Transformation Partners in Health and Care

NHS Yorkshire and the Humber Clinical Networks

Promoting peer and lived experience support within community mental health transformation for older adults

This guide supports the increase of peer and lived experience support within community older adult mental health (OAMH) services, and specifically for older adults living with severe and complex mental illness. It draws on:

- **Learning from a workshop held with NHS, third sector and social care stakeholders from London and the Yorkshire and Humber regions exploring barriers and enablers for peer and lived experience support for older adults**
- **Discussions with older adults with lived experience of mental ill health**
- **Existing good practice in providing MH peer and lived experience support with and for older adults**

This guide has been developed in partnership between Transformation Partners in Health and Care (TPHC) in London and the Yorkshire and Humber Clinical Network

Transformation Partners in Health and Care

Contents

NHS Yorkshire and the Humber Clinical Networks

How can I use this document for my role?

This document is intended for use by NHS, third sector and social care professionals working across a range of areas - including clinical, commissioning, transformation and service management roles. Different sections of the guidance will be useful for particular roles, as follows:

If you are thinking about developing a peer support service for older adults	read pages 14-22
If you want to understand how organisations can take practical steps to recruit and support older adults in peer support and lived experience roles	read pages 11, 12, 18 - 21
If you have lived experience of mental illness and want to know more about what peer support in older adult MH services involves	read pages 23-25
If you want to read about existing examples of MH peer support services for older adults	read pages 26-30
If you want to understand how policy and commissioning can enable peer support in community older adult mental health (OAMH) services	read pages 31-33

Key messages

What older people told us (pages 9 – 13)

1. **We have common needs as older people, but we don't want to be defined by our age** - we want our skills and experience to be respected.
2. **We already use our lived experience to provide advice, support and care to our friends and families, and across our communities** – we want this to be valued and supported by MH services.
3. **We value being able to come together in groups** to help one another with our MH, to access support and to socialise.
4. **We want options to be involved in different ways. Some of us want to be paid, while others want to engage voluntarily.**
5. **We want to stay connected to people with similar experiences and to MH services during gaps and transitions in care**.

Considerations for service development (pages 15 – 22)

1. **Start small** – the evidence base for OAMH peer support needs to be built through piloting, iterative learning and evaluation.
2. **Coproduce peer and lived experience support services** with groups that represent the diversity of local older populations.
3. **Create opportunities for older adults to use their skills and lived experience on both a paid and voluntary basis.** But be cautious when developing volunteer peer support roles.
4. **Map, celebrate and enable spaces where informal MH peer-to-peer support is already happening** in your communities.

Considerations for policy and evaluation (pages 32-33)

1. **Provide multi-year funding for OAMH peer and lived experience support** to enable iterative service development and learning.
2. **Prioritise appropriate commissioning coproduction activities** that meet the accessibility needs and preferences of older adults.
3. **Fund evaluation of existing good practice and further research on OAMH peer support.**
4. **Address gaps and contradictions regarding OAMH peer support in national policies** and develop accountability mechanisms for delivery of these services.

Background

This section provides:

- An overview of the challenges we are seeking to address with this guide
- How we are defining MH peer and lived experience, and why
- The purpose of the document and how it can be used by different services and professions

Background

Scoping and consultation led by TPHC suggests that there are very few MH Peer Support Worker (PSW) roles within NHS community older adult mental health (OAMH) services nationally. This contrasts with adult services, where PSWs have been a cornerstone of the transformation.

This inequality derives from the fact that the existing peer support model has yet to be effectively adapted for older adult services:

- **Evidence and learning from practice to date is under-developed** for the role peer support can play in OAMH services.
- **People with lived experienced of mental ill health in later life are less likely to seek professional peer support roles.**
- **Development of volunteer models of peer support can be challenging**, particularly within statutory clinical MH services
- **Community MH policies and commissioning frameworks do not provide adequate guidance on the need for these roles** in OAMH services or how they can be adapted for this population

At the same time, there are significant opportunities for involving older adults in delivery of community MH services

- **Older adults can bring a wealth of skills and experience to services**, including lived experience of mental ill health.
- **Older adults are often eager to invest spare time and have excellent knowledge of community groups and social networks**
- **Other non-clinical models have been extremely successful in offering older adult sources of peer and lived experience support in their communities** – including befriending, community connection and intergenerational contact

Defining “peer support” for the purposes of this guide

In mental health, “peer support” refers to a specific model whereby a paid PSW offers empathic emotional and practical support to people living through similar experiences. The model is evidence-based and is underpinned by principles and standards.

Given that peer and lived experience support in OAMH is in an earlier stage of development, a looser definition will be required in order to draw on existing practice. This follows recommendations set out by Centre for Mental Health in **the only evidence review to look at peer support with and for older adults**

> *Using a looser definition of peer support that involves befriending, volunteering, social groups and activities… may make it harder to ‘manualise’ peer support, but it has a number of benefits. These include the existence of some well-developed and evaluated models, being accessible to a wide group of older adults, and being effective both in preventing poor MH and improving the wellbeing of older adults with MH problems.*
>
> ***Centre for Mental Health, 2020***

For the purpose of this document, the term ‘peer support’ will therefore refer to a broad range of activities where individuals with peer and lived experience are involved in the mental health care of older adults. This includes:

- Mental health peer support and peer coaching services
- Befriending, connector or other non-clinical support roles provided by either staff or volunteers with lived experience
- Groups where people are providing practical and emotional support to each other for their MH recovery
- Informal forms and structures of peer-to-peer MH support in services and communities

Consultations with older adults with lived experience

We spoke to older adult MH involvement and coproduction groups in London and Yorkshire about peer and lived experience support

This section provides details of these important discussions…

What would you want from a peer support service?

