

The Future is Peer

Celebrating the Power of Peer Support

Information

Mel Ball, Director of Lived Experience for Midlands Partnership University NHS Foundation Trust, discusses the journey she has been on while working for her organisation and how England's landscape for peer support and lived experience has developed.

Mel Ball:

Thank you so much. And it's such a pleasure to be here. I'm so excited. Yeah. When I was invited, when Louise kindly invited me to join you for today's event, I was kind of pinching myself, to be honest. Yeah.

Don't usually share this, but I have family roots in this part of the world. To come to such a special place into a room full of incredible, enthusiastic, amazing people who think about this stuff maybe in a similar way to I do feels really special. So, thank you for such a warm welcome and for the invitation to join you.

What I'm going to speak a bit about today is some of the journey that the organisation I currently work for has been on, that's Midlands NHS University Foundation Trust, as Louise has said. We operate physical and mental health services as well as drug and alcohol services all over England, but we primarily deliver services within Staffordshire, Shropshire, Telford and Wrekin, so, as the name suggests, in the Midlands.

Nonetheless, the journey that we've been on actually is better put in a context.

So actually, the bigger piece of what I'm going to talk to you about today is the national journey and some of what we've done in terms of England's journey around peer support and lived experience.

I hope as, as Louise has indicated, maybe we' be useful food for thought in thinking about what the Scottish journey could look like, might look like.

How it looks differently in different parts of, you know, our United Kingdom, but also a few ideas of what we've developed and what's happened since some of the ideas I'm going to talk about today were first written in a thought piece which was commissioned by Health Education England a few years ago.

So just first off, to talk a bit about the context, I was chatting a couple of days ago with a friend of mine who verified all of this because she was there and doing it at NHS England back in 2018. There was an aspiration to really commit to hearing from users, as is regulation and legal commitment.

In terms of consultation, there wasn't at that point the full commitment to co-producing but consultation about the long-term plan for mental health, as it would be published in January of 2019, led to surprise, surprise, an outstanding voice calling for peer support in increasing numbers in the future of mental health service delivery. And committing to following through from that call led to not just user voice calling for

peer support, but other services that you might consider making the difference that makes the difference.

So more support around employment, which is a huge issue for lots of folks affected by mental health conditions, particularly in England, drug and alcohol support. So the feeling that people shouldn't be falling between the gap where drug and alcohol services wouldn't see folks because they have mental health issues and vice versa. Housing support and as I said, peer support as well as alternative ways of responding to crisis, which we know are often really steeped in peer support history, ways of working and often lived experience has a really dominant place and role to play in those service models.

Once all of the modelling had been done around what the implications of this new way of working in the long-term plan would be, they realised that the numbers didn't check out in terms of workforce.

So in other ways of saying it, there were too many nurses than the English universities were churning out nursing students who were moving into practice. And so there was, I would say, real bravery at that stage from the team who were looking at the NHS England plan and they reviewed what they had previously assumed would need to be done by a registered, traditionally trained healthcare practitioner and instead said, well that could be done by a peer and that could be done by peer and that could be done by a peer.

So they took an opportunity to do things differently, heard the user voice. And so what culminated in January of 2019 was a long-term plan for mental health which stipulated two big things: a commitment to

partnership working with the voluntary sector and a real big commitment for peer support.

There were more than two things, but those are the two big things that I was really interested in, if I'm honest. And not only did it say there needs to be more peer work, there needs to be more peer training, there needs to be greater partnership with the voluntary sector, but it actually set out numbers.

And so what we saw was that England was making a commitment to raising the number of peer workers who would be embedded and nestled in the heart of service delivery in mental health services just under 5,000 strong across England.

Not an insignificant number, perhaps not the brave kind of outstanding visionary place that we might want to get to next but that's another story and there were specific areas within mental health service delivery that the team had set out where peer support particularly needed to feature.

So perinatal mental health and thinking about what happens for families when a new little life arrives in the world. Maternal mental health loss services, so when that arrival perhaps doesn't go to plan. Gambling harm services, community mental health services, crisis alternatives and eating disorder services as well as homelessness were a few of the areas where the long-term plan for mental health said we need to see peer support.

People are clearly saying the voice of lived experience is a loss here and it's absolutely imperative that we build that in from this point of writing the strategy.

