ their route to recovery to others), as well as how comfortably they identify a variety of self-management strategies, can be useful.

Importantly, to ensure compliance with the Equalities Act 2010, it can be useful to consider a peer support worker’s interview much like a recruitment process for an expert witness within a legal context. In the legal field, an expert witness can be described as ‘someone who – by reason of his/her education, training, skill or experience – has specialist knowledge of a particular field or discipline beyond that of a layman, such that other people may rely on his opinion about issues within his area of expertise.’ (Hadley-Piggin, 2016). In the instance of peer support worker recruitment, the ‘specialist knowledge’ will relation to the specific topic of ‘recovery’ and the expertise acquired via experiential learning.

At times, applicants’ understandings or conception of recovery might include critiques or scepticism regarding recovery culture, in a way that can feel challenging for recruiters whose commitment to recovery-focused services and culture is especially strong. However, the future and continued efficacy of the peer support workforce being described here relies on having ‘a foot in both camps’ in terms of survivor and statutory service cultures and thinking: with a firm heritage in one, while operating within (or

reaching into) the other. Therefore, critical engagement with a plurality of perspectives on recovery and associated politics is necessary.

It is critical to recognise the need for peer support workers to have a conception of what can support them to live ‘a satisfying, hopeful, and contributing life’ (Anthony, 1993) without imposing this or any other construct of recovery and/or ‘self-management’ onto others. The relational nature of peer working should also ensure that the language of ‘recovery’ and ‘self-management’ should be adjusted as necessary for individuals who do not find it helpful.

Though the cultures of contemporary mental health services appear to have moved towards a ‘recovery-focused’ space, with mixed efficacy, there is often an acceptance within survivor community and activist groups of the ‘true’ (survivor owned) definition of recovery. After all, Recovery in the Bin begins its key principles by acknowledging that ‘the Recovery approach started with noble principles …’ (Recovery in the Bin, 2014) Therefore, peer support workers engaging with critical perspectives on recovery and associated politics is imperative.

It could be argued that these perspectives highlight the common issues which prevent some service users feeling that their needs are met by mental health services. Perhaps if these issues can be heard, and engaged with, by peer support workers and fed back within services, then services’ ways of relating to individuals who are not feeling helped can be successfully adjusted, and these experiences might improve?

Certainly, critical debates proffered by the user and survivor communities can be considered critical to peer support workers’ CPPD especially as it is the activism from these same communities that has led to peer support workers’ existence.

Closely linked with this debate is the common query of what makes an appropriate length of time ‘out’ of or ‘away from services’ before becoming a peer support worker. There can be a well-intended but inherently paternalistic desire to provide career opportunities for an ex-service user, as if the offer of employment is a continuation of their care plan. However, this can be deeply problematic for establishing new boundaries and rarely leads to colleagues being able to establish relationships as equals. This approach can also hinder opportunities for achievement based on the merit of their own work; preparing for an interview for a post within an organisation where there is no ‘therapeutic hangover’ (Ball, 2017).

However, many service users do indeed return as peer support workers to settings where they have been treated. In other cases, some peer support workers (as with many other staff who have lived experience) have ‘dual identities’ as workers in one context, while being treated in others. But it’s problematic finding a consensus on the optimum arrangements. It seems to be of benefit that these discussions are led by the individuals concerned, with the caveat that most organisational policies will stipulate that, if possible, all staff (peer and non-peer) should not be treated within their workplace.

Realistically, inpatient services' bed pressures often mean that individuals being treated are at highly acute stages of distress. Therefore, it is reasonable to consider that, outside of completely unexpected traumas, if someone has experienced a recent inpatient admission, the likelihood of their recovery being developed enough to use professionally is low. However, it is important to stress that this cannot legally be used 'against' peer support workers already employed, but purely to guide recruitment in terms of 'readiness'. Inevitably there will be exceptions.

This supports the case for voluntary or non-peer working roles, to give someone the chance to 'try and test', and to assess and develop their self-management in relation to the demands of working life. It is not usually appropriate, therefore, to quantify an arbitrary amount of time 'out of' services in order to reliably possess the recovery required to sustain a post; rather, a self-reported 'sustained' recovery, with evidence of robust strategies to retain wellness and self-management should suffice.

Alongside continued development of recovery, the other area highlighted in the arrow in Figure 3 is CPPD. Peer support workers will find it useful to access training and learning opportunities available to all staff. However, experiential learning opportunities, and training that is user-led, survivor movement or grassroots-linked, can be of great benefit to counteract the dominant impact of working in statutory environments and reinforce the values base and history from which these roles have emerged.

We now reach the debate regarding suitability of lived experience in relation to differing contexts. Issues of credibility (and what we mean by 'sharing lived experience') come into question in relation to more specific or specialist roles, such as carer peer support workers, forensic peer support workers, and Early Intervention in Psychosis peer support workers.

To retain fidelity to the values of peer support, and for peer support workers to sustain any level of authenticity in the role modelling they are employed to undertake, it is important for their recovery narratives to reflect those of the populations they are employed to work with. For example, is it realistic for a peer support worker who has never experienced secure care to attempt to inspire hope that recovery is possible with individuals who might have a double stigma of their mental health journey and an offending history to contend with?

Though Gillard *et al* (Gillard 2014) discuss 'a broad consensus that peer workers should have lived experience of using similar services to those they are working in', we have already discussed the shortcomings of relying on service access as an indicator of a person's narrative or recovery story. Instead, it can be useful to ensure person specifications include a requirement for a lived experience of recovery which is 'tangibly relevant' to the working context (though the exact phrasing of this may need consideration within different organisations).

Moving beyond entry-level roles: senior peer support workers

‘The vast majority (of peer support worker roles) are low pay and low status. There are few opportunities for peer workers to advance their career while maintaining their lived experience as their primary source of expertise.’ (Repper, 2019, personal correspondence). Now that we have highlighted some helpful indicators of what can be useful for appropriate movement into entry-level roles, we can consider what happens next.

As well as the work they undertake directly with service users, peer support workers are often tasked with challenging the culture of the organisations in which they work. This can be partially achieved by the sheer fact of their existence, but also requires additional efforts in challenging attitudes, language or practice. It might be considered problematic to task people in low pay band, low status roles with the responsibility of leading culture change, especially when considering that their training rarely includes any useful theory in leadership, organisational culture and dynamics or influencing systems.

Subsequently, many organisations, such as CNWL NHS Foundation Trust, have developed Senior Peer Support Worker posts. These roles comprise a reduced caseload of work with individuals, along with a number of duties related to the supervision, management and development of peer support worker colleagues; as well as duties related to the promotion of peer roles, culture change and championing the recovery agenda.

These posts are comparable to newly qualified, traditionally trained staff, given the levels of knowledge, awareness and skill required to undertake the more strategic, managerial, and culture-based aspects of their roles.

In terms of the Career Pathway, people could progress into these roles from roles before them as follows (Figure 4):

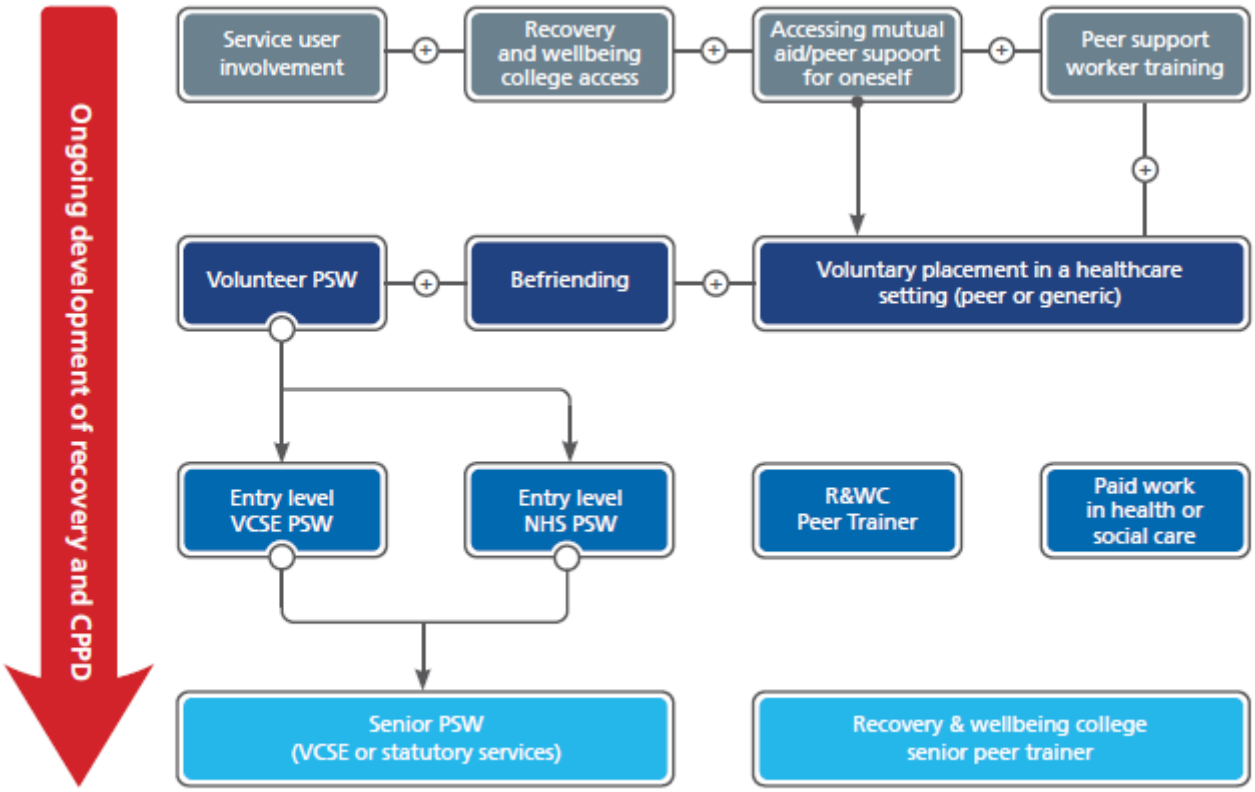


Figure 4

As well as relevant lived and working experience, senior peer support workers require additional competencies to be effective in post. Although some postholders may have existing skills in areas such as public speaking and presenting, recruiting, inducting, training, supervising and managing staff, these cannot be assumed, and training that ensures an emphasis on a relational and lived experience-focused practice should be made available.

