Peer Support in Secure Services

Final Report

Clare Shaw

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Acknowledgements:

Sincere thanks are due to each person and every service who helped to make this report happen:

- All members of the Forensic Partnership, including St Andrews, Priory Group, Emergence, National Survivor Network for Mental Health, Department of Health, West London NHS Mental Health Trust, Nottinghamshire NHS Mental Health Trust, Mental Health Foundation, Avon and Wiltshire NHS Foundation Trust
- The National Survivor User Network for Mental Health (NSUN) who have part funded this work
- The services who hosted scoping workshops: St Andrews, Northampton; Arnold Lodge; Thornford Park; and Fromeside.
- The staff who supported the project by supporting scoping workshops; taking part in telephone interviews; distributing questionnaires to patients; and filling in staff questionnaires
- Elinor Joyce and Elina Stamou for providing support and guidance

Most importantly, a sincere thanks to all the patients who took part in scoping workshops, questionnaires and surveys.

1. Introduction

This consultation has been undertaken by Together: for mental wellbeing. Together is a national mental health charity working alongside people with mental health issues on their journey towards independent and fulfilling lives. The Service User Involvement Directorate (SUID) at Together are trusted leaders in service user involvement, leadership and peer support who develop and support innovation in these areas.

SUID has brought together key national partners across the country to establish a Forensic Partnership that is made up of forensic mental health services. The Forensic Partnership have commissioned this piece of work and been key in enabling it to take place.

It should be noted from the outset that as the majority of people using secure mental health services prefer to be known as 'patients' rather than 'service users', this language is reflected throughout the majority of the report.

The report draws from an evidence base which demonstrates that peer support can be invaluable to those who experience distress. It is also based on a recognition that - whilst there exists a wealth of evidence to support the value of peer support in community and acute mental health settings - a striking lack of attention has been paid to peer support in secure settings; and it aims to address this gap in the evidence base.

- It presents evidence from staff and patients in secure services about their understanding, experience and opinions on the issue of peer support.
- It draws from the existing literature on peer support in mental health services and other relevant contexts.
- It highlights the values and benefits of peer support of peer support for mental health; as well as obstacles and concerns.
- Using the evidence gathered directly from patients and staff in secure mental health settings, it identifies examples of current peer support in practice.
- It considers the specific benefits, difficulties and concerns facing peer support in a secure mental health setting.
- It draws from patients and staff - as well as the existing evidence base - to consider how these challenges may be met.
- It makes recommendations for best practice and for further research.

In short, it follows this evolving story as it turns the page into the next chapter - peer support in secure mental health services.

2. Peer support - the context

Mental health service provision is a constantly changing landscape. Concepts and practices that were unfamiliar just a few years ago are now an increasingly accepted part of how services operate. Until relatively recently, many people were unfamiliar with the term "peer support". Now it is becoming a significant aspect of mental health care provision; its practice is widespread; and its benefits widely acknowledged.

“Peer support is an invaluable tool in the armoury of coping skills” (CL8)

“I can get help from other people who are in the same boat” (M3)

But the history of peer support in mental health did not begin with its recent emergence onto the mainstream agenda. It predates the mental health survivor movement of the 1970s, and the foundation of international networks of peer support and activism like the Hearing Voices Network and the Bipolar Organisation in the 1980s. It extends beyond the formation of Alcoholics Anonymous in the 1930s, and the subsequent foundation of over 115, 000 peer support groups across the world (General Service Office 2014). It reaches way back to the earliest asylums (Porter 1987; Pussin, 1793) - and still further.

It's a safe and happy assumption that as long as humanity has existed, human beings have helped each other out. In times of struggle, one of our primary instincts is not only to seek help and companionship, but also to offer it. The mutual support offered by people who use experience mental distress and/or use mental health services is one example of this.

"when someone has sent an awful long time being misunderstood in the mental health system, Peer support is like a breath of fresh air and can be lifesaving"(Peer Support Worker,Peer2Peer member).

"Peer support appears to be a particularly popular buzz word in mental health circles at the current time. But what exactly do we mean by it?" (Lawton-Smith 2013)

Taking into account ongoing discussions about the nature of peer support, this project worked from this simple description: *"peer support is the support that people with lived experience of mental health problems can offer each other" (Together "Peer Support in Secure Services" Patient and Staff survey).*

2.1 Types of peer support

This support may be practical or emotional; and it varies between contexts, situations and individuals. Peer support in mental health exists in many different forms. Broadly, these can be organised into three categories (eg Broadstreet 2006; Lawton-Smith 2013):

1. informal, naturally-occurring support: for example, the friendships and day-to-day social contact that occur between patients.

2. organised, intentional and unpaid: for example, AA support groups

3. formal and paid: for example, Peer Support Workers employed by an organisation to provide a service.

It is worth noting than in reality, peer support does not always fit neatly into these three categories (Faulkner and Kalathil 2012).

2.2 Value of peer support

All of these forms of peer support are valuable; and there is a large evidence base to support them. The benefits of peer support in mental health may be summarised as:

- increased wellbeing/greater rates of recovery

- a sense of self-esteem, independence, equality, mutuality and empowerment.

- acceptance, solidarity, empathy and understanding

- companionship and improved social functioning

- reducing stigma and isolation

- decreased use of services

- hopefulness; a focus on strengths and potential

(eg Basett et 2010; Repper and Carter 2010; Lawton-Smith 2013)

Benefits are also experienced by staff - in terms of a reduced workload (Mowbray et el 1998) and improved communication with patients (Chinman et al 2006); and by wider society, in the form of reduced reliance on services and consequent reductions in health care spending (eg Rinaldi 2009, Basset et al 2010).

2.3 Legislative framework

Since the National Service Framework (Department of Health 1999) - which advocated patient and carer involvement in the planning and delivery of services- peer support has been closely aligned with government policies of personalisation and choice, mental health recovery and self-care/self-management. "Putting People First" (Department of Health 2010) recognises that *"the availability of effective peer support is essential in the transformation of adult social care and in enabling people using services to have greater choice and control"*; and the English (2011), Scottish (2012) and Welsh Mental Health Strategies (2012) each recognise the positive potential of peer support.

NICE(National Institute for Clinical Excellence) guidelines, briefing and scoping papers recognise the potential benefits of peer support for a range of mental health problems including anxiety, bipolar disorder, Borderline Personality Disorder, self-injury, post-natal depression and depression in long term physical health problems. Most recently, NICE guidelines for the Treatment and Management of Psychosis and Schizophrenia in adults (2014) advocates peer support; whilst recognising a relative lack of evidence; and recommending further research in the impact of peer support for people experiencing psychosis. Whilst NICE (2011) advise commissioners to consider peer support and self-help groups (amongst other interventions) for people with mild, moderate and severe mental health disorders; guidance for the treatment of patients with complex mental health conditions tends to focus on specialist treatment, medication and other forms of exclusively professional support. However, the Joint Commissioning Panel for Mental Health (Royal College of Psychiatrists and Royal College of Practitioners) support peer support as part of the rehabilitation process for people with complex mental health needs, a significant proportion of whom have used secure services.

2.4 Peer support in secure settings

A small evidence base also focuses on peer support in prison settings - most notably, Listeners schemes in prisons , which were established by the Samaritans and the prison service with the aim of reducing levels of self-harm and suicide in prisons. Published evidence on the role of Listeners shows benefits for those offering and receiving support, as well as for staff and the service. Research also points to some of the problems facing this scheme, notably the challenge of confidentiality in a prison setting, plus residual difficulties with staff attitudes (Foster 2011).

The evidence base for peer support in secure mental health services, however, is largely absent, and secure mental health services are rarely mentioned in existing literature on peer support. The policy context for secure services is also limited.

Why? It might be speculated that this absence is because peer support is self-evidently unsuited to the secure forensic environment. Levels of physical and emotional risk are especially high in secure services; and many patients experience mental health issues which may impact on their perceived ability to offer support. As well as the care and support of people in their care, services are concerned with the management of risk, and the environment is restrictive. Transferable evidence from criminal justice settings also suggest other obstacles including: staff attitudes; confidentiality; and a lack of skills and confidence amongst patients (eg Foster 2011).

However, as this report will go on to describe, one of the most outstanding findings of this research is the level of commitment to what is seen as peer support amongst both staff and patients. The report also maps a wide variety of forms of peer support taking place in secure services across the UK.

In fact, it could be argued that peer support is particularly relevant to the secure setting: patients, after all, live on a full time basis with their peers for long periods of time. With the higher levels of resourcing attracted by secure settings; and with secure environments as a highly managed, highly structured environment with fewer variables than community services; there is arguably great potential for secure services to actively facilitate peer support. In addition, there is increased potential for more stable, long term relationships between patients than in acute or community settings. It may also be speculated that the benefits associated with peer support may be particularly relevant and valuable in a secure context: for example, the role of peer support in countering stigma and promoting social functioning (Mowbray et al 2007); and in offering the secure patient the chance to experience themselves as *"a valued and contributing citizen"* (Hutchinson et al 20060

2.5 Challenges facing peer support

Whilst there is a strong evidence base for peer support in mental health services, literature still reflects a number of significant challenges and ongoing debates. These include:

- the tension between authentic, naturally-occurring peer support; and formal peer support

Mutuality and equality are a crucial aspect of peer support: based on shared experiences, a shared identity, and an absence of formal hierarchy: *"peer support means receiving support and understanding from someone who's equal, had similar (not necessarily the same) experiences and insight"* (Peer2Peer Steering Group).

As services recognised the benefits of peer support and invested in its provision, so a gradual formalisation of peer support has often been observed (Repper and Carter 2010; Falkner and Basset 2010). The understanding of peer support shifted from self-directed, reciprocal relationships of emotional and practical support taking place between equals, towards a more professionalised model of peer support workers and professionally facilitated groups. For some, this represents a drift from the historical roots and essential principles and values of peer support; and may lose or compromise some of its unique benefits; specifically, the equality and mutuality at the heart of peer support *"I fear that we might lose that togetherness, if we go down the route of formalising peer support".* For others, it represents a valuable opportunity: *"formalisation validates the service that's offered. It becomes a more effective service" (Faulkner and Basset 2010)*.

- the challenge of changing an entrenched risk-averse and top-heavy culture in mental health services to one which is more supportive of peer support .

Closely allied to this is the challenge of addressing staff and patient expectations and attitudes which have been shaped by this culture (Repper and Carter 2010)

- the challenge of facilitating and promoting peer support in a context of reduced resources (Lawton-Smith 2013)

These challenges may be particularly prominent in a secure setting; alongside challenges which are specific to the secure setting including:

- the lack of evidence specific to the secure context

- the impact of secure restrictions on interpersonal relationships, expectations, attitudes and peer support.

3. Consultation methods

3.1 Choosing our methodology

"user involvement in research is not just about making the interview questions more user friendly to the research participants (though this is an area where evidence does support the advantage of involving patients); it is also about questioning some of the philosophical foundations for the research itself" (Faulkner 2005).

Traditionally, mental health literature was written by academics and researchers, resting on the assumption that objective, scientific, professional accounts have more validity than the accounts offered by mental health patients . Both within literature and services, the voices of people who experience mental health issues have been systematically sidelined and disregarded. This has been particularly true for those people who use and live within secure mental health services. *“I was brought up to believe volumes of very strange ideas, one being that no-one was interested in anything I had to say, ever” (Bressington 2004:14).*

Alongside other progressive social movements - such as the feminist and Civil Rights movement - the mental health survivor movement challenged this marginalisation (REF). Instead, it was argued that experience is not only a valid source of knowledge, it also offers a unique insight into the issues at hand (Faulkner and Morris 2005). This approach - accepting lived experience of mental distress as a powerful form of knowledge - is at the core of recent changes in mental health service delivery, and at the very heart of Peer Support.

For these reasons, it was important to us to place people with personal experience of mental distress at the centre of the report. We wanted to maximise our opportunities to listen to and represent directly the voices of people in secure services.

"Patients just “get” it, all that complexity – they can just sit with this big, mixed complicated thing. They are experts on being in medium secure services" (Occupational Therapist: F1).

Qualitative, descriptive data, with its capacity to reflect personal accounts and opinions with their nuances and emotions, plays an essential role in the research. But we also recognised that it was equally important to generate larger scale numerical data from which more general conclusions could be drawn.

It was central to the aims of the research was that it was carried out by people with personal experience of mental distress. Informed by the values of participatory research - *"Nothing about us without us" (Advocate, AL1)* - the Forensic Group took the important decision to recruit a researcher and workshop facilitator with personal experience of mental health issues, mental health services, and peer support. Both draw directly from personal experience of mental health difficulties; and from giving and receiving peer support in community and acute setting.

Throughout the report, the term "patients" is used. The scoping workshops also gave us an opportunity to consult with participants about their preferred terminology. The majority of participants expressed a preference for "patient", as they felt it most accurately described

their status within secure health care. Consequently, the report uses this term - alongside "peer".

The research process.

Stage 1: Patient experiences

3.2 Scoping workshops and questionnaires

In October and November 2013, Elinor Joyce and Clare Shaw conducted a series of 6 scoping workshops in 4 pilot sites across England. Information about pilot sites is recorded in Appendix I. The scoping workshops aimed to gather initial ideas about how patients within secure services understand peer support; and how peer support is experienced throughout the journey through secure services.

Workshops were supported by a brief questionnaire which were distributed prior to the workshops; they were designed to reflect the opinions and experiences of those patients who were unable or who preferred not to attend the workshops (Appendix II).

Information gathered through the workshops and questionnaires was used as the basis for the survey which was then rolled out to services across the UK. Opinions, thoughts and experiences shared in the workshops guided the issues addressed in the survey. Information shared with by participants shaped our understanding of the significant points in their journeys through secure services, which in turn shaped survey questions. Direct quotations from scoping workshop participants were used to explain and illustrate questions. This ensured that the consultation reflected the experiences, concerns and priorities of patients, not only in its findings and conclusions, but from the very outset in its structure and its questions. We also aimed to provide an opportunity for face-to- face interaction and discussion, enabling a deeper exploration of the issues addressed and a more direct representation of patients' voices.

The project initially focussed on medium secure services. However, as the project evolved, it was recognised that there is considerable movement between levels of security. A typical journey through secure services will often involve movement between services of high, medium and low security; through to rehabilitation. For this reason, it was decided to widen the scope of the research to include all forensic services, including specialist services such as brain injury and learning disability.

Workshops were designed to encouraged the active participation of patients. However, given the secure context of the consultation, it was necessary for staff to attend workshops. Some staff took an active part in discussions, whilst other staff chose not to participate.