As I said, it also emphasised the importance of the third sector and it also made funds available for what they called "accelerating the development of the workforce".

Now for those of us, and I understand in Scotland, the picture is rich and there is lots of third sector peer support that's been around for a long time. That's true too in England to an extent, perhaps not the same extent, but for those of us that have been around peer support for a while, we might think, well hang on. "Accelerating the development": what does that mean? We've been doing this for a really long time. But one of the big things that this was a difference and a change maker around was that there would be funds available to really think about moving this work on and really starting to do some brave and bold things inside the NHS systems, which was a turning point. And so one of the things that was commissioned as a result of this work was a big task force. Lots of us were getting together from organisations all over England who'd been working around peer support for a while. And a piece of work that came out of that task force was that myself and a colleague I was working with regularly at the time, Sienna Skinner, were commissioned to write this thought piece which set out a career pathway for peer workers.

We were going to think about a framework, but actually we acknowledge that to get into a framework means to look at the agenda for change banding system that the NHS uses, the knowledge and skills framework, which is a matrix that underpins that system. It starts to get into university accreditation levels and usually all of these other traditional professional routes have a Royal College who's doing this work for them,

universities who train their practitioners. All of it quite neatly fits together within these large institutions. And we know that that's not peer support's history.

So we chose to call it a pathway to indicate choice, to indicate empowerment of local tethering into local practice, and to make an invitation of what would be useful by knitting things together that already existed, rather than trying to impose something that was kind of not like peer support should be. We did however say that the next thing that needed to happen after this piece of work was that there'd be lots of training and a full framework piece done in order to ensure that there wasn't unnecessary variation in the way that it worked out.

So I'm just going to talk through some of the headlines really that the thought piece tried to introduce some of the solutions and ideas that have come about as a result of lots of us getting together and the big piece of co-production that was done.

It's important to say everybody who was very much at the centre of helping us think about this thought piece were long-term peer workers. Myself, I started as an entry level peer worker in a therapeutic community longer ago than I care to share, but a good while ago and I've been involved in grassroots peer support since I was 17 years old. So I certainly write with that lens I have not gone and got trained in anything else along the way. That's no commentary on anybody that does, but I felt it was really important to retain that lens in my work and ensure that it wasn't mixed with another lens and another way of perhaps perceiving

some of this work. I've done my learning viral osmosis mostly. I haven't gone and got accredited in anything.

And so we sought out voices who had gone and got trained in other things that they felt were complementary to the peer lens, but that were very much informed by their peerness first and foremost. Others like myself who hadn't, and people who we've referred to as super allies who were consciously devolving their own power and actually thinking about how to stand out of the way of this developing when it was really needed.

So we started to think about what are the things that helpfully lead someone to peer working inside the system. It was important to say that the thought piece didn't try to give rules and regulations to folks doing grassroots work, community-based work, but actually started to think about how does this thrive within big NHS institutions primarily. We talked about the idea that service user involvement opportunities, co-production and seeing behind the curtain actually, for me, was really important. I was shocked when I came into services and realised what they were really like if I'm honest. And that's what that little Wizard of Oz picture is, really. It kind of reminded me I felt a bit like Dorothy when I first started to realise that nobody's looking after themselves. Everybody's running around kind of a bit chaotic, and things feel quite different when you're in the staff room than when you're in the waiting room.

We talked about the role of volunteering placements. The idea that actually moving into services and having an experience of what it's like to be there to support the service, or maybe even people in the service rather than yourself, is an important change to rehearse before you're in

a perhaps a paid employment opportunity for some. Though, it's important to say that lots of folks would come in at a latter point, perhaps have a few difficult learning journeys along the way, but actually do brilliantly within their work and give a huge valuable contribution to the field.

And so this model started to emerge. The idea that you might mix and match some of that top layer, the things in turquoise, some service user involvement, perhaps attending a recovery and wellbeing college, that you might access peer support for yourself and that you might also engage in training around peer work at that point. It would be a pick and mix and it certainly wouldn't be prescriptive. Those things might reliably allow you to move into volunteering, peer support work, befriending perhaps, which is maybe like peer work without so much of a demand or an expectation that you share your lived experience. Or that you might undertake a voluntary placement in a health context.