In addition, learning on leadership, with an introductory awareness of organisational dynamics, and influencing and managing change, can be useful when leading their colleagues in supporting culture change within the organisation. Similarly, knowledge of the history of peer support and the survivor movement, co-production, trauma-informed care and critical approaches to mental health are all important for them to be effective and informed in role. In this way, the Senior Peer Support Worker's role and competencies can be depicted as follows (Figure 5):

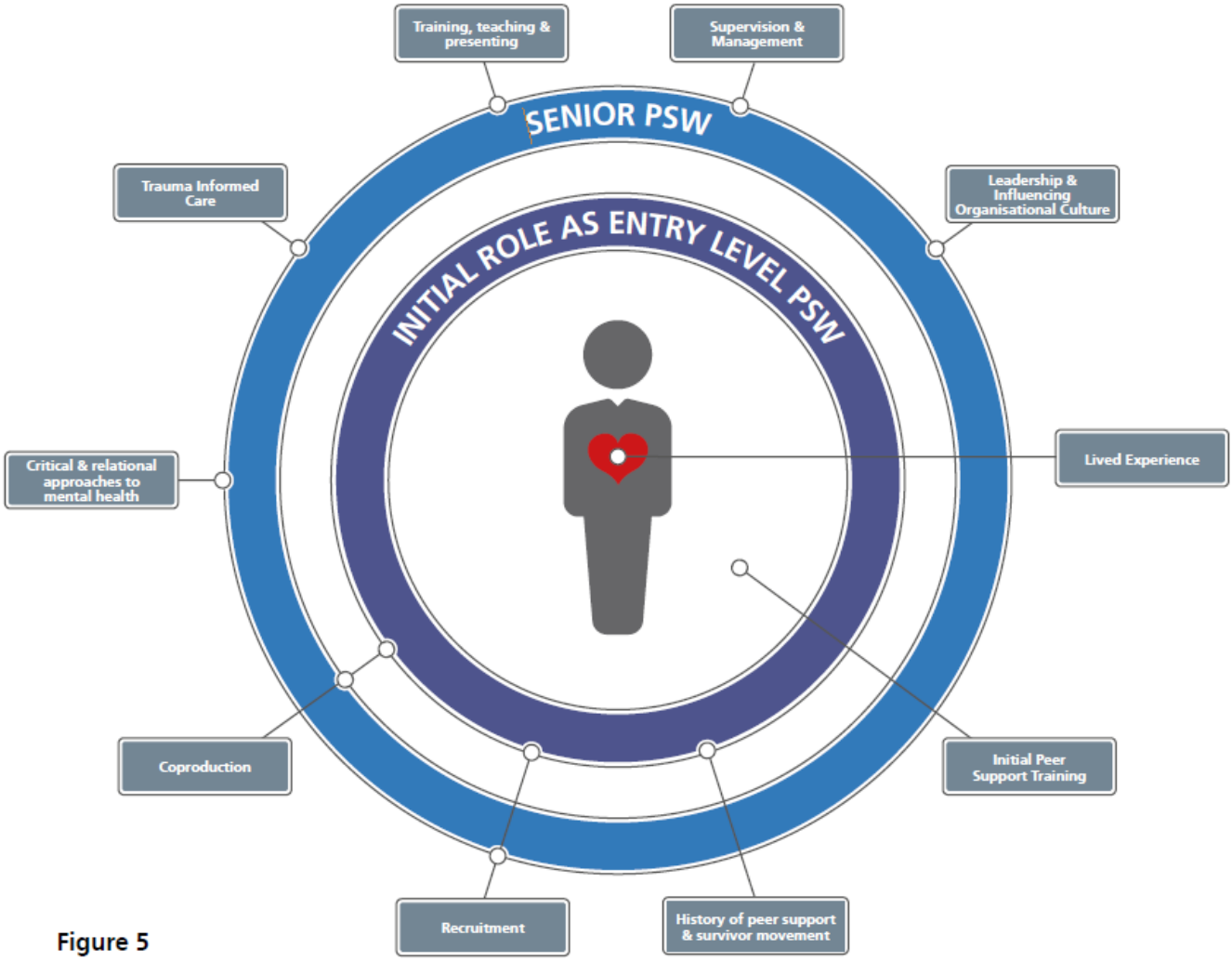


Figure 5

Certainly, the creation of these roles seems a positive step. However, all too often, they are few and far between, with some organisations not investing in them at all, since a 'critical mass' of peer support workers has not yet been achieved to justify such roles in a business case. There can be real challenges to attempting to implement standardisation as a result of the reliance on local buy-in, and so executive-level support becomes even more critical at this stage (see IMROC Thought Piece '*Preparing Organisations for Peer Support: Creating a Culture and Context in which peer support workers thrive*' for more information on this'.)

Recommendation: As the peer support workforce grows nationally, low expectations of those in entry level roles must be challenged, and more senior roles seen as natural progression route for those who have undertaken peer work before, ensuring a deep familiarity with the model, training in the approach and credibility in providing supervision to entry level workers.

Moving beyond senior peer support working - what's next?

For a senior peer support worker, one of the commonly suggested progression routes is into traditional training for roles such as nursing, occupational therapy, psychology or even medicine. With the growing number of apprenticeships for health, many entry-level peer support workers are also undertaking this route, which we can indicate on our career pathway model below (Figure 6):

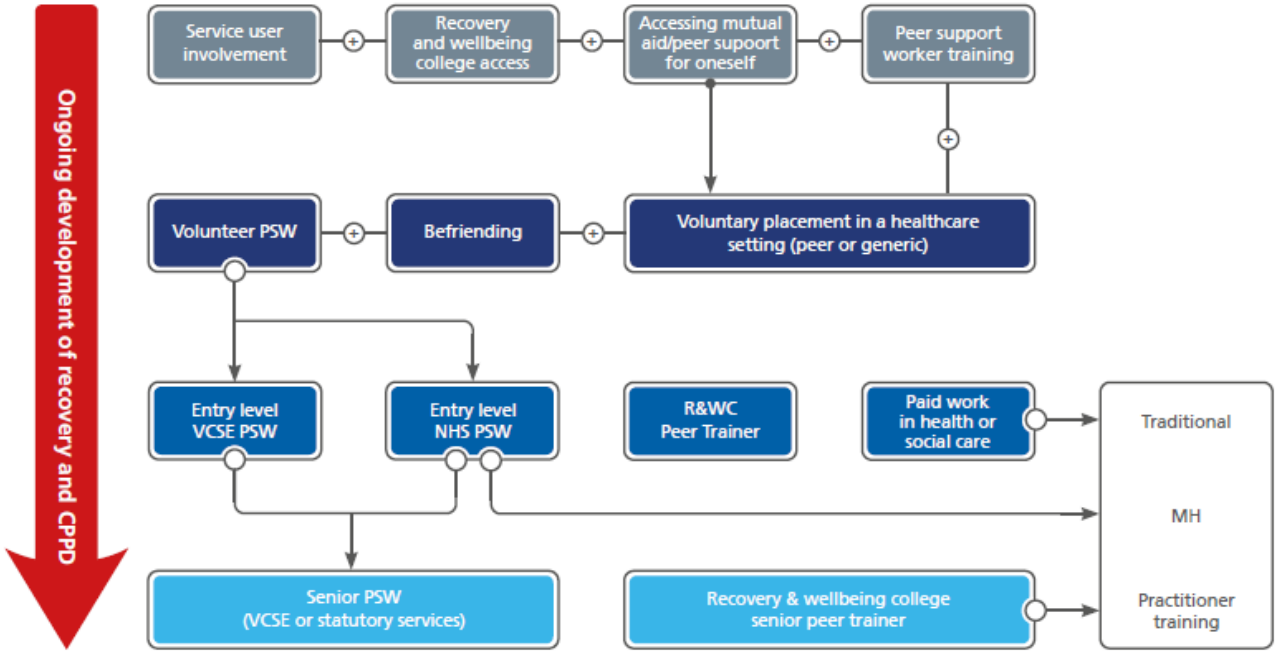


Figure 6

Even if this route into traditional training seems attractive, for some there are a number of sacrifices to be made if this route is taken. Primarily, and perhaps most significantly, the lived experience lens and approach to the work are compromised.

Other disciplines do not draw on their experiential knowledge as the *primary* source of reference or a relational way of working as the only appropriate way of undertaking their role. These aspects of working would be 'add-ons' to other models and ways of undertaking their jobs, vulnerable to sacrifice when pressure is high, and time is lacking.

Though many organisations advocate for the 'therapeutic use of self' (Currid, 2010) by traditionally trained staff, ultimately the task at hand for nurses, social workers, occupational therapists, psychiatrists, psychologists and other traditionally trained staff is not to inspire hope via positive use of self-disclosure. There are alternative models, theoretical approaches and tasks which must be adhered to, and codes of conduct and professional frameworks which guide the work, and which must be complied with. The

likelihood of these ‘ex-peer workers’ regularly using positive disclosure with services users in a successful and safe way may be more likely, but not without risks.

Many peer support workers testify to the surprising number of their colleagues who privately disclose to them their own lived experience, but do not feel comfortable ‘outing themselves’ to the broader team owing to the stigma associated with mental health problems amongst staff groups of mental health services (Thornicroft 2005).

Furthermore, the notion that a ‘peer-based approach’ embedded in a traditionally trained role *does not* result in potential conflict of interests denies the complexity of the work undertaken by peer support workers. Certainly, a basic disclosure might be possible in many roles, but the values, principles and complexities of the work transcend this basic act. If attempts were made to combine or embed this with other models, at times there would be significant conflicts. For example, an Approved Mental Health Practitioner or psychiatrist attempting to undertake a Mental Health Act assessment while simultaneously incorporating a peer-led approach would, most likely, encounter a complex set of power-related politics and dynamics, forcing them to prioritise one way of working over another.