Whilst attendance at the workshops was variable - from 3-8 participants - they nonetheless formed a crucial foundation for the research; both in terms of the data they provided; and in terms of the personal connections they enabled. Participation was lively, and the workshop format allowed for an exchange of ideas, experiences and information between patients, staff and workshop facilitators. This personal interaction allowed exploration of some of the complex issues on hand.

Feedback also indicates that the workshops were also a positive experience for participants. Patient feedback included the following observations:

"Well presented, relaxed, informative";

"enlightening"

"excellent. Informative and interesting. It gave me a new idea of peer support".

"Good discussions. Insightful. Relevant".

whilst staff members reflected:

“you guys coming here was a brilliant event – it made us really inspired about getting involved – the patients really liked how you were and really valued that you shared your story, especially the women” (OT, F1).

It was a "brilliant event" for the researchers too: an invaluable opportunity to visit the services; to witness the variety of contexts in which our peers are living; to hear first hand about their experiences, opinions and ideas; to share our own stories; and to meet with and witness the work of staff. This personal connection with the people and services involved in the research deepened our understanding and our sense of commitment to the issues we were addressing, as well as our respect for, and our sense of connection with, our peers in secure services.

3.3 Workshop summary

Whilst there were significant differences between sites, there were also shared themes which may be summarised as:

- an overall commitment to peer support in secure services (*“other patients understand me. They know what I’m going through”*); which was limited by:
- service restrictions which differ drastically within services, including

    fears and concerns about the nature of peer support (*“they’re sick and that’s that”*)

    a lack of organisational – and personal – resources, including skills, motivation and confidence. (“*you might say the wrong thing and make it worse”*)

- different understandings of peer support: eg

    informal/ unintentional versus formal/ intentional

    relational versus informational

- the different roles played by peer support at different points through the journey through services.

These themes informed the surveys, which were then distributed via the Forensic Partnership to services across the UK. findings are presented below, alongside more detailed information and feedback from the scoping workshops.

3.4 Patient surveys.

Following the scoping workshops, the patient survey was constructed on the basis of the information, experiences and opinions that patients had shared with us. The surveys also included direct quotes from workshop participants, intended to make questions more accessible and relevant, and to encourage participation in the research. The survey can be seen in full in Appendix III.

The survey aimed to identify whether patients in secure services see a role for peer support; what they specifically value about peer support; to identify barriers and concerns; and how these might be addressed.

Via the forensic collaboration group, the survey was cascaded to services throughout the UK. Completed surveys were received from 213 respondents in 29 different services. The names of these services are listed in Appendix IV.

Stage 2: Staff experiences

3.5 Staff interviews

The value of lived experience is not limited to those who use secure services. It was also felt to be important that the research represents the experiences and opinions of staff working in secure services.

Staff have a practice-based experience of services, and hold a particular form of practice-based knowledge. They hold unique insights into context, conditions of work, the limits of the service, service and cultural changes. Where staff experiences are presented alongside patient experience, the shared themes and significant differences that may emerge offer a third layer of knowledge and insight. Finally, in a setting - like secure services - where power imbalances are particularly acute, staff attitudes, opinions and feelings are likely to impact on the provision and availability of peer support - both formal and informal - amongst patients.

Given the importance of the scoping workshops in Stage 1 of the research, it was therefore decided that Stage 2 of the research should also involve an opportunity to explore staff attitudes, opinions and experiences in conversation with the researcher. In April 2014, a request was sent out through the Forensic Partnership for members of staff to take part in a telephone interview on the issue of peer support.

Twelve members of staff from different services responded to this request; and interviews were arranged throughout May and June. Seven interviews were eventually completed and transcribed with staff from the four pilot sites represented in Stage 1. Roles represented within these interviews included: Occupational Therapist; Advocate; Consultant Psychiatrist and Recovery Lead; Clinical Director and Head of Clinical Services.

Interviews loosely addressed questions raised within the survey; with more opportunity to explore any issues raised. Interviews ranged in length from 20 to 55 minutes. Information from these interviews forms an important part of the research findings, presented from page 23.

3.6 Staff surveys

The patient survey aimed to identify whether patients in secure services see a role for peer support; what they specifically value about peer support; to identify barriers and concerns; and how these might be addressed. The staff survey followed this format, in order to enable a closer comparison of staff and patient perspectives.

In April 2014, the survey (seen in full in Appendix V) was distributed to staff throughout the UK. 54 surveys were completed by staff in 24 services .

3.7 Limitations of the consultation

Workshops were designed to encouraged the active participation of patients. However, given the secure context of the consultation, it was necessary for staff to attend workshops. Some staff took an active part in discussions, whilst other staff chose not to participate. This is likely to have impacted on the information shared by patients.

No information was gathered on the demography of those who attended the workshops: neither was a record kept of how many staff were in attendance.

The survey offered two gender options - male and female - however, one respondent disclosed the fact that they were intersex; and two workshop participants identified as transgender. The failure to include a wider choice of gender identity options was an oversight which should be corrected in future research.

Whilst the question asked for the length of time respondents had been in their current service, they were not asked how long they had spent in secure services in total. Several responses indicated that the question had been read in this way. *"34 years, on and off"* (CL:1), which means that results are unclear. Future research should distinguish between how long patients have spent in their current service; and how long they have spent in secure services overall.

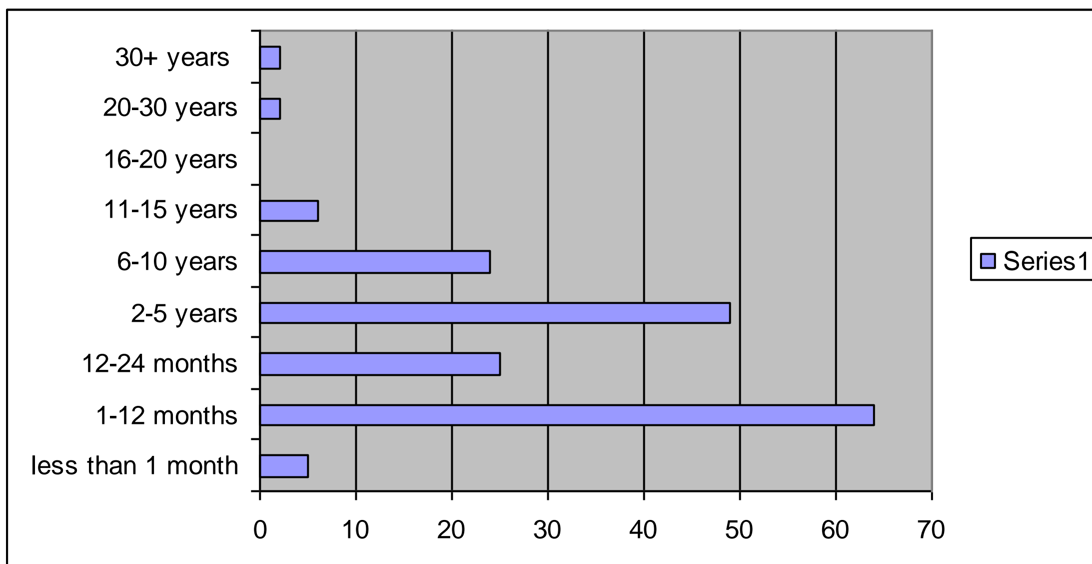
4. Demographics: who took part?

4.1 Stage 1: patient survey

Respondents represented 29 services across the UK. 31% of respondents came from medium secure services and 61% from low secure services. Specialist Brain Injury, Adolescent; Deaf; and Aspergers' services were also represented, along with an enhanced medium security service.

The scale of response to the survey was unexpected; and in itself gave insight into the level of interest and commitment amongst the patient group; as well as the support offered by services. 213 respondents from 29 different services completed a 7 page questionnaire; their feedback was thoughtful and considered, with often lengthy explanations and examples. Some were completed on Christmas Day, New Years Day – at sometimes crucial, often challenging times in the lives of peers in secure services. As such this initial research project is underpinned by a sense of privilege in being able to partake in the insights and experiences so generously offered by those living in secure services.

1. How long have you been in this service? - number of patients.

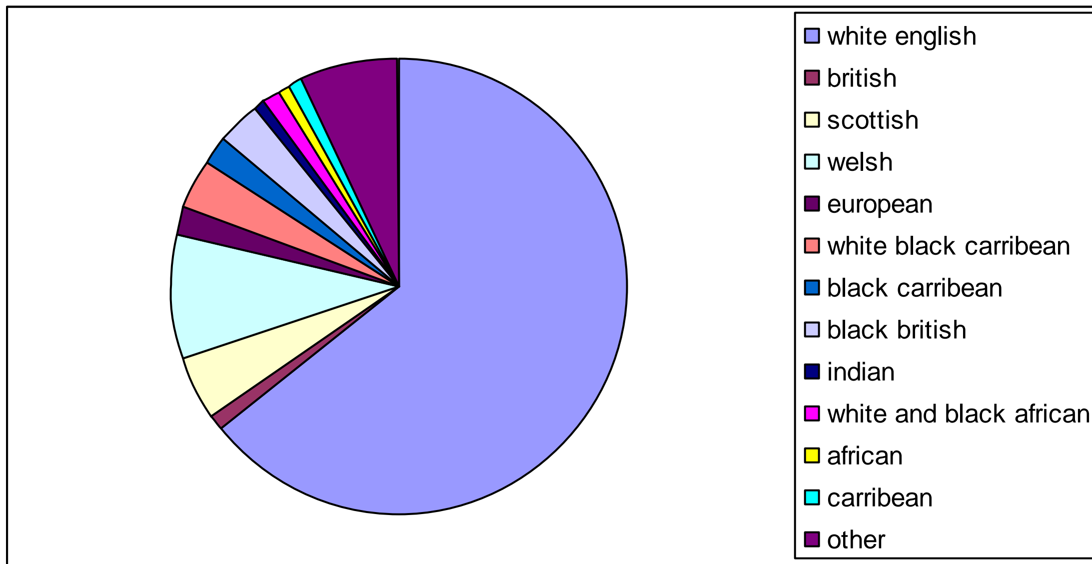


Respondents reported that they had spent anywhere from 2 weeks up to 34 years in their current service. 42% had been in for less than one year, and 83% for 4 years or less. 10% respondents reported that they had been in secure services for ten years or more.

The project was particularly successful in securing the participation of women. Whilst 68% respondents were male, at 31%, women's participation far outweighed their representation in secure services (which in 2007 stood at 12%). One respondent disclosed the fact that they were intersex; and two workshop participants identified as transgender.

A wide variety of ethnic backgrounds were represented, including Albanian, Chinese, Indian; and gypsy/traveller. Whilst there was significant representation of Welsh, Scottish and Afro-Caribbean patients, a majority of respondents (65%) identified as White English.

2. Ethnicity of respondents: patient survey.



Initial observation reveals no significant differences based on gender, levels of security and ethnic identity; although there are some differences when gender and age were combined. More obvious are differences in responses between units. These could be based on the differences of demography - eg brain injury *"patients when first introduced to new surroundings may or may not be able to understand what is happening so soon after brain injury" (BIS4)*. It may also be the result of features not named in the survey eg impact of socio-economic class on peer support. Differences in experiences of peer support are more likely to be based on sometimes sharp differences between ward cultures, practices and existing peer support schemes, which are addressed later in the report.

4.2 Staff survey:

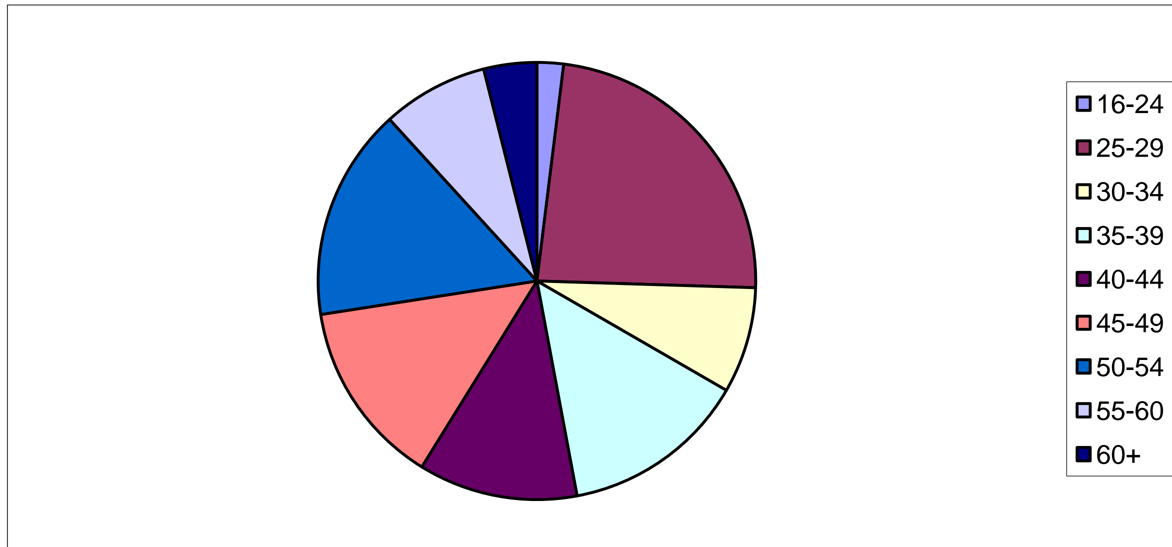
54 members of staff from 24 services completed a 7 page questionnaire.

50% of the 24 services represented in the research were identified as low secure; and 30% as medium secure. Other services represented a range of levels of security; or levels or security were unspecified. 11% provided services for patients with learning disability.