It might be that you go in, see how it feels to work there, again without that long-term commitment to paid employment. Perhaps the move away from any welfare benefits that some folks are in receipt of at the point where they come in to peer work and that next a combination of those things sometimes for some of the people would reliably lead to a successful move into paid employment at an entry level role within peer work, peer training and either within voluntary sector organisations that NHS organisations were commissioning, which happens quite a lot because of the commitment made in the long-term plan that I talked about earlier, or within the NHS itself.

We talk in the thought piece about what happens when you're both perhaps a service user or accessing a service in one part of your life, and working in, usually a different service, but nonetheless a service in another. What happens when those things are quite close to each other geographically?

It might be that you live in a part of the world where actually the services are quite remote and the closest work and place to access a service is one building.

What about when the learning opportunities aren't steeped in what we know about survivor politics, about experience being key, what happens when you're constantly having to translate ways of working or models which aren't suited to our particular approach to the work.

We address the notion that peer support workers, we would say, need to have tangibly relevant lived experience for the context they're working in. So that sounds a bit lofty, but to put it really plainly, I haven't experienced being in a forensic mental health service. My colleagues who have do a better job of being authentic peers in those services than I ever could be. I'm happy to say that that's a point where I need to get out of the way and empower somebody else to take up that spot.

But opinions on that sometimes differ. And is it arguable to say that sometimes having something rather than nothing is preferable?

Some of the folks in some of the services would say actually having somebody who shares my sexual orientation, my cultural, ethnic background, my way of viewing the world in terms of my spiritual life or identity is more important than the service access. So it's complex stuff. It

can't just be encapsulated and you need to have lived like me in terms of the health journey I've had.

And so we talked about this idea that, actually for easier to ignore populations, you know, for folks who might have experienced marginalisation, racialised experience of services, sometimes thinking about culture, and all the things that culture can be for people, might be more appropriate than that service access being exactly identical.

So, once we've moved on from that entry level role, we might have done this pick and mix, as identified at the top of this diagram, and moved into the orange. Next, what's emerged in England, certainly is, and I think also in places in Scotland from what I understand, is senior peer working. So the idea that we have a really valuable offering of lived experience supervision to give that we can support each other's professional development. That we're able to retain that clarity of purpose when we talk with each other in a particular way that we might call supervision. That we reflect together and that we embed reflective practice in the way that we do our jobs.

And of course, it's important to say that the recovery and wellbeing colleges, as I would often say, and I feel having led a couple of colleges myself over the years, a real hub of where this stuff belongs.

At home sometimes in some organisations, in some places, we need to think about the peer training journey as well, not only because actually recovery education and being alongside each other in learning environments is a really valuable, credible, important aspect of the way this stuff works, but also because the recovery and wellbeing colleges, as

I say, can provide a home if we're considering a model of doing peer work where we cascade it into the services that already exist elsewhere. People need to have somewhere where they feel they can come home to, I would say. And certainly I would suggest that where our CPPD exists as peer workers is often recovery colleges. And that's indicated with that pink arrow down the side.

So we acknowledged as a working group that actually it's not just about professional development, it's not just about going on some trauma informed training and maybe learning about shared decision-making and maybe understanding co-production. It's about living it on a personal level, having an ongoing recovery journey that you are thinking about within your work. Not because you have to necessarily stay vigilant that it's always tip-top, because it's not about that, but actually just because it's a tool that you want to keep fresh and keep engaged within your wheelhouse of tools available as a peer worker. Otherwise, perhaps you're becoming something else.

That something else might be valuable, it might be really good at what it does.

But is it maybe peer work if we're not thinking about our recovery as the bedrock of what we do? I'm using the word recovery, but we also acknowledge in the thought piece people use different language to describe the thing that makes them like each other.

We also acknowledge that, over the years, and particularly in the wake of there being no other option, lots of people have left either an entry level or a senior level to go and engage in other forms of employment. A lot of

people have gone into traditional mental health practitioner training. That might be nursing, occupational therapy, psychology, and we wanted to acknowledge that that's a departure. So it's an amazing thing for those fields. Sometimes it's a brilliant thing for peer work as well to have allies who are flying the flag from within another space, but actually it's not the same as progression in a straightforward manner.