Similarly, a nurse who was tasked with forcibly administering intra-muscular medication to someone who was unwilling to be medicated, would need to prioritise their nursing approach over their peer approach. These might be especially extreme examples, and of course there will be instances when the work undertaken is less coercive by nature, and thus the potential to include peer support principles and ways of working may be more realistic. However, these roles mark an exit from their experientially informed model, and entrance into a new role. For this reason, ‘peer-nurses’, ‘peer-psychiatrists’, ‘peer-psychologists’ and so on - often muted as a possible direction of development for peer workers – are problematic at a conceptual level. They assume the ‘peer’ aspect of the roles as shorthand for ‘a person with lived experience’ as opposed to a discrete, values-based approach to the work. When peers exit lived-experience specific work to enter a new professional group, which is often interpreted as a natural progression route in the absence of alternatives. A more appropriate parallels would be to an assistant psychologist training as a mental health nurse, or an occupational therapy technician training as a psychiatrist.

At times self-stigma can emerge in peer support work, with postholders not fully realising the stigma and discrimination in mental health services until they have witnessed conversations behind the closed doors of the staff room. Some peer support workers challenge these cultures, but others may feel unable to do so, or do so to no effect, and then relinquish hope of change. Combined with a lack of career progression and scarcity of roles, unless a career in mental health is abandoned altogether, the only viable option for those who crave development may seem to be assimilation. Of course, for some peer support workers, pursuing this route can be absolutely appropriate, as it is for many other career changers who enter traditional training, and can mark a poignantly significant milestone in the individual’s journey.

Low pay, and the subsequent financial inaccessibility of peer support worker roles are other significant, and often underreported, reasons for peer workers leaving their trade to access traditional training. It is often suggested that the creation of peer roles demonstrates an organisational commitment to coproduction and Recovery. Yet ensuring they are structured in a way that prevents career progression and the possibility of more financial freedom seems contradictory. It would suggest that some of the commitments and pledges to valuing the contribution of lived experience are actually limited. We call individuals 'Experts by Experience' but reject the idea of them ever being as expert as a nurse who has been qualified for longer than a year!

But whether peer support could and should be considered, compared and contrasted with other professional groups is, in and of itself, not a simple question in relation to the creation of a career pathway.

Beyond senior peer support working: what should a peer career pathway run parallel with?

Some advocates of peer support would purposely refuse to map a peer support career alongside other registered health disciplines, and anecdotally, there appears to be a particular refusal to do this on behalf of activists and survivors whose experiences of the mental health system have been particularly dissatisfactory.

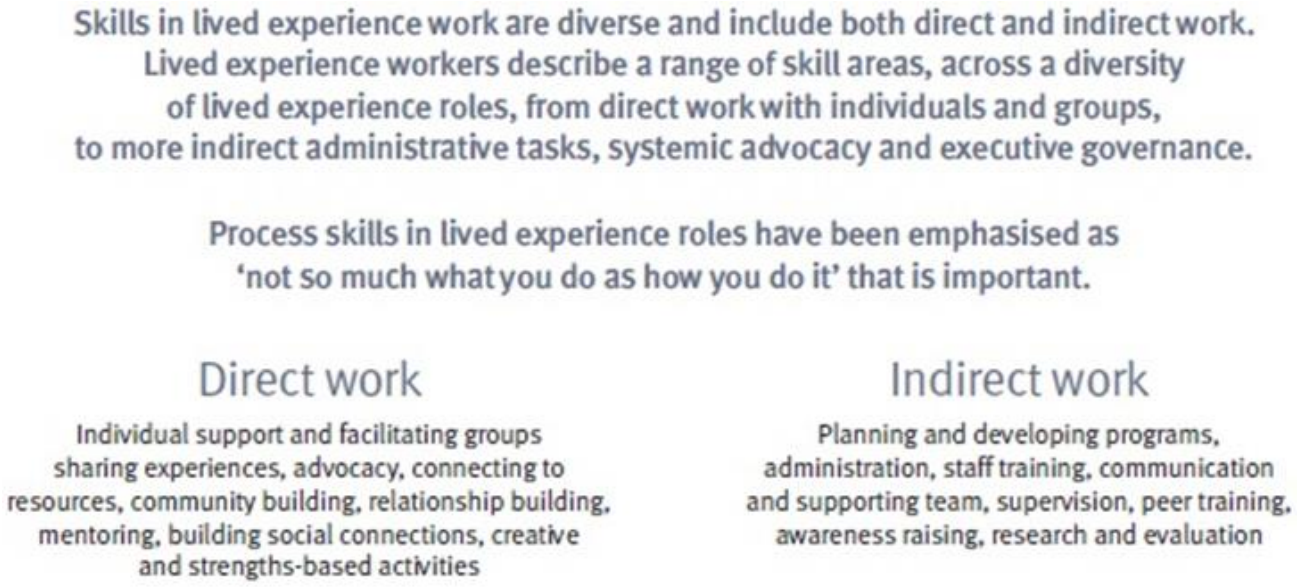
This is based on the premise that traditionally trained roles have flaws in the way their work is organised and delivered, often to the great dissatisfaction of service users and the staff themselves. As the value of peer support is partly due to the fact that it works differently, there would be a loss to the role if it were to attempt to reflect some aspects of other healthcare disciplines (Recovery in the Bin, 2020).

In other schools of thought, some theorists on peer support would 'pitch' the skillset and competency, and training required, to undertake peer support work at a level similar to those of other 'types' of support workers. Certainly, this is reflected in the remuneration these roles generally attract, with most organisations who employ both peer and non-peer support workers paying both groups equally.
Yet others would be in favour of retaining fidelity to the values of peer support whilst also creating roles far beyond the level of expertise, autonomy and skillset of *support working*. This is certainly the argument presented in this thought piece.

This approach recognises a number of existing roles created in recognition of the more advanced skillset which is still deeply rooted in the 'peer approach' but require additional or different competencies and skills to that of support working.

Attempting to construct an idea of what the variety of these roles might look like builds upon the work of others, including the Queensland Framework for the Development of the Lived Experience Workforce (Queensland Mental Health Commission, 2019). This suggests 'Lived experience roles span entry level to more specialist roles and

leadership positions. Regardless of the role, all lived experience workers share a focus on relationships as instrumental to the work and connection to the broader lived experience movement.' (Queensland Mental Health Commission, 2019).
The Queensland Framework distinguishes between 'direct' and 'indirect' work, underpinned by shared values:



(Queensland Mental Health Commission, 2019).

Attempting to conceptualise activities that correlate directly with the values, identity and relational focus of peer work and lived experience has been undertaken previously in the UK, too. The 2003 Sainsbury Centre for Mental Health Report 'On Our Own Terms: Users and survivors of mental health services working together for support and change' (Wallcraft, 2003), illustrated activities undertaken by the user and survivor community as follows overleaf:

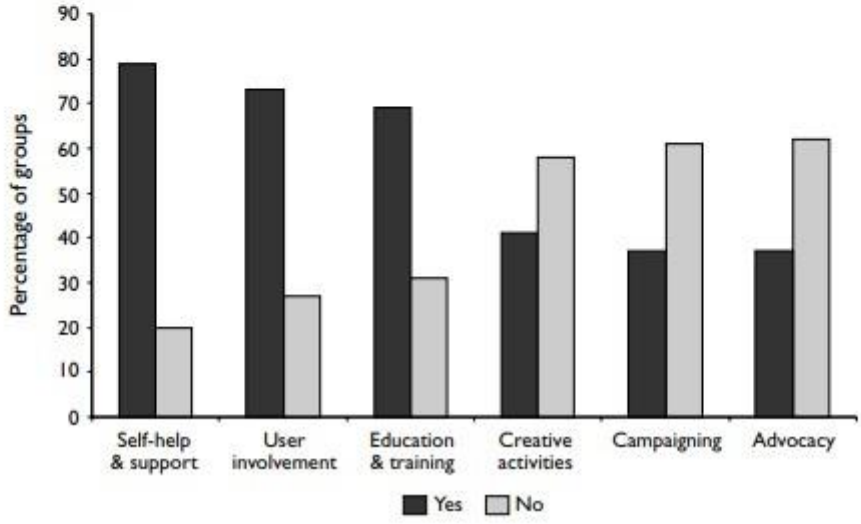
What do service user/survivor groups and organisations do?

To understand the movement better, we need to focus on what local and national groups do, and the problems and successes they identify. Our information comes from the postal survey of 318 local groups with a combined membership of around 9,000 service users/survivors, and from interviews, focus groups and visits to group premises. We spoke to leaders and project workers from six national service user/survivor networks with a total membership of 6,800 and 450 local affiliated groups.

Local groups' activities

The postal survey asked groups to state whether or not they engaged in six given activities. Figure 2 shows the response to those questions.

Figure 2 – Local groups' activities



(Wallcraft, 2003)

In the above graph from the report we can see that a large proportion of groups reported a role in delivering 'self help and support', 'user involvement' and 'education and training'. The report also made a recommendation of 'a new integrated prevention, self-management, recovery and inclusion focus for all mental health services and related social and employment services' (Wallcraft, 2003), with a vision for the next 50 years that 'Service user/survivor led services and service users/survivors employed in mental health services will be commonplace' (Wallcraft, 2003).

We would suggest that these three activity areas, of 'self help and support' 'user involvement' and 'training and education', combined with the four pillars of practice (discussed in detail below), as widely referred to in other healthcare career frameworks, could be considered useful in considering the career trajectory for peer support workers working beyond entry level within mental health (Wallcraft, 2003).

In the Multi-Professional Framework for Advanced Clinical Practice, published in 2017 by Health Education England, the four pillars of professional practice and how they relate uniquely to individual disciplinary groups and roles are described as follows:

‘[the pillars of] clinical practice, leadership and management, education and research are […] applied to […] specialist competencies [in relation to the specialty or subject area]. These may be manifested/demonstrated in different ways depending on the profession, role, population group, setting and sector in which an individual is practising.’ (Health Education England, 2017).