People felt strongly that support from peers could play/could have played an important role in their recovery, and that group support was particularly highly valued. These are some of the reasons they gave…

Peer support could provide advice for how to manage MH more holistically. It could enable someone to navigate through clinical and social services, while also helping them to access support across their family, social and community networks.

Support between peers, particularly within groups, provides a unique space where people can share experiences openly, not fear judgement and gain a feeling of independence. This could be a way to complement support from MH services, families and carers.

Practical advice was a recurring theme. Older adults are often accessing services across MH, physical health and social care. Advice from individuals or groups sharing lived experience could help navigate these services.

Peer support could provide a feeling of continuity when accessing care. This was particularly associated with service user networks and involvement groups. These provide much-needed connection with services during gaps in care.

> *MH services structure you and they give you a timetable: take the pills, attend the sessions. A peer support person could help structure, a more flexible care package around me, and go down a more holistic route.*

> *Being older and having a MH issue is very isolating. Peer support would enable communication and it takes the responsibility outside of your family. It could help us to develop the coping mechanisms to move back into our own lives again.*

> *At first I saw nurses and psychologists a few times a month. But then it went down to seeing a psychiatrist every 1, 2, 3 months. But with these groups you can come together and meet your friends. It has really helped me through some difficult times.*

What does "a peer" mean to you?

There is no agreed definition of a MH peer or lived experience supporter for older adults. We asked older adults what they would look for in a peer…

Shared lived experience, including of similar mental health conditions, was the most commonly mentioned priority. Age was not regularly mentioned, but people did emphasise a need to work with someone with similar experiences.

Some stated explicitly that they would be more comfortable working with someone in their age group. This was often related to having shared experiences related to later life.

Speaking to someone without fear of judgement or stigmatisation was a recurring theme in conversations. People also felt strongly that they did not want to be defined by their age – and so both older and younger peers would need to be able to question their own biases regarding ageism.

It was often difficult for people to envisage what they would look for in "a peer" – no one we spoke to had received 1-1 formal MH peer support. This reflects issues in the wider evidence base and learning for OAMH peer support.

> *You need to know that the person you're getting support from has that similar experience and can listen to what you've got to say and not be alarmed or ashamed or upset. They need to be completely open minded. Being prepared to listen and empathise is the most important thing.*

> *Peer support to me isn't about all of my MH, it's about supporting me and myself and the person who is there with me. I have lots more to me than my MH, I have likes and dislikes, I get excited and calm. It's all what makes me who I am. I want someone who is open, honest, and can talk about their own history.*

> *Age doesn't come into for me. Honesty, open mindedness and willingness are the main things. And not focused on supporting the status quo. Someone who doesn't project onto you and fit you into a box.*

If you were to be involved in delivering these services, what would you want to know?

We wanted to understand some of the potential barriers and enablers for older adult involvement in peer and lived experience support…

Overwhelmingly, older adults said that they wanted to be more involved in MH services and supporting each other, whether through formal peer support or other models. This was often seen as a way to use experience from their own recovery to help others.

Involvement was often linked to empowerment and challenging ageist assumptions. People were eager to learn new skills, meet new people and be valued as contributors to services.

Many people would need to be involved on a voluntary basis. Reasons for this included personal preferences around workload and flexibility, and also practical restrictions around pensions and benefits.

At the same time, some older adults would be eligible for and interested in paid peer support roles. This was linked to perceived esteem versus volunteers, and also practical pressures around escalating cost of living.

> *For me it would be voluntary. At our age anything is an experience. And so anything I get involved in, I really get involved in! Older people like to talk. We have potential. And we're less shockable at this age. We are a valuable pool of information IF YOU USE US PROPERLY.*

> *I would be interested in a paid role. It lends credibility and also I'm having to think about getting my house in order. With cost of living and my savings, all of a sudden I've now identified myself in the struggle.*

> *Supporting people in this way is something I would definitely like to do. But my questions would be: How many hours? Can I chop and change my time each week if I need to? How flexible would it be?*

Informal systems of peer support

People regularly described how they were supporting each other through informal groups and networks in their communities. How to build on these networks was a priority in all discussions…

During COVID-19 lockdowns, MH structures such as therapy groups, service user groups and involvement networks often continued to stay in touch and support each other independently.

Many people were providing informal MH support within community organisations that did not have an explicit MH purpose, and also through social networks. Again, this had become more frequent during COVID-19.

Others who had experience of mental ill health or caring were regularly approached by people within their communities with questions about MH, dementia and how to access support.

With all of these examples, some older adults expressed fears around not providing the right advice and not being able to meet everyone's needs. There was a request to have ready access to MH expert support, infrastructure and guidance around boundary setting.