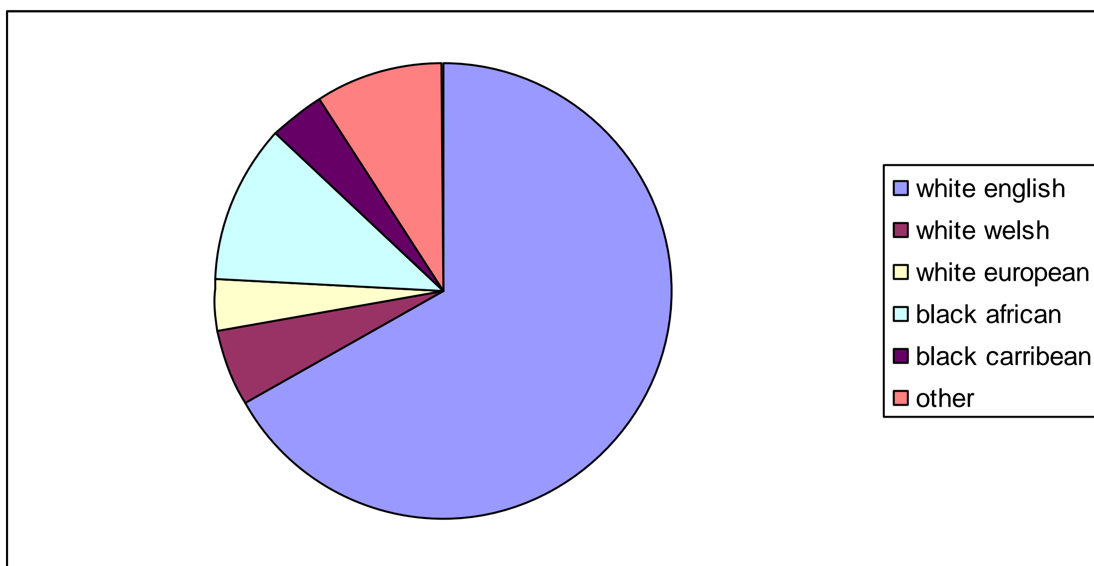
Occupations and roles represented in the research include: occupational therapist, service/ unit/ ward management; psychiatrist; support workers; nurses and nursing assistants; psychologists; DBT therapist, involvement co-ordinator; Mental Health Recovery Officer; administrative staff; and advocate.

61% of research participants were female; and 31% were male. 22% of those participants who specified their age were aged 25-29, 50% of respondents were aged 40-64.

3. Age of respondents: staff survey



4. Ethnicity of staff survey respondents



80% of respondents were white; 67% were white English. 15% respondents identified as Black; 3.7% as being from Mixed/multiple ethnic groups. No respondents identified as Asian.

The impact of demographics on staff and patient experiences and understanding of peer support is a subject for further research and exploration.

5. What peer support currently takes place in secure contexts?

Scoping workshops:

During our visits to the pilot sites, patients and staff reported variety of formal schemes and forums in which patients come together to spend time together and offer support to each other:

- Community/ward meetings
- Patient and ward representatives
- Buddying/ peer links/ formal support at admission
- Peer mentoring
- Peer inclusion in interviews/ policy/ resource writing
- Recovery college: co-production and co-delivery.
- Peer Training
- Patient Steering Group
- Patient's Forum
- Patient Information Group – which has a role of reviewing policies and information
- Identity group support eg LGBT group; older adults group
- Therapy group support eg DBT.
- Activity, work and interest group support.

However, when peers were asked during the scoping workshops **"What forms of peer support exist within your service?"**, responses emphasised the importance of emotional support; and focussed largely on informal peer support – for example:

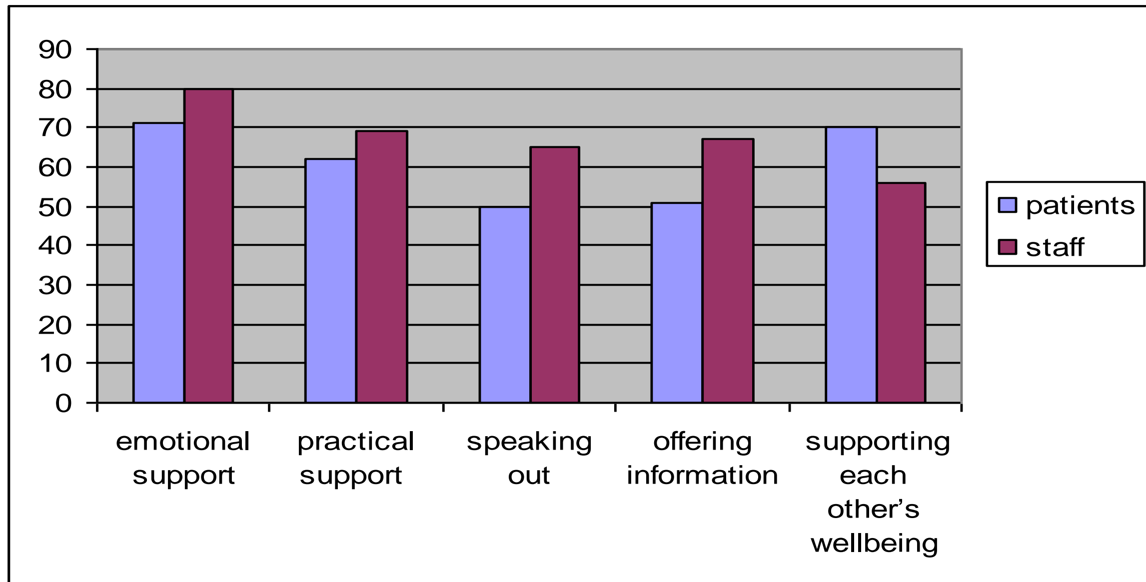
- Friendships and *"just being there" – "even if you don't want to talk, I'm there for you when you do".*
- Just talking; asking *"are you okay?"*
- Informal day-to-day on the wards…… "*'hello' from a fellow patient*"
- Talking to each other whilst playing a game or X-BOX
- Socialising and support during structured activities eg reading or walking group; games, social times and events.
- Talking to other patients about illness and symptoms
- Asking if someone is ok. Just noticing, asking the question, *"Are you ok?*".
- *"Make you laugh, when you're feeling shit …..changes your mood sometimes"*
- Offering hope and reassurance – *"you can do it!"*
- *"Sharing what you've tried and worked"*
- Love and care….

This emphasis on the informal aspects of peer support is supported by the patient survey.

Emotional support, and support for emotional wellbeing were the forms of peer support which most patients recorded. 63% said that peers within their service offered each other emotional support: examples included: *"just being there at sad times" (AM1); "just really being there for someone. Even a kind word helps sometimes" (CL1); "talking someone out of*

a hostile situation" "encouraging a peer to take medication" (PF2); "listening to music, watching TV programmes and shopping and cooking" (JH6); coming to the ward and having a conversation" (RRH2); "a shoulder to cry on" (RRH8); "Being there for each other" (SAB2). Closely allied to this was the role that 64% peer support played in supporting each other's wellbeing: *"just support each other" (AM1); "not really in any formal way" (LH1).*

How do peers support each other within <u>your service</u>? - percentage of staff and patients



80% staff reported emotional peer support taking place within their service. Examples include: *"giving a hug when upset" (9: Nursing assistant); "talking/ physical contact/ hand holding" (19: Staff nurse)*. There is an interesting disparity in that a considerably lower proportion of staff - 56% - felt that peers offered each other support for emotional wellbeing, offering examples such as: *"socialising, motivating others, encouraging each other to go the gym, healthy competitions eg rowing a mile in a set time, health walks; talking therapy groups – confidentially sharing experiences" (23: Senior OT).*

49% patients also felt that peers offered each other practical support within their service – examples included *"help and share tobacco and lighters" (PLC5); "doing things for each other" (PLC2)*. 69% staff felt that this happened within their service. Examples include: *"showing other peers how to work a cigarette lighter. If peer is physically unable to do a task offer assistance" (59: forensic); "Share information, show new patients around, give new patients information about services, if one is physically unwell others offer to complete their chores get them supplies when on shopping trip etc". (32: clinical psychologist).*

47% patients reported that peers supported each other by offering information: for example: *"warning the inexperienced how the system can work in your favour" (SB1); "show the new guy the ropes" (TP8).* 67% of staff felt that this happened within their service where patients were observed *"telling new patients about the staff, what groups are taking place, about s17 leave, how the shop runs, about medication" (34: OT).*

45% patients reported that peers stand up/ speak out for each other within the ward and the service: *"we try to stick together"* (TP1). 65% staff felt this happened within their service through processes such as ***"****Representatives from the ward attend patient involvement meetings across the whole hospital and in the geographical area". (1: OT).*

Perhaps the most striking feature of this data is the scale and vibrancy of peer support currently taking place within secure services.

One striking feature of this data whilst staff, throughout this research, are more likely to respond positively to peer support; in this instance they were significantly less likely to report peers supporting each other's emotional wellbeing.

This suggests that staff are less likely to encounter examples of peer support for emotional wellbeing - perhaps because this takes place within informal relationships or marginal spaces. It may also suggest that staff are less likely to recognise or value peer support for emotional wellbeing where it is encountered; possibly for similar reasons.

6. Research findings.

Where possible, issues raised throughout this report are illustrated by direct quotations from patients and staff; drawn from the scoping workshops, questionnaires, staff interviews, and patient and staff surveys. All direct quotes are in italics. Patient surveys are identified by service (initials) and number; staff surveys are identified by role (Nursing Assistant3) and number; staff interviews are (*Occupational Therapist*) identified by role. Direct quotes from the scoping workshops are not identified by service or number; however, where the quote came from a member of staff, this is identified.

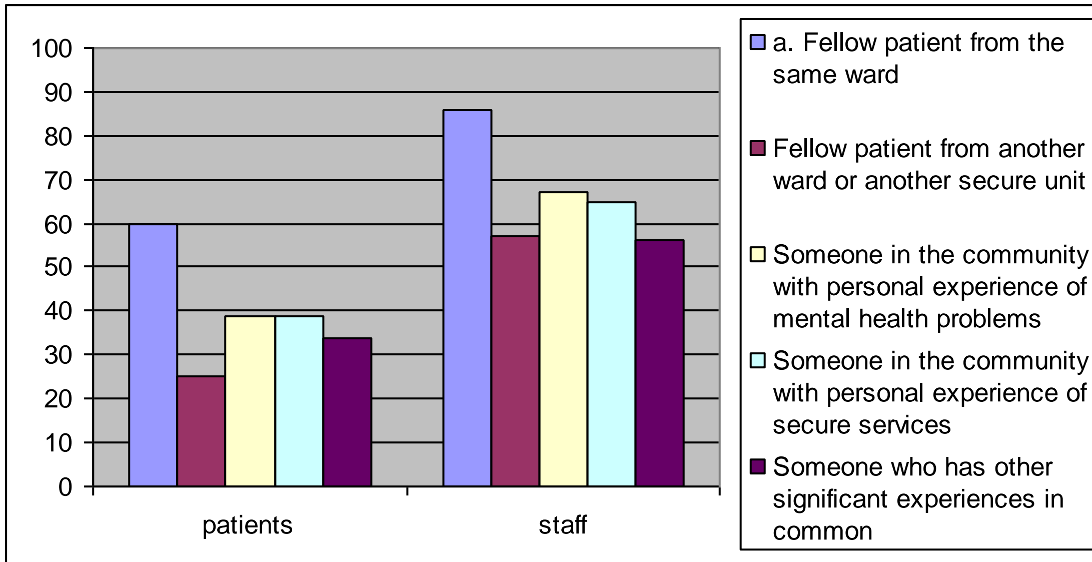
6.1 What is a peer?

Reflecting the wider literature, the scoping workshops identified a number of potential responses to this question, including: *"someone I get on with", "an equal"*; someone at the same stage in illness/ wellness and recovery; someone with the same illness; *"friend"; "shared experiences";* gender; *"people who know me"*; and experiences of secure services - *"you're in the same boat".* For most respondents to the survey, what defined a peer was based on shared experience of mental health issues and/or using services.

A majority of patients (60%) wanted to receive peer support from a patient on the same ward as them; and 25% felt that peer support from someone in another ward or unit would be useful. The community was also seen as an important source of peer support: 39% wanted support from someone in the community with experience of mental health problems; a similar number wanted support from someone in the community who had used secure mental health services.

For 34% of respondents, peer support focussed on other aspects of identity and experience. 34% named gender; 31% wanted someone who enjoyed the same hobbies. 29% wanted peer support from someone with the same diagnosis. Other significant experiences included ethnicity (17%), age (17%) and sexuality (10%). Respondents contributed additional issues such as shared experiences of bereavement (AM1) (K2); *"physical diagnosis"* (C15); religion (SB1) and personality - *"depends on whether I like them or not" (CC7).*

"Who do you want to receive support from/ Who do you think can offer support to patients within your service?" - percentages



Staff also expressed a range of views about what constituted a "peer". For 56% of staff, being a peer meant sharing significant aspects of identity such as gender, sexuality or diagnosis. Several powerful examples of this form of peer support in practice were offered, including groups for patients based on age, ethnicity and sexuality. However, like patients, most staff agreed that shared experiences of mental health issues and using services was key. 87% of staff felt that peer support could be offered by a fellow patient from the same ward; 57% felt that support could be offered by patient from another ward or unit. 67% staff also felt that peer support could be offered by someone in the community with personal experience of mental health problems - 65% felt that this should be someone with personal experience of secure services. *"Someone who has only had experience of community mental health services, who has not been detained, not in secure services, can't necessarily relate", (Psychiatrist); "these are specialist services with specific issues" (Head of Clinical Services).*

Other interviewees, however, felt that shared experience of secure services was not necessary for a peer relationship; and that shared experience of mental health issues and using services of lesser security might be enough. *"It is down to the individual … somebody who has trod that journey with you, who has been where you have been, who may be where you are at now, who may be one step in front of you" (Advocate 1)*. Two interviewees described how the scoping workshops had shifted their perspectives. *"I used to think it was people who had spent time in medium secure- now I'm not so sure. Since you guys came and shared your stories – that was powerful. I think there are things that happen in secure services that don't happen in other care pathways but – it's helpful but not necessary to have spent time in medium secure" (Occupational Therapist 2).*

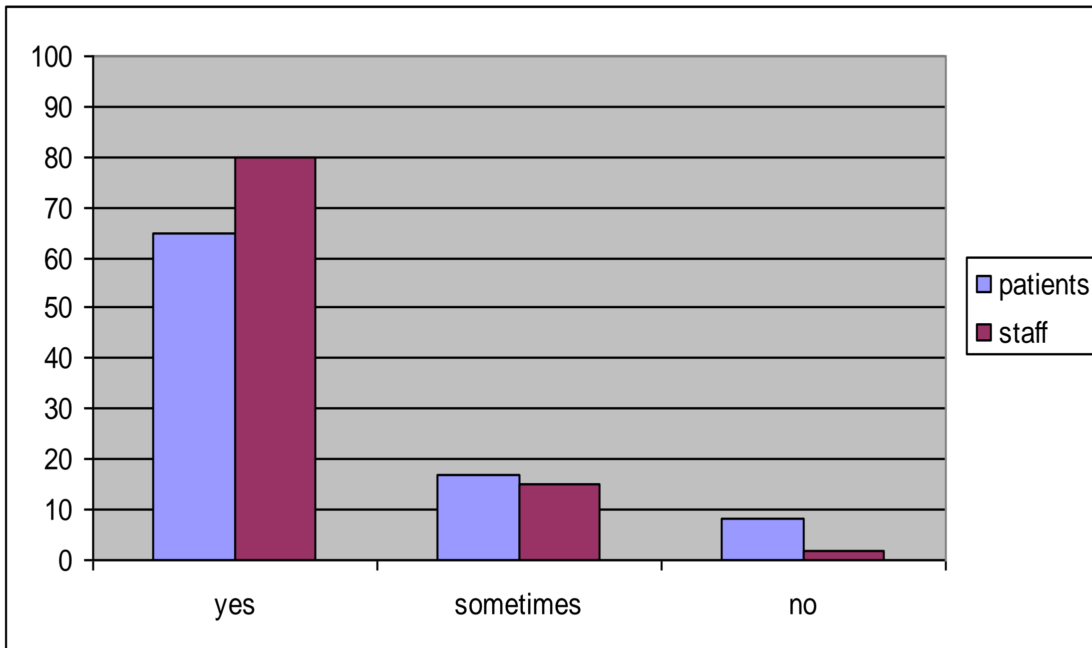
Facilitating peer support from a patient in a different ward or unit may be a useful way of negotiating concerns around boundaries and confidentiality which may arise when peer support is restricted to patients living in on the same ward. Facilitating peer support from a patient in the community who has shared experiences of secure service can be a useful way of addressing the challenging processes of discharge and rehabilitation; whilst enabling peer support from someone in the community who has shared experiences of mental health

issues can offer an important point of connection to a wider community; and open up a much wider pool of expertise, experience and support to draw from. Finally, peer support from someone with a shared identity and experiences around diagnosis, age, sexuality, hobby and gender etc can offer an important point of connection; can challenge isolation and stigma; and can enable patients to create supportive networks and positive self-identity.