Based on Professor Kim Manley’s 1997 work, ‘A conceptual framework for advanced practice: an action research project operationalising an advanced practitioner/nurse consultant role’ (Manley, 1997) the four pillars of practice may have started life in relation to nursing practice, but have gone on to serve as the founding principles for other disciplinary groups too; the Occupational Therapy Career Development Framework states:

‘The Career Development Framework […] offers a structured process to guide careers, learning and development within our profession. Four interacting Pillars of Practice (Professional Practice; Facilitation of Learning; Leadership; and Evidence, Research and Development), each with nine Levels, make up the Career Framework. Used together, [they] highlight the breadth and range of opportunities available, from […] support worker or student, […] to those at the forefront of advancing the profession.’ (Dancza & Tempest, 2018)

Though some may baulk at the idea of referring to peer support in relation to the words ‘clinical practice’, the Occupational Therapy alternative of ‘professional practice’ may be more palatable, and irrespective of the specific language used, it may be useful to consider more senior roles as specialists in:

- the *doing* of peer support at an advanced and expert level
- the *leading* of peer support at an advanced and expert level
- the *teaching* of peer support at an advanced and expert level
- the *research and development* of peer support at an advanced and expert level.

In the case of the professional group we are thinking about in the context of this thought piece, peer support workers, there has been great variety to the number of roles operating at a highly skilled level. However, consideration of how roles might develop in relation to the pillars of practice has never been presented in an organised way before. Furthermore, for roles informed by lived experience at highly sophisticated and advanced levels, there has never been unifying language to describe their work. The language of ‘Lived Experience Practitioner’ may begin to meet this challenge, with subsequent roles mapped as follows (Figure 7):

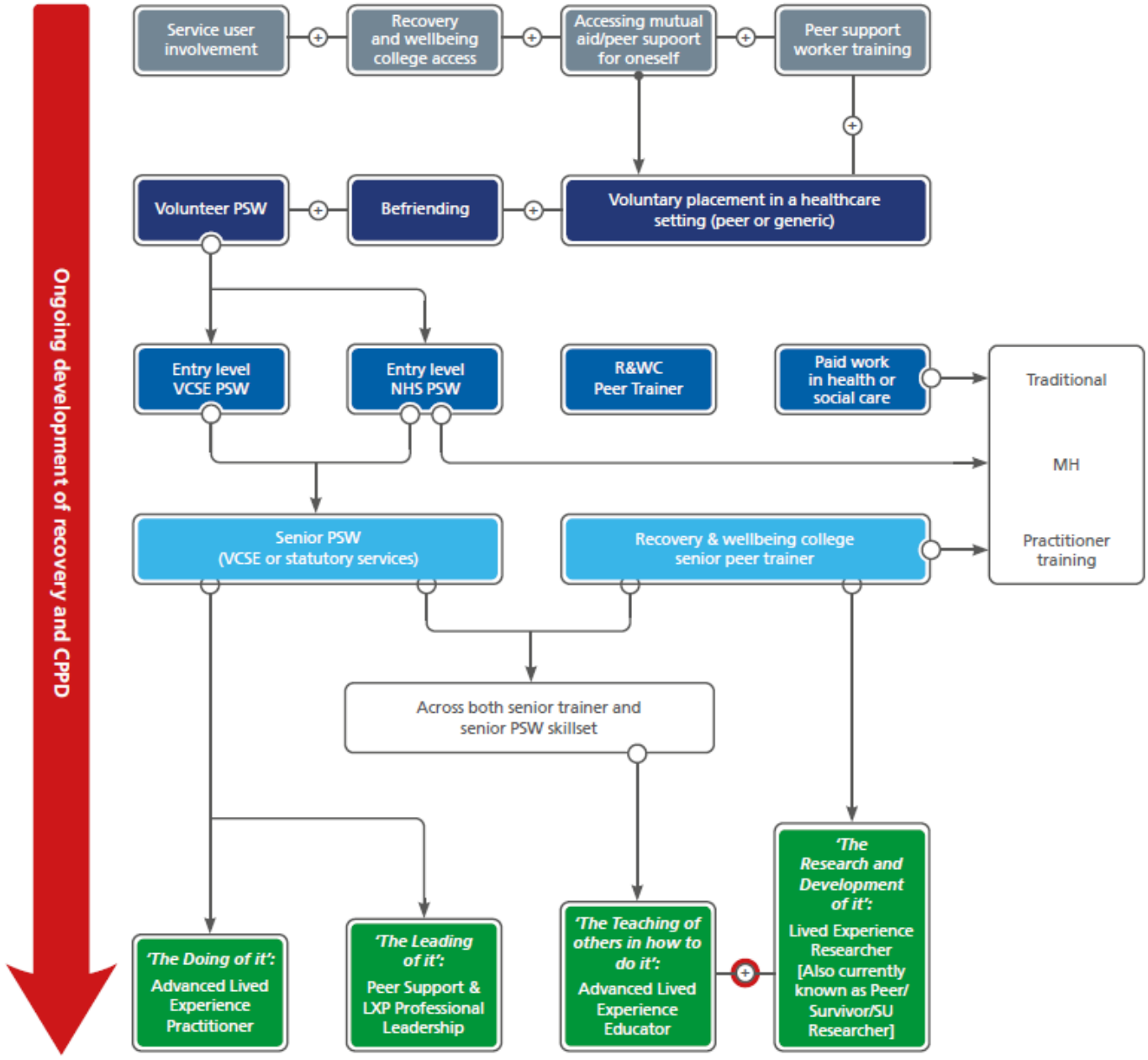

Ongoing development of recovery and CPPD
Service user involvement
Recovery and wellbeing college access
Accessing mutual aid/peer supoort for oneself
Peer support worker training
Volunteer PSW
Befriending
Voluntary placement in a healthcare setting (peer or generic)
Entry level VCSE PSW
Entry level NHS PSW
R&WC Peer Trainer
Paid work in health or social care
Traditional
MH
Practitioner training
Senior PSW (VCSE or statutory services)
Recovery & wellbeing college senior peer trainer
Across both senior trainer and senior PSW skillset
'The Doing of it': Advanced Lived Experience Practitioner
'The Leading of it': Peer Support & LXP Professional Leadership
'The Teaching of others in how to do it': Advanced Lived Experience Educator
'The Research and Development of it': Lived Experience Researcher [Also currently known as Peer/ Survivor/SU Researcher]

Figure 7

Advanced Lived Experience Practitioners - the *doing* of it

Irrespective of arguments which may oppose the creation of these more senior roles, nearly all perspectives agree that beyond a certain level of seniority, the work undertaken is no longer peer *support work*. A job title including 'support work' has connotations of a valued, but largely junior, role, without a high rate of autonomy nor a primary task beyond direct work with service users, and their carers.

The term 'Lived Experience Practitioner' is used in other countries (Byrne, 2016) and use in the UK appears to have started with a collaboration between Canterbury Christ Church University and Oxleas NHS Foundation Trust. Described on the Oxleas NHS trust website as 'a new role to help mentor people with mental ill health', colleagues at Oxleas NHS Foundation Trust, have explained that there was thought to be significant stigma and low value associated with the job title of peer support worker. The team developing the 'Lived Experience Practitioner' roles in 2017 felt, however, that 'Lived Experience Practitioner' was a title more likely to command the respect deserved of such a significant role in Oxleas' services.

Additionally, self-identifying Lived Experience Practitioners are increasingly using this term to describe a variety of roles which require additional skills, knowledge and competencies beyond those that would be expected of an entry level peer support worker, but which retain an absolute emphasis on lived experience as the foundation and primary knowledge-base for the approach.

The lack of centralised organisation or recognition of these posts means they have historically had a variety of names, including 'Service User Consultants', 'Peer Practitioners', 'Lived Experience Workers', and many more. These roles have often been created by particularly radical innovators in positions of influence at local service delivery level, and thus often existed in isolation; rarely have there been significant cohorts of these workers.

In my own experience, it was only at professional networking events where a few other 'fortunate ones' had been supported to attend by their employing organisations, that I was able to meet my contemporaries. At times, posts being funded from budgetary underspend, or without the involvement of overarching middle management, has even meant that these roles are somewhat shrouded in secrecy, and post holders are left without working rights, forced to be paid as suppliers via complex and challenging financial systems with NHS Trusts or charities who are not set up to ensure rapid payment for individuals. I wrote about some of the risks and challenges of these roles as they exist within systems relevant to personality disorder in a chapter for the book 'Working Effectively With 'Personality Disorder': Contemporary and Critical Approaches to Clinical and Organisational Practice.'

Mel Ball, Trustwide Lived Experience Practice & Peer Support Lead, CNWL NHS Foundation Trust

In CNWL, Advanced Lived Experience positions have been created, which are considered a direct continuation of the peer support worker career pathway as they have a focus on the pillar of practice emphasising 'the doing of it' at an advanced level.

The Multi-Professional Framework for Advanced Clinical Practice (MPFACP) describes 'specialist competencies' in relation to a particular expert area that Advanced Clinical Practitioners might possess which correlate with the specific setting in which they work. Relating this to advanced lived experience practice, our learning has suggested that the specialist skills and knowledge required to credibly supervise other peers working in, for example, a community mental health context, differs from the skills and knowledge required within an acute context. Therefore, the undertaking of peer work within a specific context should begin with employment at an entry level peer support role within the setting, which, in turn, would begin with lived experience of accessing services also within this context. Therefore, the 'specialist competencies' akin to those descried in the MPFACP emerges in relation to lived experience practitioners; just as one might expect with other professional groups in healthcare.

It is also crucial that postholders are able to demonstrate:

- a high level of critical thinking in the politics, history, theory and evidence base in relation to peer support working (the *research and development pillar of practice*),
- how to safely use one's own lived experiences and to support others to do the same and develop the 'lived experience lens' in relation to their roles (the *leading and teaching* pillars of practice).
- organisational development skills and understanding how to undertake effective service user and carer involvement and coproduction.
- a level of knowledge and competence comparable to that of someone who has studied their subject area to Master's degree level.

- Awareness of how to support individuals through all entry points in the peer career pathway, including Recovery College engagement, service user involvement, and voluntary work.

Appendix 1 of this document has an example Job Description for an Advanced Lived Experience Practitioner.