> *I help run a group of over 65s associated with football. Four people over lockdown were having MH issues and I gave them confidence to go to the GP. They wouldn't have done that with their families. You hold your MH for a long time and then it explodes out of you when you're ill, but you don't always want to share it with your family.*

> *Many of us have these local connections with neighbours who are having struggles. Somehow you get mentioned – why don't you ask X? But there is a limit, it's peaks and troughs and can be very demanding on our time.*

> *We've got very caring and very confident NHS workers for our group. They're always very available. Some of us would struggle with boundaries if we were doing this on our own. I would find it overwhelming if someone shared all of their emotional problems. I would feel guilty.*

Peer support with and for carers

Through our consultations, we also spoke to carers of older adults living with severe mental illness and also dementia - some of who had benefitted from peer support within dementia or carer services. This is what they told us:

Peer support would be extremely welcome to carers in helping with isolation, practical and emotional support. This was seen as an impactful way for carers to remain positive and able to look after their loved ones.

> *My husband has had mental illness for a very long time. I used tell people he has a bad back. The support we give each other [at a carers support hub] is unbelievable. I don't share with my really good friends what I share in the hub. And that is lovely – you come out feeling a lot, lot better than when you went in.*

Peer support could provide an important, confidential and empathic space where someone could share their struggles and gain a sense of hope. Carers are often unable to speak openly either to clinical staff or loved ones about the problems they're facing.

> *I know a hub and they support with discharge. My husband gets a lot of (clinical) support when he comes out, but I have to find the more social activities. I know how activities really help him and we all need that purpose to get up in the morning.*

Carers particularly needed support during transitions in care. People spoke of peer support hubs that were able to help with linking their loved ones to social networks and groups – which was a much needed complement to clinical support.

> *My friend's care coordinator left and her support had expired. She was there by herself during lockdown with no support. I used my life experiences to help her deal with it, but I wouldn't wish that on anyone. What I needed was a psychiatrist, a nurse… but it was just me.*

Enabling peer and lived experience services with and for older adults

This section presents considerations and recommendations for services that want to develop new models or enhance existing offers for older adults. It draws on:

- consultations with both experts by experience and experts by profession
- learning from existing models and approaches

Examples of good practice that have informed these enablers are included in Appendix 1 of this document (pages 23-26).

Designing new peer support and lived experience services

This guide refers to four overarching approaches for providing MH peer and lived experience support for older adults.

1. **Older adults working as paid peer workers** on a sessional or staff basis
2. **Developing volunteer and unpaid models** as a way of involving older adults with lived experience in services and enabling informal peer-to-peer support
3. **Younger peer workers** supporting older adults (e.g. through coaching models)
4. **Peer support being provided with and for carers** of older adults living with severe mental illness

This section refers to considerations for 6 areas where organisations can enable these approaches:

1. Service design
2. Coproduction
3. Developing volunteering models
4. Supervision and governance
5. Enabling informal structures
6. Training and professional development

Designing new peer support and lived experience services

Organisations will have to allocate time and resources to design, pilot and evaluate ways of providing MH peer and lived experience support with and for older adults. Evidence of good practice is scarce and existing models may need to be heavily tailored.

This section provides key considerations as starting points for designing services.

Start small. New and adapted approaches will need to be coproduced, piloted and tested. Existing peer support models and roles for younger adults are unlikely to be easily transposed into OAMH settings. This will require multi-year budgeting and commissioning timeframes.

Work with OAMH specialists. Clinicians, service leads, team leads and transformation staff from OAMH services understand the needs of older populations. These teams are also facing unique constraints and so need to inform feasible supervisory and clinical support structures.

Build on and learn from existing practice. Can existing services be more inclusive for older adults, e.g. carer peer support? If older adults are already being reached through all-age offers, has this been evaluated? What existing spaces are there that bring older adults together that could be better supported?

Avoid medicalising peer support from the outset: older adults may be more likely to have co-occurring physical health, mobility and social care needs. Clearly define the role of peer support versus clinical support, maintain boundaries, and embed services in robust physical and MH clinical support structures.

Involve older adults from the start. Older adults are as diverse as any other age group. Understanding what older adults in communities want from peer and lived experience support should be the starting point for service development (also see next page re: coproduction).

Prioritise partnerships: Collaboration across NHS, third sector and social care is key to ensuring that peer support can meet local needs. Service design and delivery needs to be rooted in an understanding of the role and value that both statutory and non-statutory partners can bring.

Coproducing new peer support and lived experience services

Coproduction with older adults is critical for designing adapted or new services. Coproduction activities have to be tailored to meet the specific needs and preferences of older adults to ensure meaningful involvement. Key considerations for meaningful engagement include:

Co-produce with groups that reflect both those currently within MH services and the wider local older population. There is significant unmet MH need among older adults. Coproduction has to engage beyond people currently known to MH services, including carers, younger people who may be future service users, and the wider community.

Prioritise accessibility. It is vital that budgeting for coproduction should include transport, accessible venues and food – this is often overlooked. Timing and pace of activities can be planned with participants in order to meet their needs for involvement.

Ensure participants can be paid and/or reimbursed for their time and expenses. Link with HR and involvement teams to understand and communicate implications for people on pensions and benefits.

Some older adults will want to participate on a voluntary basis and so factors including recruitment, reasonable time commitments and support need to be carefully considered.

Coproduction and involvement models

Participating in service design, evaluation and governance through **coproduction and involvement networks.**

Supporting staff induction and training, including through **Recovery Colleges, Lived Experience Connector roles and preceptorship programmes**.

Strengthening lived experience voice through **Service User Networks** (see page 19)

Allocate time and resources for socialising within coproduction activities. As with all groups, coproduction and involvement can offer an important opportunity for older adults to connect socially and build relationships. This can be a powerful incentive for participation.