So if you're an occupational therapy assistant and you go and do your mental health nursing training, you've moved professional routes. You've still progressed, it's amazing for you, and we would certainly wish you luck. And I've supported lots of my colleagues over the years to make that transition. I wish them well and I'm happy to support them in every step of their journey. But I have to acknowledge that it's not a straightforward movement and growth upwards in terms of their career trajectory.

And for a long time that was debated I think. There was a sense that you graduate from peer work into what, proper work? I would say no, definitely not. And why is that? Well lived experience stops being the primary lens that informs the work.

And it's important for me to credit Tamar Jeynes who illustrated this bottom diagram and talked about the ceiling of peer work prior to myself, her and another colleague of ours, Fiona Sterling, undertaking some work around a glass ceiling that we could see within peer work at the time.

And the fact that people were left with very little choice. It was either fall in line and start to become like what else is out there or face the fact that you can't progress. And I refuse to accept that and I'm grateful that I did

because thankfully, toughing it out has kind of led to me getting to do some of the amazing work I've been able to do in the last few years.

But we have to acknowledge when people move into these other roles, there will be clashes and some of those clashes will be significant ideological ones, like coercive treatment, like having to think about making difficult choices on behalf of somebody in their best interests.

Also, we know that stigma within those roles can sometimes be a really, really difficult force to reckon with and actually, assimilation is often one of the key, I would say key facets of a lot of this mental health practitioner training. They take people from being a person to being a member of a professional group and there is some required knocking off of some sharp edges along the journey for most people that go through those experiences of training.

Now does peer work perhaps have a way of accepting some more of those edges so that there is more room for diverse shapes?

Maybe, maybe that's the case, and it's important to say as well that often with people I spoke to who made that move, it was what was available at the time for them to progress and there's no shame in people wanting to move on with their lives, follow their dreams, fulfil their potential and aspirations.

But there was often a financial constraint, particularly to people staying for long periods of time in entry level work or senior peer support work, which kind of provoked them to think about options beyond.

So when we started to think about what could go beyond peer support work, and this is where I would say it starts to get really exciting because

this is what we've started to develop big time in England. And the organisation I currently work for, as well as the organisation that I was working at the time where we wrote a lot of this work, we acknowledged that for all the other professional groups that are working in health, four pillars of practice basically define what you do after a certain level of getting to know your craft.

So you either do things really well clinically and, alongside people, you deliver interventions at a really high standard, or you professionally lead and you think about the development of your workforce, people coming into it, people progressing, the different ways that it needs to lead the agenda in relation to what you do. You either teach and you think about how to develop other people, or you research and you develop the evidence based around your profession and what they do and how they do it and hopefully how well they do it.

And so we acknowledge that when we looked at these four pillars of practice, actually they weren't as out of step with a lot of what we've seen in the user survivor peer movement for a long time as they might have been. And even more brilliantly, they correlated beautifully with the work of Jan Wallcraft in 2003, who wrote a Sainsbury Centre for Mental Health paper noting what the survivor movement did.

Now this is important I would say, because at this point in history, the survivor user movement had not been decimated by austerity the way that I would say it has been today by the current government. Certainly in terms of England, a lot of our user and survivor movement organisations

no longer exist because of the constraints on funding that have been available in the last while.

At this point in history we can see the movement in a much more healthy place financially, being able to really fulfil its desire to get active and do what it could do. And funnily enough, they're doing the thing. They're researching the thing, they're changing the system so that it gets better, and they're teaching other people to do it.

There's also work around campaigning and advocacy and creative work which feels important to honour, but there wasn't as much of that as there was of other things. And in addition, some of what we've seen in Australia in terms of the Queensland framework developed in 2017, also acknowledged the role of leadership, the role of roles which went beyond an entry level of delivering services. That there was ways in which lived experience could be powerful, impactful and directly progress from peer work.

And so what we started to work out was that actually we could have four pillars of practice in relation to peer work from just noting and mapping what we'd already been doing for quite a long time.

Jan's work said in 2003 over the next 50 years we want to see survivor users leading the way and employed in mental health services commonly. And it also talks about the idea of integration of prevention, self-management, recovery and social inclusion for all services. And we felt like maybe we were at a turning point where we could start to really organise some of those aspirations. And so what develops next after

senior peer support work are advanced lived experience practitioners. So the people doing the do.