As time goes on, those undertaking these roles may begin to identify less with the person they were when they attained the lived experiences that initially qualified them to undertake their roles. They may feel that their 'story' has become 'out of step' with the contemporary systems that using it with service users can feel inauthentic. Of course, the essence of recovery stories is timeless, but as peer support workers mature in their roles and development, the mastery of their work serves to support and supervise others to tell their stories, reserving their own narratives for different arenas and using disclosure of their lived experience in collaboration with other skills, and a healthy dose of political acumen.

Similarly, they may also consider how their lived experience reflections, perspectives and narratives can be used in supervision with staff of other disciplines, including as a co-facilitator of whole team reflective practice or in a psychological formulation meeting.

In order to competently contribute to discussions, Advanced Lived Experience Practitioners (LXPs) must have the same access to local CPPD training as their colleagues and that their lack of professional registration doesn't exclude them.

In addition, the service context of the Advanced LXP's specialism may commonly be informed by a specific theoretical and/or therapeutic model, as in the case of the IPS model in relation to the work of peer employment specialists, MBT, DBT and Schema therapy in personality disorder services, and with systemic family therapy in CAMHS. Although it is important that Advanced LXPs are exposed to basic training in the mechanics of these approaches, the purpose of this is not for them to replace their relationally focused, lived experience-based approach in favour of an alternate model, or becoming therapists.

The Advanced LXPs' application of this theory should always correlate directly with their relationally focused approach, for example, co-delivering a therapy group with a registered professional therapist, infusing the group's process with observations and insights from lived experience. Equally, they might provide consultation and supervision to their non-LXP colleagues by having a 'light touch' awareness of their supervisees' informing model, but much more regularly referring to and relying on their own insights from lived experience in their contributions.

Again, the importance of lived experience which is clearly relevant to one's working context comes to light: if a pre-existing familiarity with these models (and the associated language and concepts) is fostered within one's own journey it can prevent this knowledge feeling separate from one's lived experience trajectory. The

theoretically informed Advanced LXP's task (and challenge) is to ensure a synergy with the team; and this theory, while not compromising their ability to challenge power imbalances, offers a differing perspective or an understanding of when to disregard theory in favour of a more ordinary way of understanding and relational focus.

Another recommendation of this thought piece, with much longer-term aspirations, would be for the full career framework for peer support workers to be accompanied by the creation of a number of educational programmes which support individuals' development into more senior roles.

We would suggest that these educational and training programmes could eventually lead to registration with a membership body of some description. A benefit of this would be to allay potential anxieties about accountability when undertaking peer work in specialist mental health settings, with parity with traditionally trained colleagues. It could be argued that this is an extension of the systems much more widely used in the United States of America and Australia, where even entry-level peers must undertake a standardised accredited Certified Peer Specialist Programme, with annual re-registration requirements.

Programmes specifically designed for Advanced Lived Experience Practitioners should be established to ensure a continuing close adherence to the peer support values-based approach and history, building upon the foundation in experiential knowledge, with learning in models which complements it, the Recovery approach and related politics more broadly. There should also be an emphasis on these programmes beginning to structure learning on the 'four pillars of advanced practice' (Multi-professional Framework for Advanced Clinical Practice in England, 2017) in order to maintain a touchstone for comparison and links with other disciplinary groups.

Programmes should ensure accessibility for those with educational gaps by allowing portfolio submission of evidence of advanced practice accompanied by an extended academic piece of work such as an essay and learner/student support provision.

Professional leadership and management of peer workforces: the *leading* of it

Managerial and strategic roles such as the Trustwide Lived Experience Practitioner and Peer Support Lead at Central and North West London NHS Foundation Trust, provide one option for progression. Previously in many organisations, responsibility for oversight of the development of the peer workforce has been considered a 'bolt on' in addition to existing roles with responsibilities considered 'adjacent' to the peer support agenda, such as a Recovery College leadership or service user and carer involvement activity management.

However, Peer Support Lead roles, where they exist, are rarely 'protected' roles for those who have actually been trained and working as peer support workers. This has been necessary in the infancy of the profession, as so few peer support workers

existed within statutory services. Though there is a rich history of survivor leadership within VCSE, grassroots and activist groups, a number of complex issues appear to have prevented leaders from the survivor community moving into roles of leadership in relation to peer workforces in the NHS.

Perhaps this is partly due to individual choice- with concerns of competing agendas and a perceived requirement to relinquish the ability to robustly challenge NHS systems? Issues of stigma and credibility and low expectations are likely. In addition, those designing and recruiting to these roles may have realistic concerns that applicants lack the necessary familiarity with NHS cultures to ensure the efficacy of their transferrable skills.

We have acknowledged at the outset of this thought piece that peer support looks quite different in these varied contexts of delivery. However, as the workforce grows, this may require future consideration. It could be argued that, as with any staff group, a professional lead without professional experience would lack the credibility and in-depth knowledge required to effectively manage their staff and workforce's activities and development.

An additional problem of outsourcing professional leadership to those who have never worked as peer support workers or lived experienced practitioners is that it maintains 'low expectations' and the stigma associated with having lived experience of mental health problems along with assumptions that someone who has worked as a peer support worker would, or could not, be capable of leading their peer support worker colleagues. As a result, person specifications for jobs are created which unnecessarily require a registration as a mental health professional as an essential; this excludes a number of potential applicants, and the unhelpful cycle is recreated.

Much like Advanced LXPs, those in professional leadership roles require additional sets of knowledge, skills and competence to be effective in their roles. Professional supervision which keeps alive and continually develops the 'lived experience lens' is imperative for peer support workers to continue using their lived experience effectively.

More generic and widely available training in theories on healthcare management, organisational dynamics, influence and system transformation can be hugely useful when in a role that considers not only the professional group one is representing, but also interacting and learning from, and with, other professional leads, influencing the organisation.

Advanced lived experience educators: the *teaching* of it

Peer trainers, most commonly found embedded in Recovery College teams or in staff learning and development teams, require different skill sets and development in their roles than peer support workers. Their development and training often intersect more naturally with educational skills, knowledge and competencies than those within health. At Central and North West London Foundation Trust, we have found that undertaking

work surrounding co-designing and co-delivering the initial peer support training as well as ongoing CPPD opportunities for peers (complementing generic training available to all staff), is an emerging area which requires specialist skills. The educational and training needs of a peer workforce and how recovery values and the voice of lived experience can be embedded in all the training offered by an organisation is important and can fall within the remit of the Lived Experience Educator.

Training for teams, for example, on the role of the peer support worker, their purpose and the scope of their input, is critical to undertake with teams prior to peer support workers' arrival, as it also gives a chance to challenge stigmatising attitudes, consider the integration of a new team members as an opportunity, and have myths busted on the likelihood of relapse, their new colleague demonstrating inappropriate boundaries, and so on.

Similarly, the input of voices of lived experience into preceptorships, student placements, local pre-registration courses, the apprenticeships programmes, as well as induction training and therapeutic management of violence and aggression training, requires the teaching skills and knowledge of both educational and adult learning, as well as their Lived Experience lens and experiential knowledge. A role such as this may additionally coordinate the work of others, both within and outreaching from the Recovery and Wellbeing College and into other teams.

For peer support workers who crave a new challenge, Recovery and Wellbeing College trainer roles can be a welcome opportunity, especially as they often have experience in presenting or training alongside their work within clinical contexts. However, peer trainers are rarely afforded the opportunity to develop their skills in relation to peer support work within a clinical context. Similarly, for Advanced Lived Experience Practitioners who are looking to diversify their skill set, a transition into an Advanced Lived Experience Educator may be a developmental opportunity to consider. It is unlikely, however, that an Advanced Lived Experience Educator would be able to 'sidestep' into Advanced Lived Experience Practice without first undertaking at least senior peer support work, if not an entry level role in some instances.

Lived Experience researcher/ academics: the *research and development* of it

In relation to peer support roles and lived experience practice, the research and development pillar of practice is significantly under-developed in the NHS. The vast majority of roles and work in the domain of peer and lived experience specific research have existed in Higher Education and VCSE contexts. Perhaps this is partially due, once again, to the limited existence of these roles in the NHS, but also the lack of a peer-specific official training pathway including basic research methods, in the way other professionals' qualifications offer exposure to this learning. As a result, the link between research and practice in relation to peer support is not well established by peer support workers themselves, despite there being 'substantially more randomised

controlled trial evidence supporting the value of peer support workers than exists for any other mental health professional group, or service model' (Slade, 2018).

There are, however, a large number of researchers working from a place directly informed by their lived experience under a huge variety of role titles, including, survivor researchers, service user researchers, and peer researchers amongst others. For the purposes of this writing, we refer to 'lived experience researchers', in order to create uniformity with other terminology used in this document.

In existing research (and researchers) in this area, there are five common concepts which clearly locate this body of work as a possible continuation of the professionalised lived experience career pathway, as opposed to being research produced by individuals with coincidental lived experience.

i) Identity: research is affected by the researcher

First, in survivor research, the researcher's identity is critical to the work: 'Survivor research is research that is carried out from a mental health service user or survivor perspective. This shared identity between the researchers and the researched is a vital element'(Faulkner, 2004), Faulkner writes, continuing 'the power relationships that exist between the researcher and the researched are challenged through process and through participation.'