A list of some coproduction and involvement groups within MH Trusts in London, Yorkshire and the Humber regions are included in this document as an annex (see page 35).

Volunteering peer support models - considerations

PSWs are paid staff working on a salaried or sessional basis. Experience has shown that introducing volunteer models of 1-1 peer support can pose challenges particularly within statutory MH services. Key considerations are as follows:

Maintaining parity

Introducing volunteers as PSWs risks undermining the significant progress in professionalising peer support as a respected element of the MH system.

Existing challenges around preventing peer support from becoming medicalised (e.g. PSWs being drawn into healthcare or MH assistant-type roles) could be exacerbated.

Workload

The workload of a PSW within a clinical service is highly taxing and can require responsibilities including line management, clinical supervision, continuous professional development, safeguarding, administration and participating in multi-disciplinary teams (MDTs).

Volunteers are unlikely to be able to perform the full range of responsibilities allocated to other peer support workers.

Support and infrastructure

Although volunteering within the NHS is growing, it still lacks the well-developed infrastructure of other sectors (particularly the community and third sector). Integration of volunteers into clinical MH services is still in relative infancy.

Introducing volunteer roles to MH peer support services therefore needs to be treated with caution, particularly given the lack of evidence and learning for OAMH.

At the same time, our consultations reflect:

- the need to increase voluntary opportunities for older people
- the potential for voluntary and informal networks to enable peer-to-peer support
- the value older people place on coming together as groups to support one another

The following slides therefore present:

1. **Ideas for how older people can be meaningfully involved in MH services;**
2. **How providers can map, celebrate and enable informal MH support in their communities.**

Creating voluntary opportunities for older adults to support one another

There are a range of ways that people can support users of MH services on a voluntary basis. However, consultations for this project suggest that these opportunities are often not available to older adults.

This section provides examples of existing models that are or could be used within OAMH services. Examples include links to information, tools and resources.

Models for people with lived experience supporting service users on a voluntary basis include:

- **Befriending services provide** spaces for volunteer befrienders to come together with users of services. This can be in third sector, NHS or community venues, people's homes or over the phone.

- **Travel buddy schemes** train volunteers to accompany clients to appointments, services, green spaces, activities and events. Some schemes are led by volunteers with lived experience, including the Hand-in-Hand scheme in Camden & Islington, London (also featured on page 28 of this guide).

- **Volunteer meet and greet services** involve people with lived experience signposting visitors on arrival to MH inpatient units and if necessary accompany them to the wards and helping them through sign in procedures at what can be a very difficult time. See here for an example of a Meet and Greet service in Leicester.

Service User (SU) Networks

SU Networks offer open-ended support bringing together people with shared experiences. They are a space where individuals can feel accepted and understood. SUs control the kind of support they receive, how long and how regularly they access support, and how much they want to be engaged.

Group sessions can be co-facilitated by the peers, who also can take on formal roles (e.g. co-chairing sessions, organising logistics, budgeting). There is shared responsibility for ensuring a safe and supportive environment. Overall facilitation is usually provided by a SU Network Manager, with support from MH clinicians.

SU Networks can also be meaningful spaces for coproduction and raising up service user voice within service design, delivery and governance.

An example of a group in Sheffield following this model is provided in the annexes to this document – see page 27.

Details of a Personality Disorder and Complex Needs SU Network service run by Essex Partnership University NHS Foundation Trust can be found here.

Enabling informal peer-to-peer support structures within services and communities

During our consultations older adults and MH staff described how people with lived experience are coming together to provide informal MH support. The question was then asked: *how can this be enabled by community MH services?*

- **Map and understand assets in your organisation and community where older adults are coming together to help one another.** Coproduction groups, community organisations and social networks may already be spaces where MH peer-to-peer advice and support is taking place.

- **When mapping assets, look beyond groups with a specific MH focus, or that are age-specific.** "Older adults" are as diverse as any other age group and will be active in different community spaces and networks.

- **Support people to stay well. Informal groups risk falling outside of NHS structures. This could involve:**
  - providing signposting to relevant guidance on wellness and self-care
  - creating pathways to staff wellbeing services and networks
  - providing contact details of a focal point/link person within the organisation – e.g. an involvement lead in an OAMH service

- **Draw on existing good practice to help groups and individuals define, agree and maintain boundaries for their peer support**. This could be provided through developing and sharing tailored guidance, developing publicly available training packages or linking people to existing training and development.

- **Share links and resources that provide clear guidance on identifying a MH crisis**, and when and how to access support in an emergency.

Informal peer support could include:

- **Coproduction groups** sharing advice and on recovery within meetings and social activities
- Current and former MH service users and carers being approached for advice through **social and family networks**
- MH advice and support being shared **within community groups and organisations** that may or may not have a specific MH focus

Supervision and governance

Feedback from older adults received for this project supports existing literature on what older adults look for and need from their place of work. In short, older workers want the same things as younger workers, but value certain things more.

Organisations can ensure that effective supervisory and governance structures are in place to allow older adults to thrive within paid peer and lived experience support roles by:

- **Creating work that is challenging**, draws on older adults' strengths and experience, and enables the development of new skills and abilities
- **Providing equal access to career and personal development,** including training, mentoring and leadership
- **Ensuring the provision of flexible working arrangements** as much as possible, such as reduced hours and flexibility in terms of both the time and place of work
- **Creating a working culture that is genuinely inclusive**, allows older worker's voices to be heard and tackles all forms of discrimination wherever it occurs, including ageism
- **Providing opportunities for older adults to participate in governance and leadership.** This could include responsibilities within management boards and other decision making bodies, or promoting more senior/supervisory peer support roles to older adults
- **Ensuring specialist support for lived experience and peer services**, including through robust clinical supervisory structures

Training and ongoing professional development

Training is key for peer support. MH Trusts use a range of accredited training courses that complement a persons lived experience to ensure that they deliver the role with confidence, certifying their skills, techniques and resilience.