6.2 Can peer support be useful in secure services?

In short, yes - the majority of staff and patient feel that peer support can be useful in secure services.

"Do you think that peer support can be useful in secure services?" - percentage.



Both staff and patients expressed an overall commitment to peer support in secure services: *"other patients understand me. They know what I'm going through" (scoping workshop participant)*; *"I've done it! It works well" (BIS 3); "I am a massive supporter of PS and have been from the start; I hear this positivity from patients too". (Clinical Director)*

65% patients felt that peer support could be useful in secure services: for reasons including *"because we can share experiences and support each other" (CC3); "it makes me feel part of the team" (M13).* A large majority of staff (80%) felt that peer support can be useful in secure services. Reasons include: *"patient lived experience is valuable - gives patients a purpose and role in helping others; promotes people's recovery who both and give and receive peer support" (36: CBT Nurse); "Staff are able to provide a lot of support for patients in many different ways, but most staff have not experienced what having mental health issues REALLY feels like. Peers are able to provide a different kind of support which may be beneficial alongside the professional support available" (F1: OT).*

17% patients and 15% staff qualified their support and specified that peer support was sometimes useful: *"it can make a difference, but it depends on the type of the ward, the abilities and progress of the patients and overall levels of trust. This is a complex environment" (CL2). "At times yes, however this can be dependent on the individuals, risk, diagnosis and other potential mitigating circumstances" (Clinical services manager)*; *"it is useful as they share similar experiences and are able to help and offer the right support. But*

also it has negatives as the women can get too involved in each others' care" (24: Support worker). Just 1 member of staff stated that they did not think that peer support was useful in secure services (the staff member did not explain this opinion); significantly fewer than the 8% patients who stated reasons such as *"causes arguments" (K9); "because they have their problems" (SAB4); and "no-one cares"(JH1).*

Other than the overall levels of commitment to peer support amongst staff and patients, the most notable feature of these statistics is that staff are more supportive of peer support. Given that this support focuses on the perceived benefits for patients (only 30% staff felt that peer support reduces the workload for staff), this finding is a little puzzling.

Explanations may focus on several possibilities:

1. the nature of the populations of staff and patients who took part in the research.

Staff may have experienced a greater level of choice about whether they took part in the research. Those members of staff who chose - and, it may be speculated, those who found time in very busy schedules - to take part in the staff survey and interviews are more likely to have an active commitment to peer support.

2. different levels of awareness and understanding of terminology, concepts and practices amongst staff and patients.

Staff may be more familiar with terms such as "peer support", and more aware of what they mean in practice. The inverse is also possible: that staff have a more formal or restricted understanding of peer support; whereas patients understand it in lived terms and are therefore more alert to its drawbacks.

3. Peer support is a *"buzz word"* in current mental health services. Staff may feel a pressure to engage with the value of peer support, which patients are not subject to.

4. the impact of culture/ "institutionalisation".

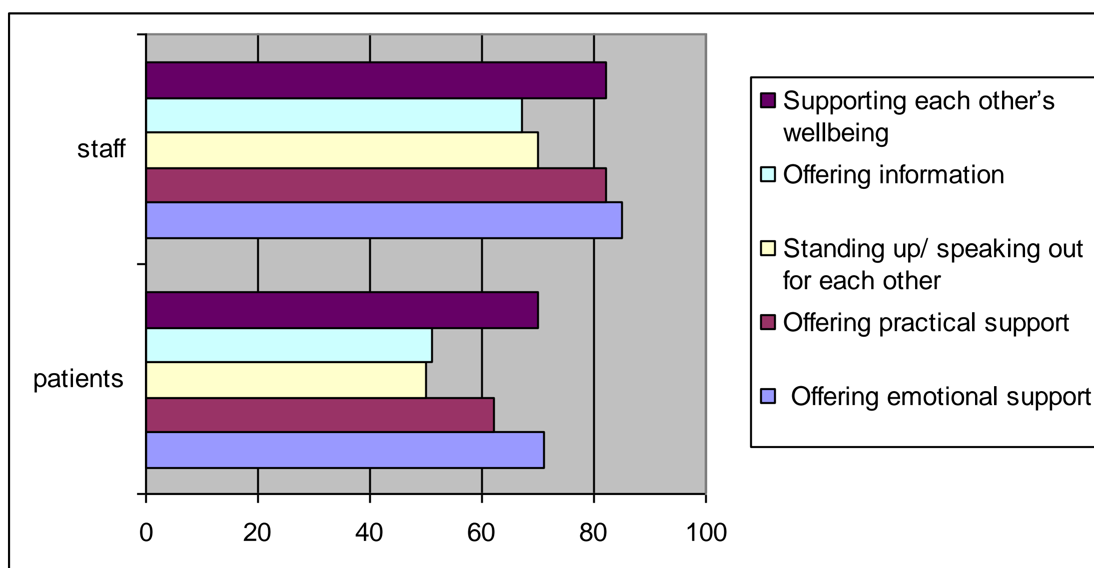
The majority of patients had spent at least one year in their current service; it is possible that these respondents had spent longer periods of time in the secure system as a whole. Long periods of time in institutions - particularly complete, or secure, institutions - will impact on patient's expectations.

This speculation is directed at the disparity in levels of support for peer support between staff and patients. It is not intended to deflect from the evidence that there are considerable levels of positivity and commitment to peer support amongst staff working in secure services.

6.3 What kind of peer support?

For the patient group, the greatest potential for peer support lay in the role that patients can play in offering each other emotional support. 71% felt that patients in secure services are able to offer emotional support such as *“just talking”* and asking *“are you okay?”*, and a further 70% felt that patients are able to support each other’s emotional wellbeing by *"having a laugh", "socialising"*, offering hope and reassurance - *"you can do it!"*, and *"sharing what you've tried and worked"*. This form of support was also valued by staff: 85% of staff felt that patients in an ideal service could offer emotional support to each other; and 82% felt that patients in an ideal service could support each other’s wellbeing.

"In an ideal service, what forms of support do you think patients are able to offer each other?" - percentage



For staff, the greatest potential for peer support was in the practical support that peers could offer each other - *"showing you around", "making a cup of tea"* - which was named by 87% staff. 62% patients agreed that peers could support each other in this way in an ideal service.

70% of staff felt that patients in an ideal service could stand up or speak out for each other; a role which was named by 50% of patients. Finally, 67% of staff felt that patients in an ideal service could usefully offer information to each other - such as *“who’s who, what’s what and what to expect”* - also named by 51% patients.

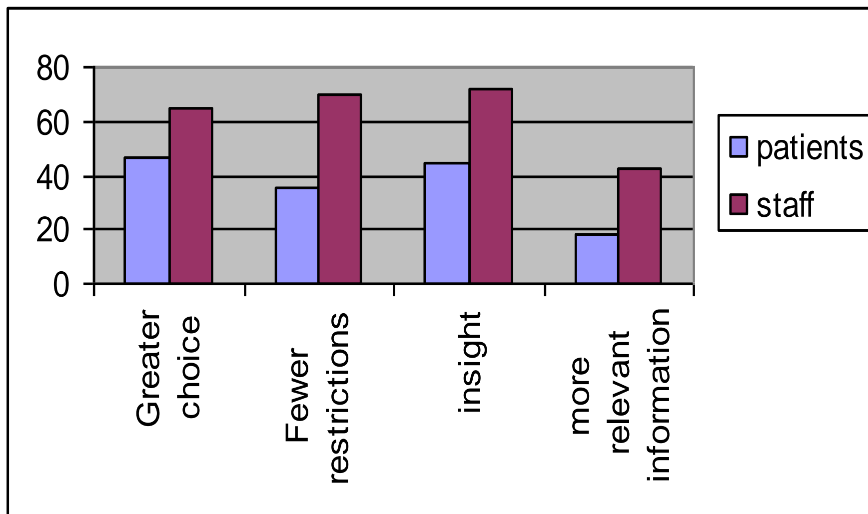
Patients and staff offered additional ideas for how they could support each other in an ideal service, including *“just be a friend – someone who can answer questions, give advice, remember times etc” (BIS4)* and *“leaving me alone when I want to be left alone” (SAN9).*

Both staff and patients recognise the importance of emotional support. Whilst the research did not ask staff or patients to categorise their responses in terms of formal or informal support, peers were more likely to offer examples of informal support, whilst staff had more of a tendency to offer examples of formal systems: *"The women have an end of day*

reflection meeting, whereby the women discuss their challenges that they have faced throughout the day, how each one of them felt at the time. How they feel the day went and what were the positives and the negatives of the day" (Clinical services manager). Staff were proportionately more likely than patients to value practical peer support, and were again more likely to name examples from formal schemes, predominantly buddying: *"Buddy system is in place so that on admission patients have someone who they can speak to who is already familiar with how the ward works. (1: OT)* .

6.4 The value of peer support

"Does peer support offers benefits that are different to those offered by staff support?" - percentage"



24% patients did not indicate that peer support had additional benefits. Some stated that they found no difference between peer support and staff support; or that they actively preferred staff support: *"I would rather seek support from staff" (CC4); "[staff] always know how to help in a crisis"* whereas as a peer *"you don't know what to say"; "Staff can offer medication when you are really struggling".*

Many patients, however, did feel that peer support offers benefits which they did not get from staff support. The greatest number of patients - 48% - named the greater choice offered by peer support: *"you choose friends, you don't choose professionals".* This was also named by 65% of staff. Patients in the scoping workshop described how the enforced nature of secure care could affect relationships with staff: *"Doctors are responsible for you being in secure settings and may want to keep you here even when you don't want to be here";* and several staff in interview also named how patients were more likely to accept support or information from a peer than from a member of staff - *"There is "better buying" – "receiving it as an equal". An alternative to treatment and therapy which in secure services are sometimes perceived as "enforced" (Head of Clinical Services)*. One interviewee (Psychiatrist) named how he has occasionally he has asked one peer to speak to another on certain issues, based on his belief that the patient will listen to someone with shared experience, and the outcome has been very positive.

A larger proportion of staff - 72% - felt that peer support could offer greater insight and understanding than the support of staff; a benefit which was identified by 45% patients - *"you don't understand unless you've had the same experiences"; "we know what you're going through - how can a doctor know what you're going through?"*

70% staff felt that peer support came with fewer restrictions - this was named by 35% patients: *"nobody is taking notes or monitoring me"; "the freedom to feel less guarded, less "on trial" (CL2).* Scoping workshop participants farmed this in terms of boundaries: *"You play a game and have a laugh and a hug. Staff have more boundaries".* The greatest

disparity between staff and patient perspectives is the role of information: 48% staff and just 18% patients felt that peers offered clearer and more relevant information than staff: *"staff information is sometimes wrong".*

When patients were asked for further ideas, several named the accessibility and continuity of peer support: *“peers are accessible all the time whereas staff shifts change” (KV2); “patients are more available as they are not busy like staff” (CC17).* These were subsequently included as a option in the staff survey and 54% agreed that peer support is more accessible/ available for patients. 30% staff also felt that one of the benefits of peer support is that it reduces the workload for staff.

Several staff and patients named "modelling" as a potential benefit of peer support - *"imparting hope and coping models to each other when looking towards someone well along the treatment pathway" (Clinical Director); “if they can do it, I can do it”.*

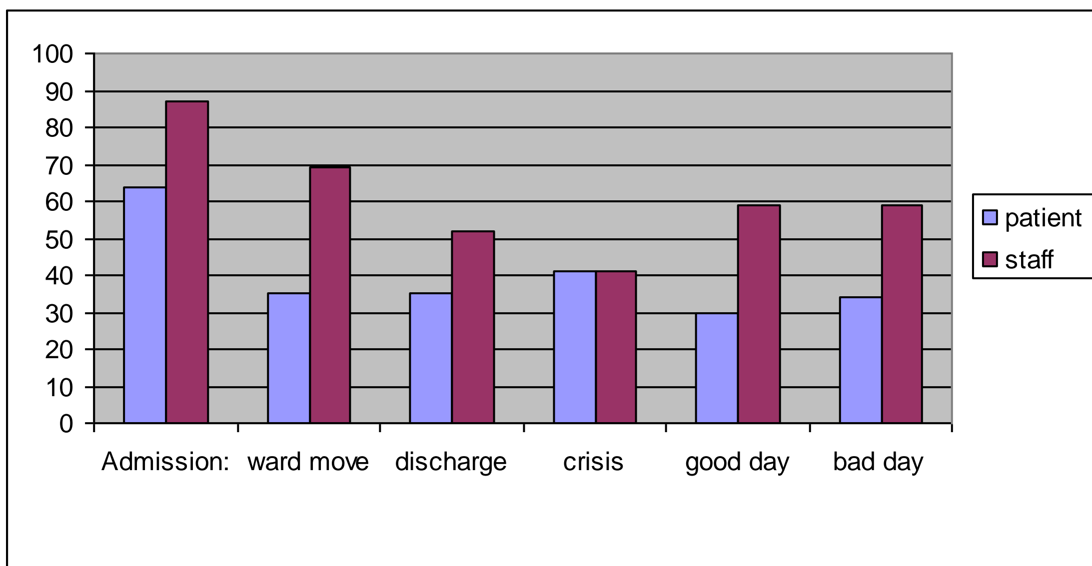
Again, a greater proportion of staff than patients named benefits offered by peer support, raising some of the issues first addressed on pages 27-28 . There was striking relative disparity between the benefits perceived by staff, and those experienced by patients. The greater value attached to "choice" by patients - as opposed to the "insight" and "fewer restrictions" valued by staff - may point to peer support as place of relative autonomy.