As such, the identity of service user researchers is usually revealed to interviewees, with reported 'positive difference to interviewees to be interviewed by a fellow service user or Survivor' (Faulkner 2004). Research into the differences between service user researchers in comparison to traditional university researchers indicate 'some differences in the ways in which service user- and conventional [researchers] conducted [and analysed] qualitative interviews. [With Service User Researchers] much more likely to code […] interview transcripts in terms of interviewees' experiences and feelings, while conventional [researchers] coded the same transcripts largely in terms of processes and procedures.'(Gillard, 2010).

ii) **Links with the Survivor community**

Second, many researchers retain links with the survivor community, bringing benefit in terms of documenting activity and perspectives within ULO and survivor movements, and bringing their influence into more formal settings for consideration in policy, as is the case with both Dr Sarah Carr and Professor Peter Beresford[2], amongst others. Faulkner discusses the 'importance of research leading to change and not to

[2] Professor Peter Beresford has generated a significant amount of research in relation to social policy. He also co-founded of Shaping Our Lives, 'the independent, national disabled people's and service users' organisation […] that is committed to improving the quality of support [and autonomy] available to service users [and also] pioneered the development of user involvement in professional education and also of user controlled research.'[2] Shaping Our Lives is also a UK partner to international project, Power Us, which takes forward the same agenda. Another significant figure in terms of Lived Experience research and academia, Dr Sarah Carr, draws links between grassroots survivor and user-led movements and correlating academic output. As well as her academic pursuits, Carr is also a former Chair of the National Survivor User Network (NSUN), and regularly blogs for Mad in America.

knowledge for its own sake' (Faulkner 2004) within the community of survivor researchers.

iii) **Understanding and analysing the creation of knowledge**
Third, survivor researchers have often researched the process of survivor research itself and consider the importance of the relationship between how and when knowledge is considered legitimate or credible, and the researchers' identity. Beresford, for example, cites influence from 'women, black and gay academics for creating studies in feminism, gender issues and black and 'queer' history' (The Guardian, 2005). Similarly, King's College London's Service User Research Enterprise (SURE) states on its website that one of its tasks is to 'critically interrogate how service users have changed knowledge production globally'.

iv) **Different results**
Fourth, there appears to be general recognition that 'research participants are more likely to open up to people they feel closer to' (Russo, 2012), and its significant impact. The work of Professor Diana Rose on collating lived experience testimonies from those who had undergone electroconvulsive therapy found that:
'Approximately half the patients reported that they had received sufficient information about ECT and side-effects. Approximately a third did not feel they had freely consented to ECT, even when they had signed a consent form. Clinician-led research evaluates these findings to mean that patients trust their doctors, whereas user-led work evaluates similar findings as showing inadequacies in informed consent.' (Rose, 2005).

Subsequently, the SURE website highlights that this work on 'consumer perspectives on Electroconvulsive Therapy (ECT) influenced current NICE guidelines.' Thus there is added efficacy to ensuring research is designed and data is collected, analysed and disseminated by those who hold lived experience within these arenas.

v) **Research priorities**
Finally, as the 'largest unit within a university to be predominantly composed of people who have both research skills and first-hand experience of mental health services' SURE states on its website 'the research priorities and perspectives of service users are different from those of people who work in mental health services, and from those of people with a solely academic background.'

This point relates especially closely to the role of peer support workers. Just as a peer support worker or lived experience practitioner brings a different set of interactions, priorities and experiences to a multi-disciplinary team, so too lived experience researchers bring a different set of priorities and knowledge to the research process.

Importantly, for both groups, these priorities are different *because* of their lived experiences, and the touchstone it provides for understanding the service user experience. Perhaps as a result, as with all the other roles in the proposed career pathway highlighted so far, values, and ethics are considered critical.

Angela Sweeney writes ‘it is vital that survivor researchers and Mad Studies scholars hold on to the ethics and values of our practices’ (Sweeney 2016).

One of the only educational programmes internationally which specifically encourages applications from those who hold lived experience, is the University of Hertfordshire Masters Programme in Mental Health Recovery and Social Inclusion. The University of Hertfordshire specifically promote the course as “the only co-produced postgraduate master’s course in the UK that focuses on mental health recovery and social inclusion, where those with lived experience study alongside service providers of all disciplines in equal numbers”. However, it is an online two-to-three-year programme, attracting and accepting a number of international students, so competition for places is high and the course has recently attracted publicity as the future of it appears to be under threat. Additionally, the significant jump between the few accredited peer support training programmes at Level 3 or 4, and this level 7 qualification, is significant. It is not necessarily a realistic option for many who have missed educational milestones. An undergraduate programme or postgraduate diploma or certificate to close this gap may be of benefit to ensure accessibility in studying in this field.

In the absence of any existing educational pathway, the majority of academics in this field appear to have organically carved out their careers after initial academic endeavours in an unrelated field. Notable figures such as Professor Diana Rose, who has recently retired as Professor of User Led Research and Co-director of SURE at Kings College London[3], Dr Sarah Carr[4], and Professor Peter Beresford[5] all undertook study in other areas before utilising their lived experience in their work.

It is important to highlight that peer support workers rarely appear to move into these researcher roles. We might, therefore, map the career trajectory of both of these lived experience researchers (and many others like them) within our diagram as follows (Figure 8):

[3] https://www.kcl.ac.uk/hr/diversity/meettheprofessors/ioppn/rose
[4] https://www.birmingham.ac.uk/staff/profiles/social-policy/carr-sarah.aspx
[5] https://www.theguardian.com/society/2005/jan/05/mentalhealth.guardiansocietysupplement

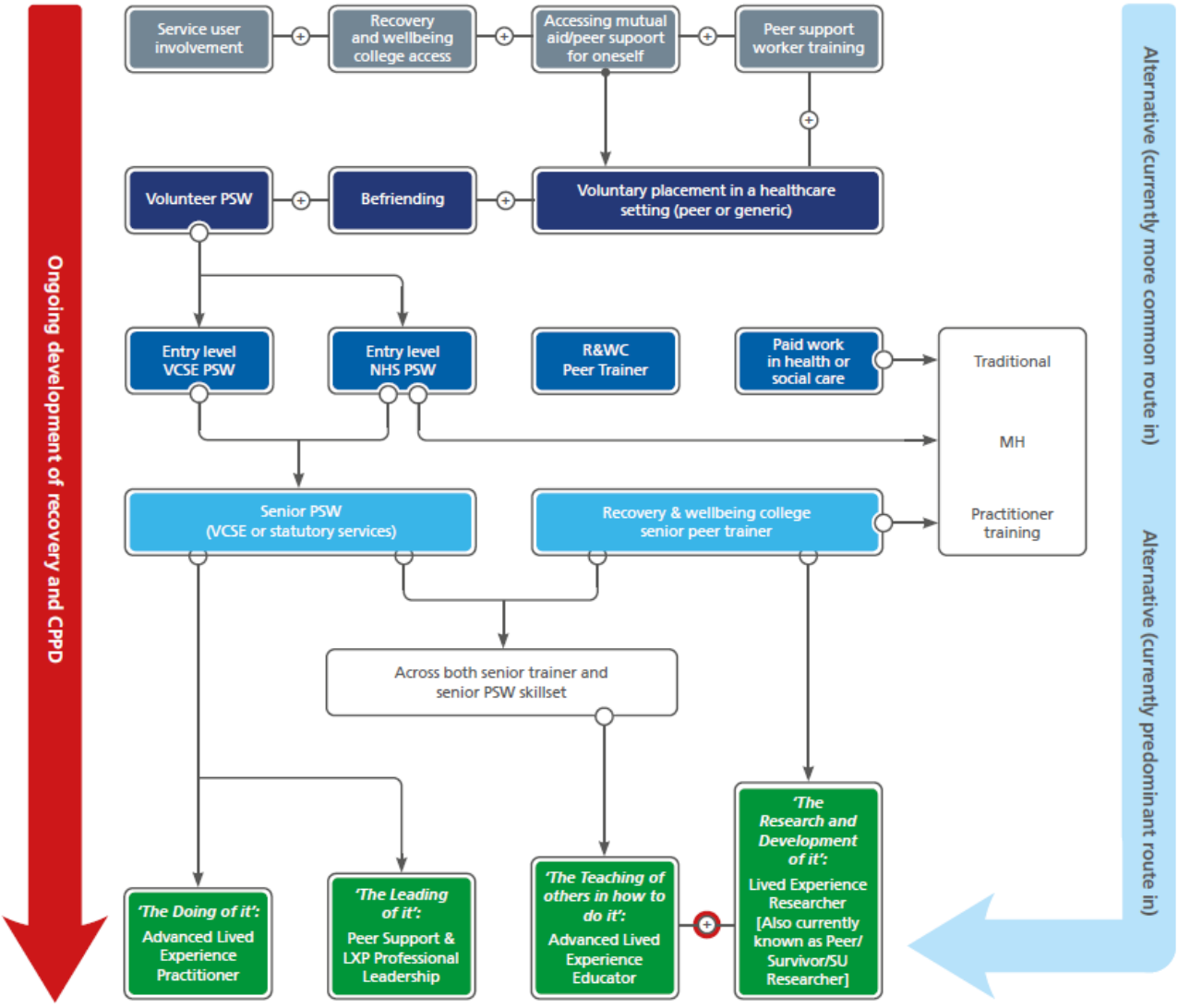


Figure 8

As is expected of academics generally, many in this field have teaching commitments in their universities. As none of these universities run courses specifically for lived experience practitioners or peer support workers, these academics are contributing to the learning experiences of other disciplinary groups (as described in the section on Lived Experience Educators). This could be understood as an intersection between the skill set of the lived experience researcher and lived experience educator.