This offers a range of opportunities to adapt training programmes and resources to support peer and lived experience support within OAMH services.

- **Existing peer support training modules on unconscious bias and addressing health inequalities can be expanded to meaningfully include ageism and age-discrimination**. This can help to facilitate important discussions among both younger and older staff and volunteers about internalised ageism.
- **Training and ongoing support for maintaining boundaries for peer support and the role of a peer supporter is particularly important for this group.** Training could be adapted for peer support staff, volunteers and for community groups (see also pages 19 and 20).
- **Training could include common needs and recovery priorities for older adults and how to access specialist support in key areas (e.g. dementia, frailty).** This can further can equip peer workers to feel more confident to work with older adults.
- **Older adults in voluntary roles such as befriending, coproduction and service user networks can significantly benefit from peer support training.** This could include safeguarding, setting and maintaining boundaries and how to refer in a crisis.

Transformation Partners in Health and Care (TPHC) has published a good practice resource focusing on peer support training, development and leadership in adult services in London. This may have useful learning and tools for OAMH services and is available on our website.

Principles

These final slides suggest a possible framing for principles of peer support with and for older adults. This draws on existing peer support frameworks* and consultations held for this guide – and can be applied to both 1-1 and group models.

These principles are intended to provide an early starting point that can be further built upon and shaped as learning, evidence and practice develops.

* https://www.researchintorecovery.com/files/RRNJuly13_ImROCbriefing_peer_support_workers.pdf

https://maternalmentalhealthalliance.org/psp/

Principles for mental health peer and lived experience support for older people

Good MH peer support with and for older adults…

…is **safe, nurturing and empowering**

- **Good peer support creates a supportive and compassionate environment. It provides a space where older adults can feel confident to be in control of their recovery goals and to articulate how they want to live in their communities.**
- **It both compliments and is separate to clinical settings, and the support provided by families and carers.**
- **Peer support can help people during times of crisis that can be more common in later life, such as during transitions in care, following a bereavement, and following the diagnosis of a severe mental or physical health condition.**
- **Peer support creates and respects clear boundaries and rules for personal safety. This includes what a peer supporter and the older adult receiving support are happy to share and how they would like to share it.**
- **Importantly, peer support is located within robust organisational safeguarding structures that ensure the safety of everyone involved.**

…is **accessible and inclusive**

- **Good peer support is built upon an understanding that the term "older adults" does not refer to one homogenous group. Older adults constitute as wide a variety of generations, ethnicities, cultures, sexual and gender identifies and other characteristics as younger adults.**
- **Peer support therefore takes proactive steps to ensure accessibility, inclusion and choice. This respects the diversity of older adults within MH services, while also helping to reduce age discrimination. This includes:**
  - ✓ **ensuring multiple points of access and referral**, including through self referral and via primary and social care.
  - ✓ **being flexible in where peer support takes place**, including within clinical settings, accessible community spaces, in people's homes and online.
  - ✓ **providing robust support for digital offers,** including for access to both devices and wifi connections, alongside training and support for digital skills, safety and confidence.

Principles for mental health peer support for older people

…is **explicitly anti-ageist**

- **Good peer support recognises people's capacity for recovery from mental illness, regardless of their age. It is built on an understanding of how people experience mental illness and MH services in later life.**
- **It values the extensive expertise and skills that older adults can bring to peer support. It builds on a person's strengths and is not limited by preconceptions around age.**
- **It accepts that older adults experience unique barriers to accessing MH support and that these are often rooted in cultural attitudes to ageing. It can play an important role overcoming these barriers.**
- **Peer support accepts that age is one in an intersecting set of discriminated characteristics, including ethnicity, race, gender, sexuality and disability. It takes intentional efforts to address these inequalities and to avoid replicating them within health and social care.**

…provides **opportunities for involvement of older adults with lived experience**

- **Good peer support is led by people with lived experience of mental ill health in later life, including service design and delivery.**
- **Peer support provides a rare opportunity to bring lived expertise of MH in later life into an organisation - including governance, coproduction and service delivery structures.**
- **Older adults can be involved as peer supporters by ensuring that there are a variety of recruitment pathways and flexible employment arrangements, including through exploring volunteering and sessional service models.**
- **Good peer support involves people in delivery and coproduction that reflect the diversity within local older populations.**

Appendix 1 – a deep dive into existing good practice

This annex provides information and resources from existing OAMH peer and lived experience support services in the London, and Yorkshire and the Humber regions

Helping One Another, Sheffield Health and Care NHS Foundation Trust (SHSC)

Transformation Partners in Health and Care

NHS Yorkshire and the Humber Clinical Networks

Helping One Another (HOA) is a peer support group for service users, carers and families being cared for by SHSC OAMH community and home treatment teams. It provides open-ended support through monthly group meetings of between 8-15 service users.

HOA was coproduced with OAMH staff and service users, with a key aim to support compassionate discharge from services. The Trust already hosted a service user group mainly aimed at working age adults, but OAMH staff were aware that older adults experienced different service offers and pathways, and so would benefit from an age-specific group.