Peer support and lived experience professional leads, lived experience educators, where they're based in wellbeing and recovery college context or in other spaces thinking about how to infuse peer ideas, survivor politics, user ways of thinking and doing into other educational programmes such as maybe some of those traditional mental health practitioner trainings.

And finally the research and development of it, lived experience researchers who might also be referred to as survivor user and peer researchers and acknowledging that actually for those folks, often their journey hasn't necessarily come through peer support work and that there's a whole annex if you like, a pathway and a route into researching this stuff in a different way than what other researchers will do, that often comes from places like social anthropology or medical anthropology or philosophy. All sorts of routes in that are more about an academia that flourishes into something that thinks about the self.

So finally I could go on for ages about what all of these things look like, but I would really welcome you to have a look at what's going on beyond the border.

There are NHS organisations in England who've taken some of these ideas, made them their own, developed them, but I think we're starting to see a really interesting assortment of these roles developing around these broad brushstrokes. That's not to say that we developed it and then people filled in the gaps. I think it's designed, and I hope it's designed, to

capture all that we do in a way that unites us and brings that unity that I think we're going to be stronger in having. We need to remember that collaboration is imperative.

So again the devastation and the systemic kind of breakdown of the user-led organisations and the grassroots activism, particularly in England around this, means that having these conversations needs to feel sensitive. And it was really important to me as somebody who'd worked for a user-led organisation in the third sector and a lot of time in the NHS, that actually the NHS didn't try and take peer support and make it its own. That we acknowledged and honoured something very ancient, something very special and something that belongs to our communities that was already happening in a super powerful way, that the NHS could respectfully and with humility think about including within what it tries to do better tomorrow in order to acknowledge the pains of today and yesterday.

Obviously since then and what the thought piece nods to is more lived experience directors would be great and I feel very lucky to be in the first role nationally, as far as I understand, that works at a board level. So I support the rest of the executive team and the non-executive directors with the direction of travel in my organisation. But also lived experience commissioning I think is happening more often than we know. It's not a particularly attractive job for a lot of people, commissioning, and yet when I dig under the surface a bit, I realise the folks who are trying to help us decide how we spend taxpayers' money to organise really good

services sometimes have skin in the game from their own personal lived experiences.

And we question, and I would question again, do we need a body that brings this together, that helps to self-organise and think about advocating on behalf of ourselves as a community? Are we in a place now where we can recognise lived experience leadership is growing in its popularity, in its reach, in its breadth and its power and potential and potency?

And, and so maybe there's something about us coming together and having a body which really recognises the contribution that we're making to the development of services tomorrow.

And finally, just to say what happened next, once we'd embedded some of the long-term plan, well actually what we're seeing now is that our inpatient services, which I'm sure lots of you will know have unfortunately been the real focus of a number of necessary, sadly necessary documentaries and in the last few years, are really starting to be thought about differently and there is a real commitment to not only co-producing but also lived experience leadership within the design of a couple what's called a culture of care programme for acute inpatient mental health services initially, but then thinking about expanding that into other inpatient environments and what we're seeing within the aspirational documents.

And I've just put a little screen grab there because they're quite new and we're just mobilising this now in England, is a commitment to lived experience directors, a commitment to patient safety partners who will

systemically think with organisations about how to ensure safety incidents don't happen over and over again and with the same tragic results at times, but also that there is infrastructure that lived experience supervision is championed.

And that final sentence I think is brilliant, is that NHS England have put in black and white: "we value the distinctiveness of the peer role in relation to inpatient mental health service delivery". Somebody that had traumatic experiences and services and sadly lost my best friend in a medium secure unit. I feel so grateful to see that written down. It actually makes me emotional when I think about it.

So I think we are not getting it right all the time for all the people. That is a problem. But we are moving, we're doing good things. I think. And I would absolutely love to support anywhere in the world where we can share and mutually and understand what's the strength of what each other are doing.

Tap into, tap into those and share it in order to extend the reach of this outwards because I think the future is peer as it said in today's event.

So thank you for listening. Really happy to answer any questions. I'll be here all day. Thank you.

Ends

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