Lived Experience Researchers and Academics require well developed skills in both the pillars of practice of teaching/educating as well as researching. This is indicated on the diagram above, detailing the potential routes to progression below, with an addition sign circled in red (Figure 9):

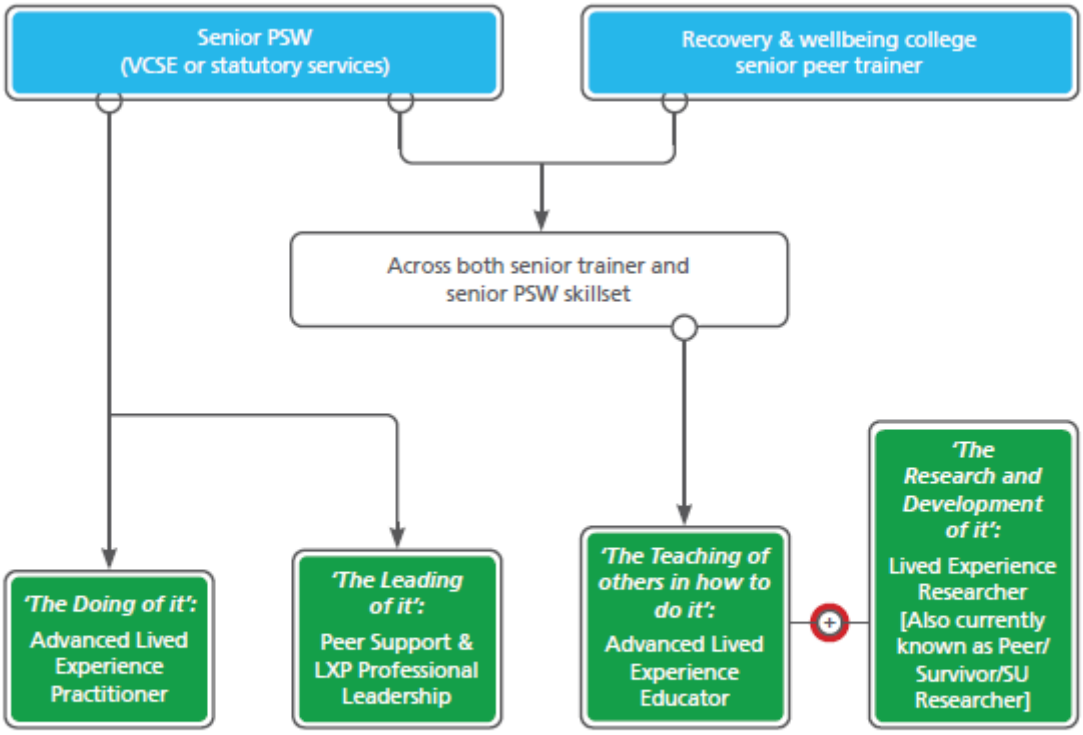


Figure 9

There is also a significant precedent of survivor research occurring outside educational institutions, and in fact Angela Sweeney (2016) writes that 'survivor research began to formally take shape […] with two major programs of survivor-led research established in national charities'. Indeed, in 2019, 61% of the projects undertaken by the McPin Foundation used peer researchers, identifying an additional cohort of individuals undertaking research directly informed by their lived experience.

How these highly skilled lived experience researchers might be able to support development within NHS and NHS-commissioned environments should be considered. Service-based improvement projects, perhaps most notably Quality Improvement (QI), in the NHS have a growing evidence base on the inclusion of service users and carers in order to raise efficacy (Bate, 2007, Ocloo 2012).

Perhaps this could be further improved by lived experience researchers being tasked with overseeing these workstreams more frequently? It could also remedy the likelihood of tokenistic involvement and PPI (Russo, 2012) in some places, with lived experience leads arguably being more likely to regularly empower others like them as individuals with lived experience.

Plus, potential benefits could pay dividends in a number of ways: as well as raising efficacy, integrating lived experience research into research and development and other departments could also influence research priorities. This would ensure research that leads to 'change and not to knowledge for its own sake' (Faulkner 2004), for the benefit of the department and, ultimately, care and outcomes for service users.

Furthermore, individual peer workers and lived experience practitioners could professionally benefit from being involved in these projects or secondments into research-focused roles, as valuable development opportunities.

Finally, important to note, Mad Studies has a growing influence in lived experience research and academia. Described by Canadian self-identifying Mad academic Le François (2013), Mad Studies is:

'an umbrella term that is used to embrace the body of knowledge that has emerged from psychiatric survivors, Mad-identified people, antipsychiatry academics and activists, critical psychiatrists and radical therapists. This body of knowledge is wide-ranging and includes scholarship that is critical of the mental health system as well as radical and Mad activist scholarship. This field of study is informed by and generated by the perspectives of psychiatric survivors and Mad-identified researchers and academics.'

Whether future academic output in relation to peer support will be bannered under Mad Studies, Survivor or Service User research, or perhaps find itself situated within other domains or faculties, remains to be seen. What seems clearer, is the commonalities between peer support and survivor research/ Mad studies in a shared emphasis on values, the use of identity, the richly diversifying influence on knowledge production and a shared impact of disruption to hierarchies surrounding knowledge.

As previously discussed in relation to the leadership of this workforce, a number of factors (including the infancy of the profession) have commonly prevented the research into peer support being led by ex-peer support workers until this point. However, as the workforce grows, as would be expected of research related to nursing practice, or occupational therapy, it would seem appropriate that these roles and research projects are reserved for those who best understand this work, both theoretically and practically, by having done it themselves.

The requirement for educational and training pathways, allowing for specialism in each of the four pillar areas, would perhaps be of use in ensuring that future research is based on *relevant* experience of peer support working, and/or lived experience of accessing peer support, as appropriate.

Concluding

This piece has examined a full route into, through and beyond a number of peer support based roles and attempted to draw parallels between existing fields of lived experience practice, research and academia; the size of the task ahead may seem ever more significant. Additionally, it is important to remember how deeply personal, emotive and intrinsically political this topic is for many.

Following the recent devastation of many user-led organisations (Disability News Service, 2017) the survivor movement may be justified in feeling systemically attacked, and the significance of these roles for the communities who originally fought for their existence cannot be underestimated. Furthermore, navigating conversation and debate and creating change are laden with the necessity of acknowledging difficult truths and, as Faulkner puts it 'the inconvenient complications of peer support' (Faulkner 2020). There is the necessity for movement and evolution on these roles to be undertaken in a way that feels respectful, trauma informed and as collaborative as possible for all involved.

Our field is currently missing out on valuable perspectives and voices at all levels which - with the appropriate routes and supports in place - could potentially change some of the most entrenched challenges related to consistently delivering high-quality mental health care for some of the most vulnerable individuals in our society.

Other roles we could mention include Patient Directors (perhaps better named Lived Experience Directors in the future?), which David Gilbert has written about in his book entitled *The Patient Revolution* (Gilbert 2020). We have not examined the role of commissioning, and other roles which might benefit from the perspective of professionalised lived experience within them: the list is endless…

If we can first establish the core pathway into the senior and autonomous roles of influence, arranged around the pillars of practice as recommended here, some level of equality with colleagues from other disciplines might be established. This alone could challenge stigma related to mental health problems (both in mental health services and beyond) in a far more powerful way than has been achieved so far, despite honourable efforts by individual activists, charities, and government bodies alike.

Finally, promoting the influence of lived experience practice will provide countless benefits for the efficacy and efficiency, and ultimately service users' experiences, of accessing care.

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Appendix

JOB DESCRIPTION

Job title	**Advanced Lived Experience Practitioner**
Division	**Jameson**
Team/Service	**Brent Mental Health Services SMT and Harrow Mental Health Services SMT**
Pay Band	**Band 6**
Hours	**37.5**
Terms and conditions	**In accordance with Agenda for Change**
Location	**Argo House, 180 Kilburn Park Road, London, NW6 5FA**
Reports to	**Trust wide Lived Experience Practice and Peer Support Lead**
Accountable to	**Trust wide Lived Experience Practice and Peer Support Lead & Brent and Harrow Senior Management Teams**
Liaises with	**Borough directors, service managers, team leaders, colleagues from multi-disciplinary groups, peer support workers and Senior Peer Support Workers, Recovery & Wellbeing College colleagues.**

Job summary:

Working across all of our community and inpatient mental health service sites in the local areas of Brent and Harrow, the role of the Inner London Advanced Lived Experience Practitioner will support the development and ongoing delivery of CNWL's Peer Support and Lived Experience Practice provision within Brent and Harrow.

Across these sites, the post holder will work to ensure Peer Support Worker (PSW) roles are created and undertaken in line with our trust wide policies and practices, and that PSWs and Senior PSWs are suitably supported with their work and that the Recovery agenda is maintained across sites.

The post holder will work with a number of service users with mental health problems currently being treated within local services, to undertake 1-1 lived experience specialist support or run a peer group to complement the work of the service.

In addition, the postholder will contribute as a leading stakeholder within the Recovery and Wellbeing College spokes and will be responsible for occasional delivery of Recovery and Wellbeing College courses.

Values Central and North West London NHS Trust expects the Trust wide Lived Experience Practitioner and Peer Support Lead to act in a way which shows an understanding of our

core values and is active in putting them into practice with service users, their friends, family and carers and also other staff members.

COMPASSION: contribution to a caring and kind environment and recognition that what you do and say can help to improve the lives of others.

RESPECT: acknowledge, respect and value diversity of each individual, recognition of uniqueness.

EMPOWERMENT: commitment to providing information, resources and support to help others make their own decisions and meet their own needs. The Trust endeavours to support all staff to enable them to develop and grow.

PARTNERSHIP: work closely with others and behave in a way that demonstrates understanding that commissioners and users of our services are the people who generate and fund our work.

Key Responsibilities

Central and North West London NHS Trust is committed to providing safe, effective services and providing those who use the services; and those who support them, with a positive experience.

1. Organisational work

1.1 To promote understanding of the principles and practice of the peer and lived experience practitioner roles across the boroughs of Brent and Harrow.

1.2 To meet regularly with Senior Peer Support Worker(s) for individual supervision (professional supervision and line management as delegated by manager).

1.3 To contribute to Boroughs Senior Management Team meetings, site based management meetings and locality wide meetings regarding peer working and lived experience practitioner roles and perspectives.

1.4 To contribute as a leading stakeholder to the local Recovery and Wellbeing College spoke. This will include attending and organising meetings to report on the feedback and delivery of Recovery and Wellbeing College snapshots across sites and regular liaison with the central Recovery and Wellbeing College team.

1.5 Contribute to service development meetings and across Brent and Harrow.

1.6 To coordinate and deliver Team Preparation sessions for teams in the process of recruiting a new Peer Support Worker or Lived Experience Practitioner.

1.7 To scope out and support teams to consider new peer worker roles within their skill mix, and co-run information sessions promoting the roles to external applicants, contribute to shortlisting, interviews or assessment centres and eventual induction of new staff.

1.8 To ensure all Peer Support Workers and Lived Experience Practitioners have a clear, up to date and expert offering to those they work with in regards to community resources to support recovery and social inclusion.

1.9 To propose policy or service changes for their own work area or beyond their own work area that contributes to cultures across Brent and Harrow that is therapeutic, productive, accessible, inclusive, flexible and responsive to service user's needs.

1.10 Promote positive understanding, awareness and attitudes towards mental health as part of day-to-day duties.

1.11 Participate in and actively contribute to Lived Experience Practitioner supervision, mandatory training and team meetings, and organisational events as required.