> *We intentionally started the group without a set goal in mind as we wanted the group to develop and evolve in collaboration with service users. We were clear that we were not offering formal group therapy but rather a space for service users to access peer support and to provide a graded, compassionate discharge pathway.*
>
> ***Dr Shonagh Scott, Consultant Clinical Psychologist***
> ***Head of OA & Neurological Conditions Psychology Service, SHSC***

Brief information about Helping One Another and contact details can be found on the Trust's website.

How does it work?

- **Meetings provide a space where people at different stages of their recovery can come together, share recent experiences and offer each other support.** They are held on a monthly basis at the Trust's offices.
- **The group offers an important source of open-ended support when people are under the care of the MH team, and during discharge and transitions between services.** Members support each other with transitions in care, and during other difficult times such as bereavement, housing and financial issues and care for loved ones.
- **The group is supported by clinical psychologists, an Occupational Therapist, CPNs and an administrator.** Staff help to organise meetings, facilitate speakers at the request of members, maintain boundaries for peer support within the group, and can be on hand to link with MH services.
- **A newsletter was started during COVID-19 lockdown to help people feel connected.** This has been maintained and is now widely circulated among current and former OAMH service users beyond the group. It includes information about community services and social events, and includes articles written by Helping One Another members.

Helping One Another is also a valuable space for coproduction and involvement. Members provide vital insights in OAMH services, advise on service design and communication, and participate in Trust governance such as recruitment and interviews. The group recently participated in the Royal College of Psychiatry's ACOMHS accreditation process for the Trust.

Choice and Control Peer Coaching, Camden and Islington NHS Foundation Trust

Transformation Partners in Health and Care

NHS Yorkshire and the Humber Clinical Networks

The Choice and Control Service (CICS) works alongside clients to improve their quality of life and wellbeing by providing flexible peer-led coaching support. The service supports people over 10 sessions to link with resources in the community, overcome barriers to wellbeing goals and gain clarity in steps to take to improve their lives.

The service works with clients from 18 and upwards, with no upper age limit. Over 30% of clients supported by the service are 60 or over. The service also includes a number of peer coaches over the age of 60, with discussions underway to expand this group.

> *What helped was that we clicked from session 1 and that we were of similar age. In my experience, older clients tend to respond better when receiving support from someone close to their own age group.*
>
> **Jean-Luc, older adult Peer Coach, C&I**

For more information on the service, including on how to self refer, visit their page on the Trust website.

How does it work?

- **Clients are often referred by social prescribers, practice based MH teams or GPs, and people can also self-refer.** Those referred are experiencing long-term physical health issues alongside mental illness.
- **An assessment conversation is carried out within 4-5 weeks of referral to understand what the client looks for in a peer and a client is then paired with a coach.** Pairing is usually based on similar personality types and interests. Age is not often cited as an important factor.
- **Early sessions are focused on listening, understanding the person's mental health and risk history and learning about their hopes and aspirations.** For older adults, there is often a focus on social aspect of the coaching, along with practical support around housing, benefits, pensions, housing and other services.
- **The service works closely with primary care. T**he Trust is currently piloting a programme with a local GP Federation where peer coaches are situated in GP surgeries, supporting clients in collaboration with social prescribers.

The Hand-in-Hand Peer Travel Buddy scheme runs alongside CICS and is popular among older adults. Peer volunteers commit at least one day a week to helping clients, accompanying them to appointments, helping plan travel, offering reassurance about what they should expect on arrival and signposting people to other sources of community support.

All-age Peer Support Groups – Peer Support Plus, Leeds

Peer Support Plus C.I.O. (PSP) provides weekly peer-led group support sessions to people who want to learn more about how to manage their mental health. Groups provide a safe, kind and supportive environment where peers can share and receive practical and emotional support drawing on their lived experience.

Groups are popular with older people. Over half of members are over 50 and 16% are over 65. Peer facilitators include people with lived experience of mental ill health in later life.

> *We advertise our service for adults and treat everyone equally, disregarding age or any other characteristic. Older people (like me) sometimes feel discriminated against by age by being channelled by organisations, like the NHS, into 'services for older people' - as if age were the principal driver of service design. Mental health and support needs don't change on passing 18 or 65.*
>
> ***Peer Support Plus Peer Facilitator***

For more information about Peer Support Plus, visit the website https://www.peersupportplus.org/

How does it work?

- **People self-refer via phone, email or PSP's website** and groups are promoted online, social media and through paper leaflets. People are also signposted from local mental health and community hubs and services.
- **New members attend an initial two hour workshop** where they can experience group work first-hand and understand expectations. From there they agree with facilitators whether they want to enrol as peers.
- **Accessibility is key.** Weekly in-person sessions of 8-10 attendees take place in accessible venues at a time of day that is convenient for members. Groups meet a range of needs, including physical impairments, special educational needs and long term health conditions.
- **Separate weekly online group sessions are also provided.** Peer Support Plus are able to lend 4G devices as necessary and regularly provide training and support to enable members to participate remotely.
- **PSP's principle of "it's okay to leave and okay to come back"** helps give peers the confidence to leave their group and continue self-managing their recovery, safe in the knowledge that they can come back if needed.

Peers agree ground rules and boundaries for groups sessions set out in PSP's Guidelines for Behaviour, which have been developed by members over 20 years and continue to evolve. The guidelines are intended to help everyone feel safe, productive, valued and equal.