6.5 When is peer support useful, and what forms can it take?

As well as highlighting the times when peer support may be useful, scoping workshops provided valuable insight into significant points in the journey through services including: CPA meetings, moving between wards, individual days of significance eg Christmas and birthdays.

These points of significance informed the survey, in which patients and staff were offered a choice of six points in the journey through secure services, and were asked to indicate where peer support might be useful. They were also asked to name any other points of significance.

"When is peer support useful, and what forms can it take?" - percentage



Admission:

Scoping workshop participants reflected on the experience of admission being difficult: *"it be can be quite daunting coming to a new place"; "scared", "full-on", "overwhelming". "It would be nice if someone was there to support you". "help to settle in – just to know that someone's there"*. Several participants reflected on not having had this for themselves; and how as a result they felt scared; and stayed in their rooms. Participants also stated that it would help to have information, produced by patients. They described how peers can offer *"insider information"* on what's what and who's who; *"what to expect"*, which can ease the process of fitting into the ward and negotiating relationships and procedures. Staff, likewise reflected on the particular relevance of information which comes from patients - patients have access to experiences, information and knowledge they don't - and its particular usefulness during admission.

Similarly, for 64% of respondents to the patient survey, admission was a time when peer support had a valuable role to play. *"buddy system – to help settle and become supportive" (BIS1); "the routine and the way the ward functions – staff rarely tell the 'ins and outs' fully" (PF5); "support within a new and strange environment could lessen fears" (CL2)*. Similar

functions were attached by 35% respondents to peer support when moving between ward/ units: *“peers can show and advise you of the way things are run” (G2); “friendly face: makes me feel comfortable” (M13).*

The largest group of staff (87%) saw a role for peer support on admission to secure services: *"to show someone around and explain who's who - patients will recall what was important to them on admission" (42: OT); "set a motivated, supportive attitude from admission" (38: Assistant psychologist); w*hilst 69% felt that peer support was useful when moving between wards: *"Buddy system for practical and emotional support: this can be a difficult time of transition" (1: OT).* Indeed, some members of staff worked from a definition/understood peer support as buddying/ support on admission; until prompted to consider other forms. This raises the possibility that expectations and understandings of peer support are shaped - and sometimes limited - by what already exists.

Discharge

Scoping workshop participants powerfully described the challenge of discharge - *“after 20-25 years it’s like you’ve been in a coma”. "You feel disorientated". "All you hear about the outside world is bad news. You think “why on earth would I want to be out there?”* and how this might be addressed by peer support:

- sharing stories about discharge.
- being realistic about challenges faced after discharge
- making links with peers in the community because *“they know where I am coming from”* and *“they have been there themselves”*
- hearing from someone else who has been discharged – *"what’s out there? What services are available?"*

35% patients felt that peer support would be useful at the point of discharge, providing valuable practical and emotional help as well as information: *“so you know what to expect: nothing comes as a surprise” (SB15); “make relationships – not been in community for a while” (SAB5)* – as well as continuing to offer support to those still in services: *“ringing patients to let them know how you’re doing and tell them they can be like you are doing. It helps to encourage peers to want to be discharged as well” (SAB13).*

52% staff also saw a role for peer support during and after discharge from services: to *"reduce isolation, prevent relapse" (31: DBT therapist); "ex-patients visiting wards. Gives a sense of hope for the future" (49: CNL).*

Good days, bad days and crisis.

Crisis (41%) and “bad days” (34%) were times when peer support was valued by patients: *“a friend can lift your mood so you don’t do anything silly while stressed” (SB15); “it’s easier to talk to peers instead of staff” (SC2).* 30% respondents also valued peer support on good days - *“it is nice to talk to friends – makes me feel better”; “joining me in games” – “we have a laugh together” (SAN9).*

59% staff also saw a role for peer support when a patient is having a good day: *"Offering friendship and support: maintaining skills and relationships are important not just in times of crisis (1: OT)*; whilst the same proportion felt that peer support could be useful when a patient is having a bad day: *"go see them offer support then inform staff if any concerns - open and honest nothing to hide from a peer, plus if peer has concerns staff can be aware of the change in risk and monitor appropriately" (7: Forensic Mental Health Nurse); "Making tea - showing they care" (42: OT).*

41% staff felt that peer support was useful when a patient is in crisis: *"Often peers listen to each other when in crisis when staff intervention can sometimes lead to an escalation" (7: Forensic Mental Health Nurse); "peers that have friendships often support each other and show each other empathy in times of crisis …. If staff are struggling to engage with staff however will engage with peers". (20: Charge nurse).* One member of staff described in interview working on a ward where "*there are many crises, and the aim of the service is to show that a crisis is not the end of the world and can be dealt with in a productive way. Emotional peer support therefore plays an important role on the ward" (Psychiatrist).*

Some members of staff, however, felt that this would be an inappropriate time for peer support: *"behaviour of the patient may be very risky/ violent/ delusional when in crisis - do not think this is a good use of peer advocacy" (36a: mental health recovery officer).*

6.6 User-led Peer Support

"User-led peer support happens when patients are in control of the support they offer each other: they make the decisions about what sorts of support they offer, when, how, to whom and by whom" (Together "Peer Support in Secure Services" Patient and Staff survey).

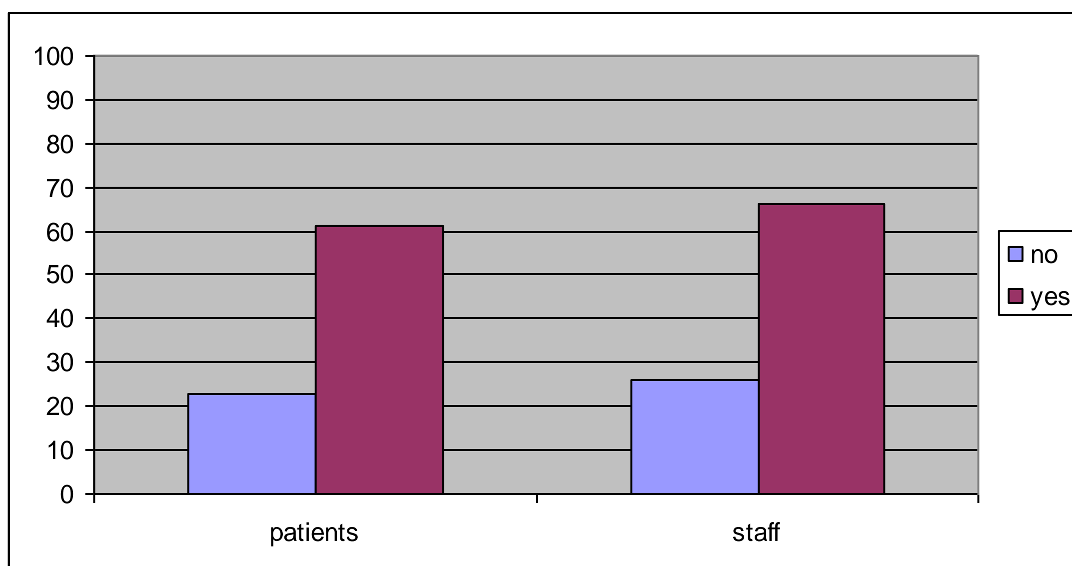
"losing the user-led nature of peer support is one of the main things that people are worried about" (Faulkner and Kalathil 2012).

The concept of user-led peer support was discussed in the workshops; it was not a term that the majority of participants were familiar with; and many found it a difficult concept to understand. Workshop participants and staff offered the following examples of user-led peer support taking place within their services:

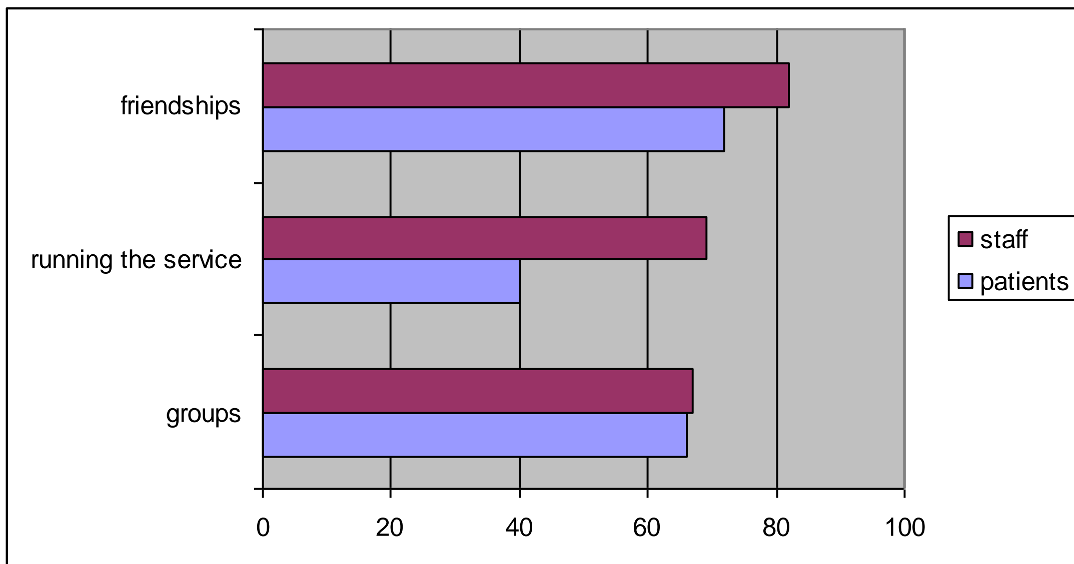
- Patient's forum
- Patient involvement in staff interviews.
- Whilst staff in one workshop named the Recovery College and Peer Training as examples of user-led peer support, patients were not aware of these schemes.
- Meet and Greet for visitors
- Patient's Shop and Education. I later visited the shop: whilst it is staffed by patients, it is run under staff supervision; opening hours are decided by staff; and the number and type of items patients can buy is subject to limits set by staff eg 3 drinks, 5 items of toiletries).

In the staff and patient survey, 23% patients and 26% staff felt that user-led peer support did not happen within their service; whilst 61% patients and 66% staff felt that it did. No explanations were offered by those who felt that user-led peer support did not happen.

"User-led peer support happens when patients are in control of the support they offer each other: they make the decisions about what sorts of support they offer, when, how, to whom and by whom. Does this happen within your service?"



"In what form?"



"Groups/ meetings are run by patients (for example patients set the agenda, chair the group and take the minutes)"

67% of staff and 66% patients reported that groups and meetings are run by patients: *"community meetings are held weekly and are chaired by the women, end of day reflective groups, and the women's forum, Governance assurance committee (locked rehab & low secure) are all opportunities for the women to have their voice heard, share information, support each other, these meetings are fed into Governance so information goes from board to ward and these meetings help make changes in a positive way with regard to their stay" (Clinical services manager).*

All staff interviewees offered examples of user-led peer support within their service; often focussing on peer support within groups: *"Service-user steering groups have recently become powerful groups – they used to focus primarily on food and décor (which are important) but recently they asked to meet with management; the lead medic met with them and they presented her with a list of demands ….. it's like the group suddenly got some balls and realised they could say "It's not okay" (Occupational Therapist 1).*

Several patients, whilst stating that groups were user-led, qualified their observations: groups/ meetings are run by patients *"sometimes, when staff let them" (PF3); "patients do not run the meeting, just participate" (TP17).*

"Patients influence the running of the service (for example being part of staff recruitment, writing policies with staff, developing and delivering training with staff)"

69% staff felt that patients influence the running of the service, for example: *"women are regularly part of the interview panel. Involvement group runs weekly where women have input into how the service runs, including policies etc. women also run their own workshops" (26: Involvement co-ordinator)*; *"joint unit policies developed by staff/ patients (17: ward manager); "Peers input into interview panels, they co-facilitate training, they input thoughts*

and ideas into policies, and they read through them and check they are user-friendly/ easy-read in the Policy Review Group" (Occupational Therapist 2).

This compares to just 40% patients*: "I'm on the interview panel, interviewing staff placements" (CL1) "v/g user involvement group" (JH2) "I have helped in staff recruitment" (SAB9).* This relative sense of powerlessness with the patient group may stem from the inherent power relationships with secure services, within which patients are inevitably less powerful than staff: it may be difficult to feel that one has an impact on the running of a service in which one is involuntarily detained. Other possible explanations include: staff may tend towards over-optimism about the efficacy of user-involvement initiatives whilst patients may be more likely to perceive them as tokenistic; particularly where previous initiatives have had limited impact. Groups, recruitment panels, training projects etc are likely to involve only a proportion of patients: those not involved may still experience themselves as powerless. Finally, patients may be less aware than staff of user-involvement/ leadership schemes.

"Friendships (patients decide who they spend time with and what they talk about)"

The majority of staff (82%) and patients (72%) identified "friendships" as the most common form of user-led peer support: *"Patients do develop friendships which sometimes continue following discharge from hospital" (2: Senior OT); "just by being 'friends' – someone who can answer questions, give advice, remember times etc" (BIS4).*

Towards the end of a three hour scoping workshop during which a strong commitment to formal and informal peer support was expressed by staff and patients; an off-the- cuff comment revealed that patients were not permitted to talk to each other about their diagnoses, symptoms, index offences, family background or personal histories. Staff and patients had not discussed these restrictions as they accepted them as standard practice, and as a taken-for-granted aspect of life in secure services. These restrictions also applied within at least one more of the pilot sites. Having been alerted to the existence of these restrictions, the following survey/ interview question was introduced:

"Are there restrictions on what patients can discuss with each other, the type of support they offer each other and how/when this happens?"