1.12 Ensure excellent communication and liaison with colleagues within the wider services of the Trust, being an agent for change and a champion of recovery in all interactions both within and outside the organisation.

1.13 Be committed to professional development through independent learning, keeping up to date with latest research and building connections with local and national peer networks.

1.14 Promote development of best practices in peer support and Lived Experience Practice across the service through active participation in internal and external training and development programmes.

2. Lived Experience Specialist Work and/or Group Work

2.1 Provide person centred, strengths based support, informed by experiential knowledge of 'lived experience' (direct personal experience of mental and emotional distress), supporting service users to maintain or regain a sense of agency and autonomy throughout contact with services.

2.2 Provide lived experience specialist support to service users to assist them in making sense of their experiences of mental and emotional distress. This might include understandings of personal and social recovery, health and wellbeing, personal and social identity whilst recognising that each individual's recovery is a distinctive and deeply personal process, and being highly sensitive to the service user's use of language and descriptions of experiences.

2.3 Deliver specialist 1-1 or group lived experience based work where appropriate. This may include working alongside service users in developing crisis, recovery and wellbeing plans, Advanced Decisions/Statements and personal network maps, peer groups on wards or within units and Recovery and Wellbeing College snapshot courses.

2.4 Contribute to care planning, support service users to prepare for CPA meetings (or equivalent) and medication review meetings.

2.5 Work in highly sensitive and complex situations, at times with people who are experiencing very high levels of distress.

2.6 To keep and maintain accurate, quality and up to date records (using the appropriate computer systems including systmOne.).

2.7 Respect integrity, confidentiality, clinical governance and data protection requirements in line with Trust policy.

2.8 Have responsibility for relevant safeguarding issues in relation to service users and their network, including making difficult decisions as a team adhering to the Trust's Safeguarding policy.

2.9 Engage in self-reflective practices and commit to continued personal development.

3. General Responsibilities

3.1 Work in accordance with CNWL's Trust Values, Aims and Objectives

3.2 To act as an ambassador for the Trust with external agencies and partner organisations

3.3 Work at all times to promote equality, diversity and individual human rights

3.4 Be efficient, responsible and maintain a high level of personal organisation; keeping accurate and appropriate records and providing information for monitoring and evaluation as required

3.5 To prioritise your own personal wellbeing, and to seek support if issues arise with work-life balance.

3.6 Work flexibly, being prepared to perform other duties commensurate with the role which may include new areas of operation following consultation.

3.7 Work alongside and ensure active service user and carer participation in all aspects of work including design, implementation and monitoring of activities.

4. Learning and development

4.1 To participate in Trust mandatory training & development opportunities considered appropriate to the Lived Experience Practitioner role and as identified in the Personal Development Plan (PDP).

4.2 To contribute and commit to undertaking an annual Development review/ Appraisal.

4.3 To receive regular line management supervision in addition to discipline specific supervision.

Supplementary Information

Job Flexibility

The post-holder will be required to work flexibly, providing assistance as and when necessary, which may involve them in a developing role.

Working Relationships

The working relationship between all members of staff should be mutually supportive, with staff deputising and covering for each other when appropriate.

Health and Safety

Central and North West London Mental Health NHS Trust has a Health and Safety Policy applicable to all employees. Employees must be aware of the responsibility placed on them under the Employment Rights Act 1996, to ensure that agreed safety procedures are carried out, and to maintain a safe environment for employees, patients and visitors.

Infection Control

The prevention and control of infection is the responsibility of everyone who is employed by Central and North West London Mental Health NHS Trust. Employees must be aware of infection control policies, procedures and the importance of protecting themselves and their clients in maintaining a clean and healthy environment.

Improving Working Lives

Central and North West London Mental Health NHS Trust is committed to the principles of Improving Working Lives and all managers are encouraged to follow Improving Working Lives practices. Consideration will be given to all requests for flexible working in line with Trust policy.

Staff Involvement

Central and North West London Mental Health NHS Trust is committed to involve staff at all levels in the development of the organisation.

Managers should ensure that staff are encouraged and involved in organisational and service developments including business planning and they are able to influence discussions, which affect them and their working conditions.

All managers should engender a culture of openness and inclusion so that staff feel free to contribute and voice concerns. They should develop and implement communication systems that ensure staff are well informed and have an opportunity to feedback their views.

Smoking

Central and North West London Mental Health NHS Trust acknowledges its responsibility to provide a safe, smoke free environment to its employees, patients and visitors. In expressing its commitment to the prevention of smoking related diseases, the Trust has a 'Non Smoking Policy' and all Trust buildings and vehicles are designated as smoke free areas.

Alcohol

Employees are expected to be aware of and understand that Central and North West London Mental Health NHS Trust has a policy on alcohol and the consumption of alcohol. Alcohol is not permitted whilst on duty.

Confidentiality

Employees should be aware that the Trust produces confidential information relating to patients, staff and commercial information. All employees have a responsibility for ensuring the security of information and to comply with the Data Protection Acts, Access to Health Records and Computer Misuse Act. Disclosure of personal, medical, commercial information, systems passwords or other confidential information to any unauthorised person or persons will be considered as gross misconduct and may lead to disciplinary action which may include dismissal.

Equal Opportunities

All employees of Central and North West London Mental Health NHS Trust are expected to be aware of, and adhere to, the provision of the Trust's Equal Opportunities Policy, and to carry out their associated duties and responsibilities under this policy. As users of the disability symbol, the Trust guarantees to interview all disabled applicants who meet the minimum essential criteria for a vacant post.

Grievances, Disputes, Disciplinary and Other Industrial Relations Procedures

Central and North West London Mental Health NHS Trust has grievance, disputes, disciplinary and other industrial relations procedures. Employees are required to make themselves aware of these procedures, copies of which are available on the Trustnet, from your manager and the Human Resource Directorate.

Personal Development

The post holder is expected to co-operate in activities which line management believes will contribute to personal and/or to team growth. This includes attending supervisory sessions and training modules, both at their work base and other selected venues of instruction.

Conflict of Interest

Employees are expected to declare any private 'interest or practice', which might conflict with their NHS employment, and be perceived to result in actual or potential financial or personal gain.

Working Time Regulations

The Working Time Regulations 1998 require that you should not work more than an average of 48 hours each week i.e. no more than 816 hours in a 17-week period. To work more than 48 hours you must have management authorisation and you will be required to sign an opt out agreement.

The Trust policy has a limit of 60 hours per week and all staff must ensure a 24 hour rest period is taken in every 7 days.

Conditions of Employment

The Trust will screen all staff who will be working with children and police checks will be carried out on all staff appointed to posts which have access to children.

This will also apply if role develops to include access to children.

Terms and Conditions

The terms and conditions of service associated with this position are those agreed by the Trust.

COMPASSION RESPECT EMPOWERMENT PARTNERSHIP

Central and North West London NHS
NHS Foundation Trust

PERSON SPECIFICATION: Advanced Lived Experience Practitioner

FACTORS	ESSENTIAL	*See key	DESIRABLE	
EDUCATION AND QUALIFICATIONS	• Completion of Peer Support Training • Undergraduate degree or able to demonstrate equivalent skills in research, writing or analysis • Evidence of continuing professional development	A	• Full UK Driving Licence and access to a vehicle • Mentorship or Clinical Supervision Training	A
PREVIOUS EXPERIENCE Paid/unpaid relevant to job.	• Lived experience of recovery from mental and emotional distress, and experience of using secondary care mental health services • Experience as a peer worker • Experience of delivering mentoring and/or supervision/appraisal • Experience of working with a range of organisations to support service users to reach their personal goals • Experience in using electronic patient records systems such as RiO, SystemOne or care notes • Experience of teaching and training or facilitating groupwork • Experience of relationship building and partnership working • Experience of public speaking • Liaising and working with colleagues from other disciplines.	A/I	• Involvement in service redesign and development. • Teaching Experience • Experience of policy development	A

FACTORS	ESSENTIAL	*See key	DESIRABLE	
SKILLS, KNOWLEDGE, ABILITIES	• Ability to demonstrate first person experiential knowledge of recovery at an expert level • Ability to demonstrate knowledge of the concept of personal recovery as it may apply to others • Awareness of the service user/ survivor movement and the history of Intentional Peer Support • Understanding of the issues and concerns of mental health service users • Knowledge and commitment to service users rights, involvement and service-user led initiatives • Understanding and practical knowledge of a variety of recovery approaches • Knowledge of Trauma Informed Practice • Demonstrable skills in effective leadership • Ability to take part in activities for improving quality • Ability to manage own workload, prioritise and seek creative solutions to • Understanding of the importance of equality and diversity. • Excellent communication skills (verbal and written) • Excellent interpersonal skills. • Excellent presentation skills • Ability to treat service users with respect and dignity at all times, adopting a culturally sensitive approach, which considers the needs of the whole person. • Ability to provide leadership and supervision to the team. • Ability to deal with pressure, prioritisation and delegation and meeting deadlines • Ability to work in accordance with Trust Policies and Procedures • Good IT skills • Thorough knowledge of social inclusion and the principles of recovery.	A/I	• Awareness of community resources and service user groups • Knowledge of current legislation which underpins Health and Social Care and a working knowledge of the Equalities Act 2010 and Human Rights Act	A/I

FACTORS	ESSENTIAL	*See key	DESIRABLE	
ATTITUDES, APTITUDES PERSONAL CHARACTERISTICS	• Ability to reflect sensitively on your personal experience of recovery to support others • Ability to identify and take steps to support own wellbeing through a personal Wellness Recovery • Develops others to grow their capacity and potential. • Exhibits and promotes respect for service users, families and carers, individual staff and teams. • Expresses and articulates ideas in a manner that is appropriate, accurate and easily understood. • Seeks to ensure the provision of a high quality service to service users, families and carers. • Coproduce service developments with service users, families and their carers • Enthusiasm for the Recovery agenda and peer working, an interest in a range of models of service delivery, and an ability to articulate the value added by peer working within the context of multi-disciplinary physical and mental health services.	I/P		
Other	Declared medically fit by the Occupational Health department to perform the duties of the post. Ability to travel across the Trust by public transport	A/ OTHER		

***Key:** Measured by **A** – Application form **I** – Interview **P** - Presentation