Sutton Peer Support Service, Age UK Sutton

Age UK Sutton are working with South West London and St George's Mental Health NHS Trust to provide individual and group peer support for people between 50 and 75 who have a moderate to severe or enduring MH condition. Discussions are also underway with the Trust to expand the service to over 75s.

The service provides users with access to practical and emotional peer support that helps them to live well. This compliments therapeutic mental health interventions available in the community. For example, peer support may be part of early intervention to avoid a deterioration, or a stepdown service after an intensive period of therapeutic support.

> *People have appreciated not feeling pressured to communicate. One person did go through a low whilst we were working with her and was out of touch for a couple of weeks, but we checked in with no pressure and she reengaged when she felt more able to. This allowed us to continue our work with her. Overall, having flexibility as a voluntary sector organisation has been a benefit to delivering this non-clinical support.*
>
> **Hilary Dodd, Services Director, Age UK Sutton**

For more information on the Sutton peer support service visit the Age UK Sutton website

How does it work?

- **The service is delivered by one full-time and one part-time peer support worker (PSW)**, both of who have lived experience of mental illness. Referrals are made via the MH Trust and Age UK Sutton are working with local partners to try to broaden that referral pathway.
- **Contact is then made by a PSW, who facilitates a guided conversation about what a person wants to get out of their time with the service.** This can be by phone or video call, but mostly takes place in person.
- **The person is then enrolled onto a strength-based programme of peer support for up to eight sessions.** This could include working towards recovery goals, connecting with local services about wider issues impacting wellbeing, or helping people to develop their own peer support network.
- **Support is highly flexible to meet the unique and diverse needs of older people in Sutton.** Sessions can be provided both online or in person, can be individual or group-based. The frequency and pace of meetings is led by the person receiving support.

After the eight sessions, users of the service are often eager to know how they can continue to be involved in other programmes and services. For example, people can be supported to enrol with the local mental health Trust's Recovery College, or they can access Age UK's volunteer social support or volunteering programmes.

Appendix 2 – considerations for policy and commissioning

This annex provides:

- a brief analysis of existing MH transformation policies
- considerations for policy and commissioning for enabling OAMH peer support

Peer support for older adults: Mental health policy guidance and gaps

There are ambiguities within NHS policies that drive community MH transformation re: commissioning OAMH peer support.

Community Mental Health Framework for Adults and Older Adults

"the full range of staff in multidisciplinary services within each local community should collaborate to deliver effective mental health care services". This includes *"full use of paid peer support workers/experts by experience".*

The framework acknowledges that "*older adults may have differing …needs and therefore may require support in different ways to meet these needs".* However, no guidance is provided on adapting peer support for people in later life.

NHS Mental Health Implementation Plan 2019/20 – 2023/24

"Staffing models for [crisis care] services must include peer support workers and will require partnership with voluntary sector providers of all sizes."

However, peer support is not mentioned within the older adults mental health section of the plan – a key NHSE policy statement outlining specificities of community MH transformation for older adults.

In addition, in 2019 NHSE commissioned a report presenting learning from Early Implementer sites for Community MH Framework that asked providers to ***"Dedicate proportional increases in funding allocation to improve care, support and treatment for older adults and carers. Increase the OPMH workforce by recruiting new OPMH-specific expert staff, older adult peer support workers and OPMH new roles"*.**

However, how this can be achieved and what services could look like was not clarified.

The MH implementation plan also refers to alternative models of peer support, including:

- peer support group facilitators
- peer care navigators
- peer trainers
- social prescribing

Addressing barriers in policy and commissioning

More can be done within national policies and commissioning frameworks to enable peer support community within OAMH services.

1. **Funding for OAMH peer support should be multi-year. New or adapted models will need to be developed and piloted over time.** The evidence base and existing good practice are in the early stages of development and so investment is required to test and learn from different approaches.

2. **Create clearer policy statements on the need for peer support in OAMH services, track investment in community MH transformation for OAMH and enable cross sector partnerships**. Incentives and accountability mechanisms must be strengthened within policy and commissioning to better-enable OAMH peer support.

3. **Fund evaluation and further scoping of existing good practice.** Development of this guide alone has identified several examples of peer support programmes that are having a life-changing impact on older adults. Further national scoping, evaluation, research and dissemination could significantly advance service development.

4. **Commission coproduction that takes into account the preferences and common needs of older adults.** Funding for travel and accessible venues is particularly important for this group. Avoid making ageist assumptions about payment and expenses: some older adults will require payment while others may prefer to engage as volunteers.

5. **Remove age ceilings for funding.** Some all-age peer support services are restricted to adults over a certain age, thereby excluding some older adults.

Appendix 3 – Existing OAMH coproduction and involvement groups

This annex presents a list of existing groups in the London, Yorkshire and Humber regions.