50% staff in the survey, and 4 of the 7 interviewees describe restrictions on friendships: specifically on what patients can discuss with each other, the type of support they offer each other and how/when this happens. Restrictions identified in staff interviews and in the staff survey include:

- **type of relationships.** No physical touching. Staff will intervene when there is evidence of sexual relationships; or negative or inappropriate behaviours and influence eg bullying, exploitation, coercion, drug taking: *. "Relationships are closely monitored and everything that goes on in a relationship will be discussed. This is bound to affect the relationship" (Head of Clinical Services).*

- when and how patients may associate with each other: eg no sharing of food, no lending of cigarettes, no entering into bedrooms or interview rooms; peer support only to be offered within formal meetings and groups.

- information shared between patients: disclosure and discussion of history, offences, trauma, personal issues, drug taking behaviours, treatment, upsetting or triggering subjects, other patients, members of staff, medical information, pornographic subjects, inappropriate issues. Staff monitor conversations and may intervene. *"We discourage patients from disclosing their index offence, as it makes them vulnerable. We also discourage patients from talking about trauma as talking about it over and over can be unhelpful" (Occupational Therapist 1)*

- type of support: patients must inform staff when they are concerned that someone needs more support; patients are discouraged form offering support to a peer who is distressed or in crisis.

- **limited confidentiality and privacy.**

A further 7% staff describe how patients voluntarily police the type, nature and content of the support they offer each other: *"women tend to set their own boundaries on the support they offer and the topics they discuss" (26**:** Involvement co-ordinator);"patients make their own restrictions on who the trust to what to discuss with each other and mostly don't deliver personal information to other patients". (15: Support worker.)*

Restrictions on contact between peers was also feature in the scoping workshops: where respondents stated that they were *"not allowed to talk about illness"*; and that disclosures/ conversations around their past, prison, index offence, symptoms, family, background - *'pretty much everything'* - were not permitted: *'it's really limited what you can say'.* Whilst the services involved had a rationale for these restrictions, they had an inevitable and powerful impact on the degree and nature of support which peers were able to offer each other: "*Someone I'm having a conversation and I have to stop it half way through and it doesn't make sense"*.

In scoping workshops, patients on an adolescent and hearing impaired ward were particularly concerned about the impact of restrictions on relationships: specifically the "no touching rule" - *"everything would be changed with a hug"* - and the tendency by staff to frame patients offering emotional support to each other in times of distress as *"interfering with care".* 29% survey respondents also identified restrictions on friendships. The impact of restrictions is highlighted when patients reflect on the support they offer each other the absence of restrictions: *"in this service women are very close and will hug one of they are struggling – we say to each other "I am here for you" and say to each other things we would find hard with staff" (GH1).*

50% staff do not report restrictions, and 3 staff in interview reported no restrictions within their service: *"Patients are never stopped from spending time or talking to each other and benefit greatly from peer support and buddying systems put in place on the wards" (3: Clinical services manager)*.

Without the scoping workshops, it is possible that these restrictions would not have been reflected in the survey; and that the research would have failed to reflect a powerful example of how the secure setting can impact on peer support. As within any institutional setting, there is a strong possibility that a distinct and unquestioned culture may form within secure services. In these circumstances, qualitative research allows for an exploration and “unpacking” of experiences and assumptions which quantitative research alone may fail to pick up on.

Throughout the findings there is a tendency - through far from absolute - for staff to focus on formal support, and for patients to emphasise informal support. The existence of multiple restrictions on the informal support that patients are able to offer each other in many secure services adds a problematic aspect to this difference in emphasis and understanding.

The emphasis on formal support echoes a similar tendency in community and acute services. Basset et al (2010) state: *"the essence of peer support begins with informal and naturally occurring support". Conceptualising peer support as a pyramid, with informal support at its base, they conclude, "the base of this pyramid is crucial and must be strong and robust if peer support, in all its various forms is to flourish. As peer support becomes more structured and organised, it can become more focused and helpful but care must be taken that its essence is not lost within more formal and professional structures" (p14).*

6.7 "Do you think that user-led peer support could happen more in your service?"

70% staff and 63% patients felt that there could be more user led peer support.
Staff suggestions include: *"patients could be trained and empowered by staff or peer educators on how best to help each other" (42: OT). "The service would greatly benefit from employing a patient involvement co-ordinator as this would spread the good work and encourage more patient involvement cross our service" (35: associate practitioner).*

Patients' ideas focussed on

1. formal structures for user-led peer support: including

"more of an involvement in staff training" (SAB5)
"meetings run by patients" (SAB9)
"fully employed peer support worker (LH1)"
"it would be good to have completely independent peer-run groups" (GH)

2. informal user-led peer-support:

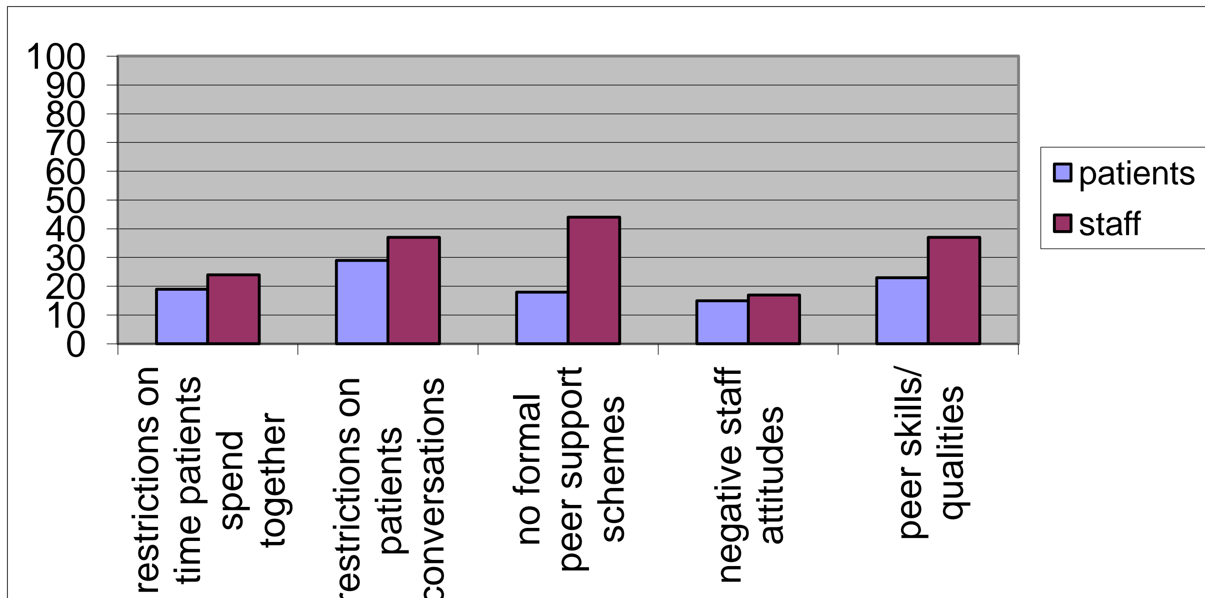
"organising take away once a week" (TP8)
"in one of my hospitals we all sat down for an hour to talk about things. We could do that here" (GH6)
"more time could be given so that patients from other wards could meet together" (SSS1)
"helping others in daily life skills like making phone calls and mailing letters" (SAB8)

23% of patients and 26% staff felt that there was no potential for more user-led peer support within their service. For some, this was because there was already an adequate emphasis on user-led peer support: *"there's enough already"(JH2); "it's okay how it is" (PIC4)*. For some it is because they do not trust or like the concept: *"might offer wrong support" (SAN 10); "can't control it" (M7); "I don't think it would work as people have bad days and might whack you for trying to help" (m11)*. *"I don't think patients are trustworthy" (GH4)*. Staff also felt that the patients they were working with precluded the creation of more user-led peer support within their service: *"patients are often delusional and tend to transfer to others" (10: nursing assistant).*

There persists a strong narrative that patients in secure services are not capable of/ safe enough to offer peer support to each other. However, as the next section makes clear, there are other, more significant obstacles.

6.8 Barriers to peer support

"What barriers are there to good peer support within your service?"



It might be reasonable to speculate that the lack of attention paid to peer support in secure services is, in part, based on the expectation that peers experiencing serious mental distress

or disturbance lack the skills and qualities necessary for peer support. Yet at 23%, patients did not feel that this was the greatest barrier to good peer support.

Rather, the greatest barrier to good peer support was restrictions placed on the conversations that peers could have with each other, identified in scoping workshops and named by 29% survey respondents; and restrictions placed on the time that peers could spend with each other, identified in workshops and named by 19% survey respondents. These was named by 37% and 24% staff, respectively.

The greatest proportion of staff - 44% - reported that a lack of peer support schemes was a barrier to getting peer support within their service. This was identified by 18% patients.

37% staff feel that peers do not have the right skills or qualities. Staff also identified the mental health issues of patients as a barrier to peer support: *"Some peers may not have the skills (or inclination) to be able to support others" (1:OT); "challenging behaviours and insight low" (19: Staff nurse). "Some patients are quite destructive – causes patients to keep themselves to themselves at times"(23: Senior OT).* Just 17% of the staff who took part in the consultation felt that staff in their service have negative attitudes towards peer support or don't believe it can work.

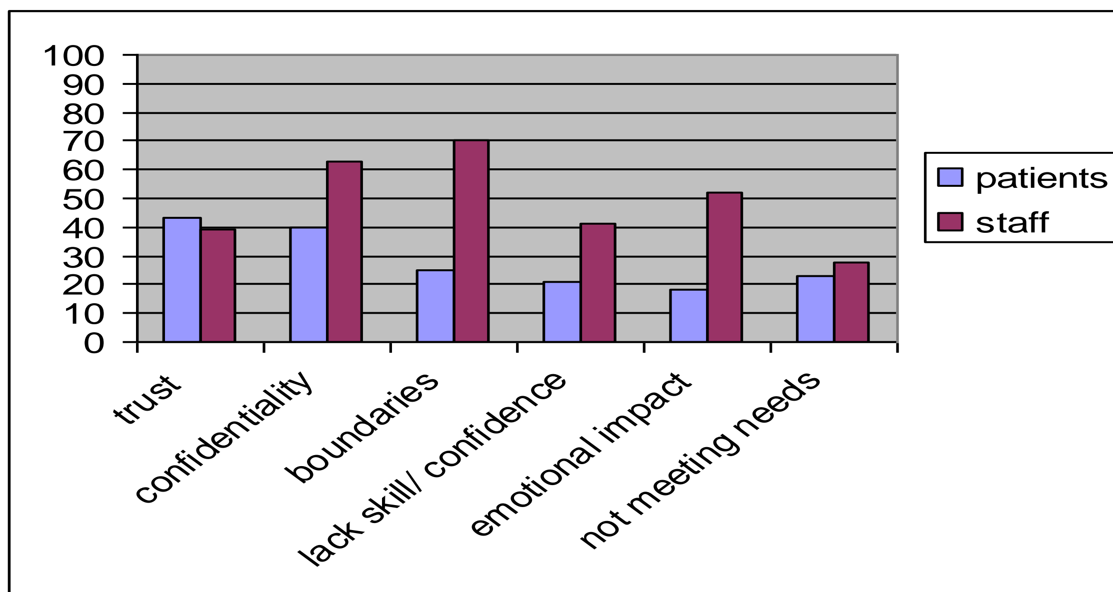
Encouragingly, only 15% patients reported that negative staff attitudes were an obstacle to good peer support; *"staff encourage: attitudes have improved" (PIC11)*. However, when a respondent identifies as a barrier *"the idea that peer support is merely window dressing and that only professionals can offer meaningful support" (CL2)*, this indicates that there may be more subtle barriers which are not captured in a survey. Indeed, in the initial scoping workshop, it was only at the end of the session that respondents mentioned restrictions placed on their conversations with each other. Cultures and practices can be normalised; and through that normalisation, stop being visible to staff and patients alike.

Additional barriers named by patients included: *"different backgrounds and age groups" (SB14); "language barrier" (TU8); "not similar in character" (TU7); and "discrimination"(GH7)*. The no-touching rule - described as problematic in workshops - was also identified as a barrier in the surveys; *"hugs should be allowed across the board" (G1).*

6.9 Fears and concerns about peer support.

As well as recognising service-level obstacles to good peer support, participants in the scoping workshops recognised the significance of the patient's own fears and concerns around peer support in secure services.

"Do you have any fears or concerns about peer support?"



Trust (43%) and confidentiality (40%) were particular concerns named by patient survey respondents; also identified by 39% and 63% staff respectively. 25% patients were concerned about maintaining boundaries in the secure setting; *“sometimes it can be pushy and make me feel uncomfortable” (VH2)*.

There is a striking disparity between the 25% patients and the 70% staff who are concerned about the difficulty of maintaining boundaries between patients in secure services: *"Issues like power and information become quite complex when people are living with each other" (Occupational Therapist 1).* The other notable disparity is between the 52% staff and 18% patients who were concerned about the emotional impact of patients offering support to others: *“there is a limit to support you can offer peers. Because sometimes it can be emotionally hard as you tend to put their problems on your shoulders as well so sometimes you have to back off a bit or offload to staff” (SAB13).*

21% patients and 41% staff felt that patients were not skilled or confident enough to offer support to others: *"Some peers may not have the skills (or inclination) to be able to support others" (1:OT); challenging behaviours and insight low” (19: Staff nurse).* 28% staff and 23% patients were concerned that peer support may not meet a patient’s needs: *"peers don't have care experience to deal with other peers concerns" (59: forensic); "I have witnessed ward reps focussing on their own issues rather than ward issues. some enjoy the power they*

have. it could be open to corruption" (36a: mental health recovery officer). "Some patients are quite destructive – causes patients to keep themselves to themselves at times"(23: Senior OT); "clients might offer the wrong support" (SAN10).

In summary, patients are relatively confident that peer support can meet their needs, and that they have the skills and qualities to deliver it. The primary concerns for them are trust and confidentiality. Staff are also relatively confident that peer support meets patients' needs, and that patients have the necessary skills. Whilst they share patient's concerns about confidentiality, their concerns about peer support are framed differently in terms of a) boundaries; and b) the emotional impact of peer support. One member of staff in interview explained this in terms of the intense interpersonal focus of secure services. *"Peer support is "really normal" in prison … formally through the "Listeners" or informally like prison staff asking a prisoner to look out for someone and how them the ropes …… because it is a less emotionally intelligent service they tend to leave people to "just get on with it" – whereas in secure we worry about risk – specifically interpersonal risk, people taking on too much, having to live together, confidentiality – sensitivities like that can cripple peer support" (Occupational Therapist 1)*.