OAMH coproduction and service user groups

London

- **South London and Maudsley NHS Foundation Trust established a Service User and Carer Advisory Group (SUCAG) in 2010, aiming to give current and former service users, along with carers a way to contribute to services.** Today, 18 SUCAG members work with the Trust's involvement team to improve services. The group is managed by a full-time Involvement Lead and also a Participation Lead and Engagement and Participation Worker.
- **Researchnet Older Adults is one of a network of co-production based groups at Oxleas NHS Foundation Trust.** They bring together service users, families, carers and staff to participate in and lead patient experience-focused research. Members are recruited on a voluntary basis by the Trust and the group is led by an older adult Clinical Psychologist. The group is approached by members of Oxleas staff with research tasks or projects, or develop their own projects.
- **East London NHS Foundation Trust** have established a Working Together Group within their People Participation programme for community MH transformation. Current and former OAMH service users are recruited to support specific transformation and service design processes. The programme is led by a People Participation Worker for older people.
- **The Advisory Group of Older Patients (AGOP) is a small group of older people who are current or previous users of Camden & Islington NHS Foundation Trust Services for Ageing and Mental Health (SAMH).** Up to seven members meet every two months to share their expertise and ideas about development and delivery of services for older people. Some members of AGOP have extended their contribution by attending clinical governance and management meetings in SAMH, bringing the perspective of an older service user. Members also represent the voice of older people within the Trust's Service User Alliance.

Yorkshire and the Humber

- **Helping One Another (HOA) is a peer support group for service users, carers and families being cared for by Sheffield Heath and Social Care NHS FT OAMH community and home treatment teams.** It provides open-ended support through monthly group meetings of between 8-15 service users, with a key aim to support compassionate discharge from services. Helping One Another is also a valuable space for coproduction and involvement. Members provide vital insights in OAMH services, advise on service design and communication, and participate in Trust governance such as recruitment and interviews.
- **The Patient and Carer Participation Group is hosted by Tees Esk and Wear Valley NHS Foundation Trust.** It provides a space where existing and former service users and carers can come together, support one another and play a meaningful role in services and governance of the Trust. The group supports a range of services that span across dementia and functional mental illness.

Acknowledgements

We would like to give thanks to everyone that contributed to this document and acknowledge their valuable input and advice.

With special thanks to…

Members of the Sheffield Helping One Another Group:

Harold Skinn
Paul Bramhall
Val Clarke
Valerie Harley
Michael Emsen
John Malcomson
Lynn Jessop
Charles Morris
Margaret Neale

Members of the East London Working Together Group

Maureen Hankin
Patricia Howlett

Members of the South London and Maudsley Service User and Carer Advisory Group

Claire Joseph
Ann Church
Ruth Hards

Members of the Tees and Esk Valley Patient and Carer Participation Group

Staff and specialists from MH services in London and Yorkshire & the Humber regions

Mel Ball, Head of Lived Experience Workforce, Central and North West London NHS Foundation Trust
Anna Berridge, Peer Support Lead, Sheffield Health and Social Care FT
Georgina Birch, Operational Lead Integrated Care Mental Health Liaison Team, Tower Hamlets, East London NHS FT
Dr Georgina Charlesworth, Honorary Consultant Clinical Psychologist & Strategic and Clinical Lead for Older People's Psychology, NELFT, and Associate Professor, University College London
Jackie Chin, Consultant in Public Health, Office for Health Improvement and Disparities, London Region
Victoria Clarke, Head of Integrated Health Services, Age UK Sutton
Nuala Conlan, Involvement and Participation Lead, PMOA Directorate, South London and Maudsley NHS FT
Dr Louise Corbett, Principal Applied Psychologist, Community Mental Health Service for Older People, Tees, Esk and Weer Valleys NHS FT
Silvia Corrias - People Participation Worker for Older Adults, East London NHS FT
Hillary Dodd, Services Director, Age UK Sutton
Rachel Eborall, Deputy Head of Inclusion and Peer Worker Development, South London and Maudsley NHS FT
Dr Fiona Goudie, Clinical Director Strategic Partnerships and Consultant Clinical Psychologist, Sheffield Health and Social Care FT
Dr Gemma Graham, RCG Assistant Director for Psychological Professions, Rotherham, Doncaster and South Humber NHS FT
Dr Saheem Gul, Consultant Psychiatrist & Associate Medical Director (Older adult services), North East London NHS FT
Cerdic Hall, Recovery Lead - Camden & Islington NHS Foundation Trust
Katy Hawkins, Trustwide Lived Experience Practice & Peer Support Lead, Central and North West London NHS Foundation Trust
Dr Guy Harman, Hillingdon OPMH Strategic Clinical Lead and Hillingdon OPMH Lead Consultant Clinical Psychologist, CNWL
Dr Lindsay Hill, Clinical Psychologist, Tees, Esk and Weer Valleys NHS FT
Alison Illif, Health and Wellbeing Programme Lead, Office for Health Improvement and Disparities, North East and Yorkshire Region
Japleen Kaur, Assistant Director of Involvement, Oxleas NHS Foundation Trust
Dr Polly Keiser, Consultant Clinical Psychologist, Greater Manchester Older People's Mental Health Lead, Pennine Care NHS FT
Dr Natasha Lord, Lead Clinical Psychologist for Older People's Mental Health Needs, Hereford and Worcester Health and Care NHS Trust
Jose Mejia, Peer Support Lead, South West London and St George's Mental Health NHS Trust
Isabel Porcel-Rohas, Recovery and Engagement Worker, PMOA Directorate, South London and Maudsley NHS FT
Dr Kapila Sachdev, Consultant Clinical Psychiatrist, East London NHS FT
Dr Shonagh Scott, Head of Older Adult & Neurological Conditions Psychology Service, Sheffield Health and Social Care NHS FT
Dr Amanda Thompsell, National Special Advisor, OPMH, NHSE
Maddy Thompson, Peer Support Worker, South Tyneside and Sunderland NHS Foundation Trust