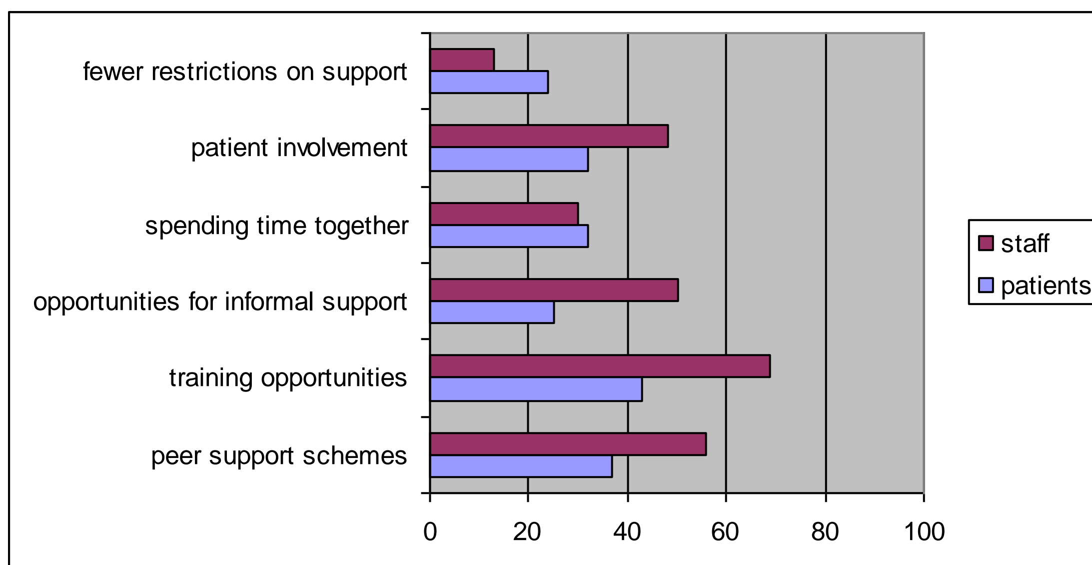
Staff in interview described how many concerns were driven by safety/risk issues: *"There are very problematic examples of PS eg. when one patient exploits the other financially or sexually; provokes a patient into an outburst against staff or other patients. Extreme examples and rare but they do happen" (Head of Clinical Services). "In secure mental health systems people tend to have complex issues; in the community services, less complex issues. Risk and safety are primary concerns, and the consequences when things go wrong are more dramatic" (Psychiatrist).* Risk was also a concern named by several patients in the survey: *"I feel wary of certain needs and behaviours of patients having goes at others out of potential jealousy at times" (CC17).*

Staff described how a concern with risk can obstruct practice and development: *"some people read risk and concepts like 'Duty of Care' to mean 'no, we can't do it'" (Psychiatrist).* Whilst variations were noted across roles, levels of seniority, types of services, all interviewees named problematic and "risk-averse" staff attitudes/ service culture as a potential barrier to peer support. *"In secure we worry about risk – specifically interpersonal risk, people taking on too much, having to live together, confidentiality – sensitivities like that can cripple peer support" (Occupational Therapist)*. Interviewees identified how a risk averse culture can act as a barrier to peer support: *" Secure services are a relatively risk-averse environment …. some people read risk and concepts like "Duty of Care" to mean "no, we can't do it". " (Psychiatrist)*. An example of this was offered in the form of a proposed weight management group for patients …. *"It was deliberated by all sorts of people with qualifications and eventually it was decided against ….They were concerned that people might try to sabotage each other and that it would be too intense and could become competitive BUT some good things could have come out of it, people could have supported each other"(Occupational Therapist 1).*

However, two members of staff in interview had no concerns at all about peer support in secure services - *"no , why would I? It HAS to be the way forward " (Advocate 2)*; whilst other interviewees were emphatic that any concerns should not become barriers to peer

support: *"There should be no obstacles …. Just positive risk taking … there's no reason to say "we can't do that"" (Clinical Director). "There are no barriers that can't be overcome. We just need to prioritise peer support and stay committed to it" (Occupational Therapist 1).*

6.10 "How do you think your service could support Peer Support to happen more?"



Patients engaged positively with the obstacles and concerns they had identified, by offering feedback about how their services could support peer support. Training opportunities – including listening skills, group facilitations skills and interview skills – were identified by 43% patients. *"access to training for group/ listening skills would develop more confidence – what about the Samaritans being involved teaching listening skills?" (KV2)*.

37% peers also felt that services could offer more peer support schemes, including buddying or mentoring schemes; whilst 32% felt that there could be more opportunities for patient involvement – for example, in running groups and taking part in interviews. In terms of informal support, 32% wanted more opportunities to spend time with each other - *"more opportunities could be given so that patients from other wards could meet together" (SSS1)* -

25% patients wanted more opportunity for peer support to happen informally and naturally between patients – for 24% this was about fewer restrictions on the support that peers can offer each other.

Similarly, participants in the scoping workshops named the importance of more resources, training opportunities, more social time, fewer rules and restrictions, and more opportunity for real involvement. There was a feeling that rules and "red tape" interfered with the ability for peer to support each other; with specific suggestions including:

- *"more get-togethers"*
- *"Patients being involved in interviews, staff training and writing policies"*
- *"magazine for patients by patients"*

69% staff felt that training opportunities would be a useful way of supporting peer support within their services; and 56% felt that more formal peer support structures - such as peer

support workers or Buddying schemes - should be offered. 48% wanted more opportunities for patient involvement eg *"More co-facilitation of groups – following a Recovery College model" (Occupational Therapy 2).*

50% staff felt that there should be more opportunities for peer support to happen informally and naturally between patients. 30% wanted more opportunities for people to spend time together, although just 13% felt that there should be fewer restrictions on the support patients can offer each other.

Other ideas included: showcasing and raising awareness of PS; and networking with other services user events: *"They give inspiration. It's too easy in a place like secure services to lose a sense of yourself as connected to a patient movement" (Occupational Therapy 2)*.

Several interviewees also recognised need for monitoring, evaluation, and learning … *"we need to build an evidence base which we can take to commissioners (Psychiatrist)*. It was suggested that the next stage after the publication of this research should be a pilot project, with quantifiable evidence to follow; and one interviewee (Clinical Director) described ongoing project which aims to formalise and evaluate Buddy systems across secure sites. This interviewee also talked about the process of effecting culture change through promoting awareness of peer support; modelling positive attitudes and practice; careful, supportive management rewarding positive practice and addressing poor practice; organisational drive and commitment; with close attention to clinical governance staff development. *"At some point tipping point is reached beyond which practices at which it becomes "the way it is"" (Clinical Director).*

7 Recommendations

7.1 Recommendations for services

1. Services should engage with peer support, and ensure that it is explicitly valued, encouraged and enabled; with a culture that promotes and values all forms of peer support between all patients.

2. Services should be alert to the value of both formal and informal support, and should facilitate informal peer support between patients as well as providing a range of formal peer support schemes.

3. Services should maximise patient control and choice within formal peer support schemes.

4. Practice should reflect the fact that peer relationships can exist in a variety of forms; offering opportunity to access support from patients on the same ward, on a different ward or unit, in the community, as well as those who share the same diagnosis, age, gender, hobbies, sexuality, age or ethnicity.

5. Support between those who share experiences of using secure services should remain the primary focus of peer support in secure services.

6. Services should take account of differences of ethnicity, language, ability, sexuality, age and gender, and how these impact on patients' ability to engage in peer support. This may involve providing specific peer support groups, such as LGBT peer support groups . It may also involve considering these aspects of difference when recruiting, allocating, and training Buddies and other formal peer support roles.

7. Buddying schemes should be provided for all new patients when admitted into secure services; and should be offered to patients when transferred between wards.

8. Services should engage with the important role that may be played by peer support during the process of discharge; and investigate opportunities for peer support around discharge; including visits from ex-patients.

9. Services should engage with the possibility of peer support at times of crisis

10. Services should not restrict their expectations of peer support to what is already on offer; but should be alert to the possibility that it may serve a positive role at other times; and to remain in consultation with staff and patients about the potential role of peer support within each service.

11. Services should reduce restrictions on relationships and conversations between peers, looking towards to services with positive, risk-taking attitudes towards informal peer support as a model.

12. Services should be alert to the fears and concerns of staff, in order that these might be acknowledged and addressed through appropriate channels of staff support such as training, supervision and other forms of support

13. Services should actively engage in the process of shared learning and networking, with the wider aim of building practice and an evidence base around peer support in secure services.

14. Services should recognise the important role that training and awareness raising can play in negotiating fears, concerns and other barriers to good peer support. Services should offer all staff the opportunity to access training on peer support; services should consider including peer support awareness in all inductions . Training for peer support in secure services should:

- address the nature and value of both formal and informal peer support schemes

- challenge any assumptions that peer support is less applicable to patients with learning disabilities or severe mental health problems.

15. Training for patients involved in formal peer support schemes should include:

- a code of conduct/practice including confidentiality and boundaries;

- understanding difference.

16. Training for patients should aim to increase the skills and confidence of all patients so that they feel more confident and able to offer informal support to peers. Services should consider awareness raising and training initiatives which address difference and maximise opportunities for informal peer support to take place across differences in identity.

7.2 Recommendations for research

Research questions:

1. Are patients in secure service less likely than those in acute and community settings to value peer support?

2. Does length of time in secure services impact on the value that patients place on peer support? Why?

3. Why are staff more positive about peer support than patients?

4. Why are patients more likely than staff to focus on informal peer support?

5. Do issues of identity (eg ethnicity, gender, sexuality) affect the experience of peer support? Is peer support in secure services more effective when it is provided by a fellow patient of the same age or ethnicity, for example?

6. How do differences of identity, experience and background impact on the provision and experience of peer support? Are White English patients more or less likely to have a positive experience of peer support, for example?

7. Is the impact and value of peer support affected by the nature of the peer relationship? Is peer support from someone in the community more or less effective than peer support form someone on the same ward?

8. Which outcome measures should be used to assess the effectiveness of peer support?

9. How can informal peer support with secure services be researched and evaluated?

10. How can secure services facilitate informal peer support between patients?

11. How can users of secure services can be actively involved in carrying out research.

12. How can services use training to support informal peer support?

Further

- Culture and organisational change towards user-led peer support can be a slow and demanding process. Case studies of processes of change within individual services may be useful.

- Boundaries are a key area of concern for staff, whereas patients are more concerned about trust and confidentiality. It would be useful to undertake an exploration of this issue, and how it is experienced by staff and patients in practice and literature.

- It would be valuable to conduct a literature review and scoping exercise on current models of peer support around discharge; both in secure mental health settings and in other services where relevant and applicable lessons may be learnt.

- More research is needed into the important role of peer support at times of crisis; mapping examples, exploring literature, for example, the work of Sherry Mead (2003); and addressing benefits and challenges.

8. Conclusion.

"Peer support is an invaluable tool in the armoury of coping skills" (CL8)

"I can get help from other people who are in the same boat" (M3)

There strong similarities between the findings of the research, and findings in literature. As in community and acute settings, peer support is valued for the choice, equality, hope, understanding, insight, wellbeing and companionship it can offer to people experiencing mental health difficulties and distress. As in community and acute settings, peer support faces a number of challenges and barriers.

Some of those challenges - such as the tension between informal and formal peer support; or concerns around boundaries, trust and confidentiality; were shared with acute and community settings. Finally, given that many patients in secure services are detained and subject to multiple restrictions, and that power relationships between staff and patients are inherently unequal; the mutuality, solidarity and equality inherent in peer-to-peer support (Carter and Repper 2010) may be particularly valuable.

However, peer support in secure services faces a number of challenges and barriers which are unique to the secure setting; including a culture which focuses heavily on risk and risk management; and the impact of this culture on staff and patient expectations. "*don't think patients should be responsible for each other's treatment" (GH4.*

Culture and expectations are hard, and slow, to shift. But they do shift. A movement towards user-focussed, positive risk-taking services is underway. Peer support reflects the current priorities of personalisation and choice, mental health recovery and self-care/self-management. Evidence from patients demonstrates that this is desirable, relevant and achievable in secure services; and is welcomed by the majority of patients. Evidence from staff confirms that this support is echoed by staff; and offers evidence of how patients and staff at all levels are working hard to support, enable and provide formal and informal peer support in secure services across the UK.

"At some point a tipping point is reached beyond which it becomes "the way it is"" (Clinical Director, TP).

Peer support in secure services works. It is valued by staff and patients alike. It is practiced in services across the UK. It is supported by a weight of evidence around peer support in community and acute settings.

"It works".

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Appendix I

Information on units which hosted the scoping workshops

One of the most notable aspects of the scoping workshops was the insight it gave us into the striking differences we witnessed between units; which may be briefly summarised in terms of:

- environment: levels of physical security;

- culture: optimism, friendly, welcoming, positive

- staff and patient attitudes

- levels of patient involvement and activity.

We recognise that our visits to services were very brief, and that our knowledge of the day-to-day reality of living and working within the service was extremely limited. Many variables may have impacted on our particular experiences of the units on the specific day we visited. However, it was felt that offering a brief impression of culture and environment, alongside objective practical information, may be useful; and that recoding direct quotations from patients and staff with reference to the unit they come from, may give another level of insight into the experience of peer support within those units.

Fromeside, Avon and Wiltshire Mental Health Partnership NHS Trust: a 80 bed medium secure unit which caters for both men and women. A small, bright service, with a lively, friendly and cohesive group of patients. Friendly staff who expressed positive and optimistic views about patients and patient involvement.

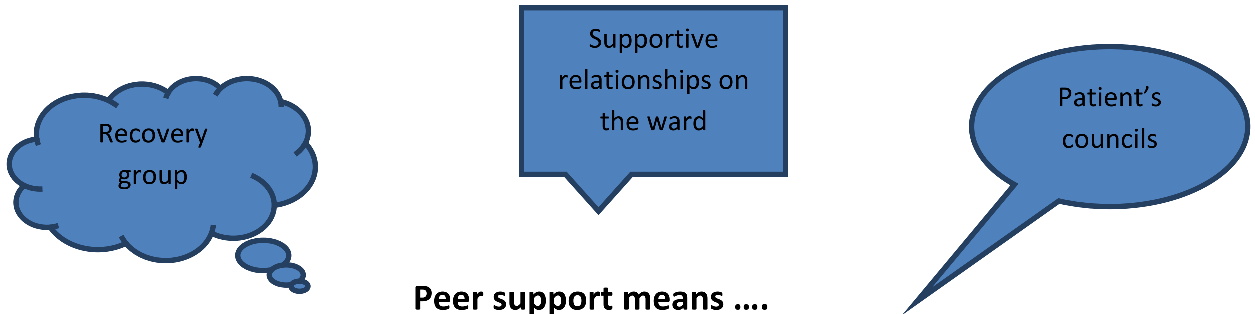
St Andrews Healthcare, Northampton: a 700 bedded site with a range of services; including male and female medium and low security, learning disability, head injury, personality disorder, Hungtindon's Disease, Older People, National Secure Service for Women; and the National Secure Service for Younger People. Well large, well-resourced, and very varied. Striking disparity between what was on display and what was reported by patients. Many, but not all, staff were friendly and positive. Big differences between wards: different levels of need, motivation and commitment in wards.

Arnold Lodge, Nottinghamshire Healthcare NHS Trust: a 92-bed medium secure psychiatric hospital with wards for male, female mental illness and personality disorder, including enhanced medium secure for women. Restrictive environment with heavy emphasis on security. Some members of staff extremely friendly and welcoming; others not. Disparity between wards and departments regarding their commitment to peer support.

Thornford Park, Priory Healthcare: a 122 bed low and medium secure facility for men.. Proactive and committed management. A small group of patients, majority were committed and vocal. Staff came and went throughout the workshop and largely did not contribute to discussions unless directly addressed.

Appendix II Patient questionnaire

Together are a national mental health charity and we're carrying out some research about on peer support in secure services. We really value your opinions; by filling in this anonymous questionnaire you could help to shape research across the UK.

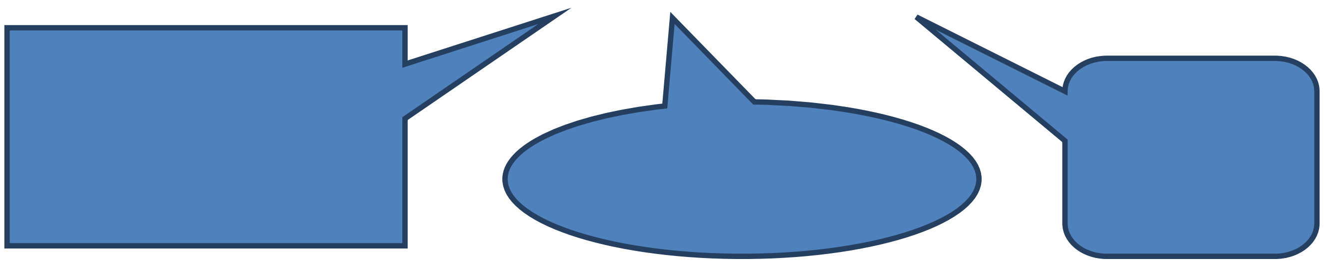


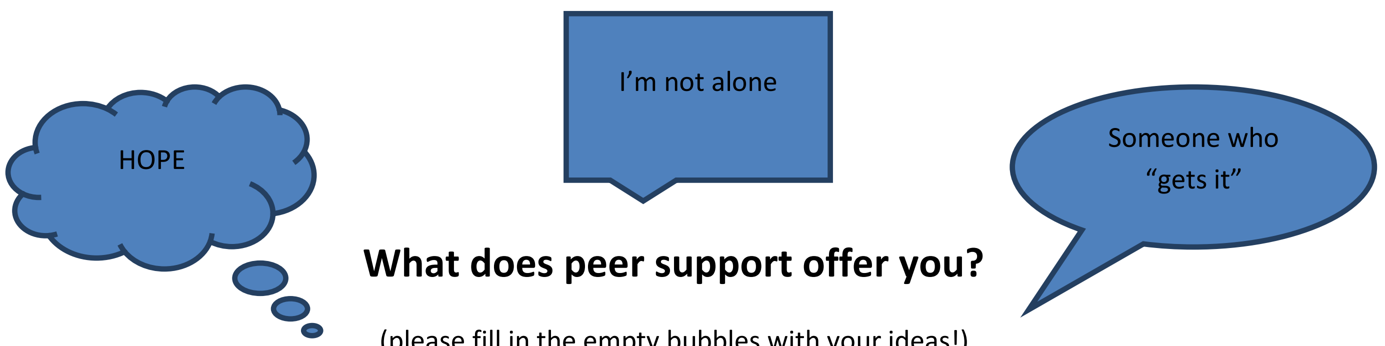
Peer support means ….

"people with lived experience of mental distress supporting each other"

…..what does it mean to you??????

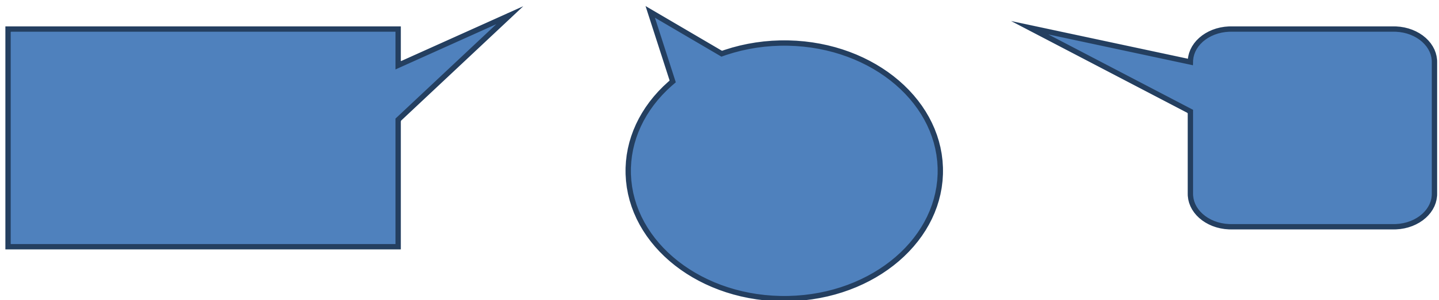
(please fill in the empty bubbles with your ideas!)





What does peer support offer you?

(please fill in the empty bubbles with your ideas!)



Appendix IIII

Services participating in patient survey

Cefn Carnau (CC) Priory Group 17 forms returned

St Andrews Northampton (SAN), 19 surveys returned

PIC Brain Injury Services, Essex 4 forms returned.

Partnerships in Care, North London Clinic. 11 forms returned.

Meadow View Independent Hospital 3 forms returned

South Staffordshire and Shropshire healthcare, 2 forms returned.

Huntercombe Hospital 6 forms returned

Pelham Woods, Low. 1 form returned

Goodmayes Hospital, 7 forms returned

Tatton Unit, Tameside and Glossop, 8 forms returned

Vista Healthcare 4 forms

Chadwick Lodge, 10 forms returned

Cygnet Hospital Beckton, 4 forms

Richmond Royal Hospital, Hume ward, 10 forms plus one form from Springfield (same authority)

Francis Willis Unit 2 forms

Scott Clinic, 4 forms

Wolfsen House, 3 respondents.

John Howard Centre 6 completed questionnaires

Morpeth, 17 completed surveys

St Barnard's hospital , 15 completed surveys.

Kemple View, 6 forms returned.

Adolescent medium secure. 5 forms returned.

Priory Group: Farmfield Hospital 5 respondents

Garrow House, 3 forms

Langdon Hospital, medium secure: 1 form returned.

St Andrew’s Birmingham. 13 respondents

Cygnet Hospital, Kewstoke 9 completed surveys.

Priory hospitals Thornford Park 17 forms

Appendix V

PEER SUPPORT IN SECURE SERVICES
STAFF SURVEY

Peer support is the support that people with lived experience of mental distress can offer each other.

There's lots of evidence to suggest that peer support in the community is useful. There is less evidence on peer support in medium secure settings. This project is about peer support in (primarily) medium secure services. It is commissioned by Together (a national mental health charity) and is led by people with personal experience of mental distress.

The first project survey explored what people accessing secure services think about peer support. This survey aims to explore staff views on peer support. Both surveys map out existing peer support provision in secure services.

Any information you share with us is confidential and anonymous. It will feed into a report which will help to shape the future of peer support in secure services.

Please return completed surveys to:

Together Peer Support Project
c/o Elina Stamou
Together
12 Old Street
London EC1V 9BE

by 6th June 2014

Many thanks for taking part!

Start of the Survey

Date: ____

Your Job title: ____

Service location: ____

Type of service: ____

Gender (please circle): Female Male

Age (please circle): 16-24 25-29 30-34 35-39 40-44 45-49

50-54 55-59 60-64 65+

What is your ethnicity? (please circle):

White: English Welsh Scottish Irish Irish Gypsy or Irish Traveller European

Other White background (please state)_____________________________________

Mixed/multiple ethnic groups:

White and Black Caribbean White and Black African White and Asian

Any other mixed background (please state)___________________________________

Asian/Asian British: Indian Pakistani Bangladeshi Chinese

Any other Asian background (please state)____________________________________

Black/ African/ Caribbean/ Black British

African   Caribbean

Any other Black/African/Caribbean background (please state)___________________

Other ethnic group (please state)____

1. **Do you think that peer support can be useful in secure services?** (Please circle the answer you think is the right one).

   Yes   **No**   **Sometimes**

   Please tell us why:

   ____

   ____

2. **In <u>an ideal service</u>, what forms of support do you think patients are able to offer each other?** (You can circle more than one answer)

   a. **Offering emotional support -** For example: "just talking", asking "are you okay?"

   b. **Offering practical support -** For example: "showing you around", "making you a cup of tea"

   c. **Standing up/ speaking out for each other within the ward and the service**

   d. **Offering information -** for example: "what's what, who's who and what to expect"

   e. **Supporting each other's wellbeing -** for example: "having a laugh", "socialising", offering hope and reassurance – "you can do it!", "sharing what you've tried and worked"

Are there any other types of support that patients can offer each other?

____

____

3. **How do patients support each other within <u>your service</u>?**
(You can circle more than one answer)

a. **Offering emotional support**
In what ways/when/how?
____

b. **Offering practical support**
In what ways/when/how?
____

c. **Standing up/ speaking out for each other within the ward and the service**

In what ways/when/how?
____

d. **Offering information**
In what ways/when/how?
____

e. **Supporting each other's wellbeing**
In what ways/when/how?
____

Are there any other ways that patients support each other in your service?

____

4. **User-led peer support happens when patients are in control of the support they offer each other:** they make the decisions about what sorts of support they offer, when, how, to whom and by whom.
   Does this happen within your service? No/ Yes

   If yes, please indicate how (You can circle more than one option below)

   a. **Groups/ meetings are run by patients** (for example patients set the agenda, chair the group and take the minutes)

      What types of groups? What do they do? What impact do they have within the service?

      ____

      ____

      ____

   b. **Patients influence the running of the service** (for example being part of staff recruitment, writing policies with staff, developing and delivering training with staff)

      Please provide examples of how patients influence the running and delivery of your service:

      ____

      ____

      ____

   c. **Friendships** (patients decide who they spend time with and what they talk about)

      Are there restrictions on what patients can discuss with each other, the type of support they offer each other and how/when this happens? (please give us more detail below)

      ____

____

____

Are there any other ways that user-led peer support happens in your service?

____

5. **Do you think that user-led peer support could happen more in your service?**

   Please circle: No/ Yes

   If you circled "no", could you briefly explain why?

   ____

   If you circled "yes", could you explain why, and briefly offer some examples?

   ____

6. **Who do you think can offer support to patients in secure settings** (Feel free to circle more than one option)

   a. **Fellow patient** from the same ward
   b. **Fellow patient** from another ward or another secure unit
   c. **Someone in the community** with personal experience of mental health problems
   d. **Someone in the community** with personal experience of secure services

e. **Someone who has other significant experiences in common** for example: gender, ethnicity, sexuality, diagnosis, hobbies, age (please circle)

Other____

7. **Do you think that peer support offers benefits that are different to those offered by staff support?** (Feel free to circle more than one option)

   a. **Greater choice** - for example, “You choose friends – you don’t choose professionals”
   b. **Fewer restrictions** - for example, “nobody is taking notes or monitoring me”
   c. **Greater insight and understanding**: for example, “you don’t understand unless you’ve had the same experiences”
   d. **Clearer and more relevant information and practical support**
   e. **Peer support is more accessible/ available for patients**
   f. **Peer support reduces the workload for staff**

Other

____

8. **Please circle when you think peer support is useful; and what form it can take. Feel free to circle more than one.**

   a. **On admission to secure services**

Example____

Why is this useful?

____

   b. When moving between wards

Example____

Why is this useful?

____

c. **During and after discharge from services**

Example____

Why is this useful?

____

d. **When a patient is in crisis**

Example____

Why is this useful?

____

e. **When a patient is having a good day**

Example____

Why is this useful?

____

f. **When a patient is having a bad day**

Example____

Why is this useful?

____

Any other ideas:

____

____

9. What barriers are there to getting good peer support within your service?

(you can circle more than one)

a. There are restrictions on the time patients spend together

b. There are restrictions on what patients are allowed to say to each other
c. There are no formal peer support schemes eg Buddying, Ward Reps or Peer mentors.
d. Staff have negative attitudes towards peer support or don't believe it can work
e. Peers do not have the right skills or qualities

Other____

____

10. Do you have any fears or concerns about peer support?

a. **Trust:** the challenge of trusting other peers
b. **Confidentiality**: for example, information may be shared or misused
c. **Maintaining boundaries between patients**
d. **Patients not feeling skilled or confident** to offer support to others
e. **The emotional impact** of offering support to others
f. **Peer support may not meet a patient's needs:** "Peers don't have the training that staff have had"

Other____

11. How do think your service could support Peer Support to happen more?

a. **More Peer Support schemes:** for example, Buddying or Mentoring schemes
b. **Offering training opportunities** eg listening skills, interview skills, group facilitation skills
c. **More opportunities for peer support to happen informally and naturally** between patients
d. **More opportunities for people to spend time together**
e. **More opportunities for patient involvement:** for example, running groups, taking part in interviews

f. **Fewer restrictions** on the support patients can offer each other (please specify)

Other____

____

Any final comments or thoughts?

____
____
____
____

End of the Survey - Thank you for taking the time to complete this!!