



Ontario Peer Development Initiative

OPDI Briefing Note: Peer Support's Value to the Ministry's Healthcare Priorities

Submitted by Deborah Sherman, Executive Director (deb@opdi.org)

June 2008

OPDI (The Ontario Peer Development Initiative) strongly endorses the Mental Health and Addiction Partnership's brief to the Minister on emergency wait times and enhanced access. We concur with its strong emphasis on the value of an expanded role for peer support, and its strong emphasis on the value of an expanded system-wide role.

Defining Peer Support and its Success in the Canadian Context

Shery Mead defines peer support as “a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful.”ⁱ Further testimony to its usefulness is available through the “Out of the Shadows at Last” Senate Committee report in Chapter 10.ⁱⁱ

The “real” and successful impact of peer support can be attributed to the following:

- It relies on the informed perspective of people with a chronic illness who are familiar with the “system”
- A strengths-based approach is preferred over a “chronic disease” model
- The possibility of hope and recovery is embedded among those helping one another

The Academic Literature's Rich Evidence Base for Peer Support

The academic literature for peer support as a “best practice” thrives. A growing body of international and Ontario-based research captures the value of peer support as a best practice in crisis interventionⁱⁱⁱ, emergency departments^{iv}, inpatient settings^v, discharge planning^{vi}, case management^{vii} and other community mental health settings.

Systemic Barriers to Implementation of Peer Support in Ontario

Despite this overwhelming evidence in the literature and in practice, peer support remains under-explored and inconsistently funded in Ontario when it comes to new community mental health investments. Peer support as it is practiced in CSOs faces systemic barriers when migrating to other settings:

- Clinical programs in Ontario, aware of the success of peer support, choose to introduce their own peer support workers into their services
- CSOs with their small budgets face amalgamation into mainstream provider organizations
- Peer support is unevenly adapted into other settings^{viii}.

It is important to recognize that role confusion^{ix}, role dilution (such as hiring a part-time worker when the standard is for a 1.0 FTE position), and other challenges can occur when a sole peer worker joins clinically-oriented teams or when a CSO is subsumed into a clinically-oriented community program.

Effective Investment Strategies for Peer Support: Partnerships and Secondments

Option 1:

Opportunity:

OPDI has learned from the CMH CAP project that consumers expressed the need for peer workers to help them complete the CAN tool, rather than available clinical staff. This unmet need for peer workers could be addressed by community mental health programs through collaborative working partnerships with CSOs to use their trained and skilled peer workers.

Solution:

Fund more peer support workers in CSOs to support this important assessment function (create more efficiently tailored roadmaps of care for consumers and improve system access).

Positive Outcome:

Both types of organizations benefit by continuing to do what each does best. The consumer benefits from a truly patient-centered system of care.

Option 2:

Opportunity:

Clinical and community services have expressed interest in greater peer support involvement with CSOs. Labour agreements make it problematic to hire directly. The secondment of currently employed peer workers at CSOs, who are already well-trained and experienced, overcomes bureaucratic hurdles and provides mainstream service providers with instant expertise and internal training opportunities. Such a pilot project is currently winding down in Hamilton and similar secondments are ongoing in Brantford.^x

Solution:

Fund secondment salaries of peer support workers in CSOs so that dedicated volunteers can be internally promoted into paying positions.

Positive Outcome

This HR policy addresses future anticipated demands for trained and experienced community mental health workers.

Additionally, partnerships and secondments have advantages such as:

- A clearer understanding of consumers' expressed needs for MH and A services
- Strengthened collaboration between CSOs and community agencies/ hospitals to ensure improved access to services and supports, and foster greater success in dealing with "hard to reach" populations
- Reduced role confusion and improved workplace acceptance as training, continuing education and personal support for the peer worker will be grounded in the CSO and the peer community
- Strengthened CSOs through program generated income stream
- Increased hope for CSI members around peer training and volunteering with the possibility of employment as an end result

Other examples of CSOs' emerging and promising practices happening now in Ontario through collaborations (just to name a few):

- The Krasman Centre in Richmond Hill operates a warm line that serves consumer/survivors in non-crisis situations (and has produced a training manual)
- Brantford Vocational Training Association has seconded peer workers in the emergency department of their local hospital and in case management agencies
- The Mental Health Rights Coalition in Hamilton has seconded four peer workers to case management agencies as a pilot, and six to St. Joseph's Health Care Hamilton for an arms'-length discharge evaluation project

Training and Supporting Peer Support Workers

OPDI holds firm in the belief that independent and autonomous consumer/survivor organizations (whether Consumer/Survivor Initiatives or Patient Councils) must have control and responsibility for training and supporting peer support workers. Pending receipt of project funding, we are poised to work in the next two years with those member partners who have well-established training programs developed organically over many years of experience, to create a "made-in-Ontario" toolkit for training peer workers and peer trainers. By making this toolkit and training available to consumer/survivor organizations throughout the province, we will bring a proven and cohesive "best practices" approach to peer support that will support the Ministry's efforts to ensure that Ontarians have access to the best mental health and addictions system possible.

Next Steps

OPDI welcomes the opportunity to further share the experiential knowledge of its membership and knowledge of the current literature around peer support. We look forward to advising the MOHLTC, along with the Ontario Association of Patient Councils, as to how to ensure that fundamentally proven, effective, and outcome-oriented investments can be leveraged to improve the lives of Ontarians who are coping with mental illness.

ⁱ Meade, S. (2003). Defining Peer Support. Retrieved June 3, 2008 from <http://www.mentalhealthpeers.com/pdfs/DefiningPeerSupport.pdf>

ⁱⁱ Senate Committee on Social Affairs, Science, and Technology (2006). Out of the Shadows at Last (2006). Retrieved June 3, 2008 from <http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/pdf/rep02may06part1-e.pdf>

ⁱⁱⁱ Pudlinksi, C. (2004). The Pros and Cons of Different Warm Line Settings. *Psychiatric Rehabilitation Journal* (28: 1, 72 – 74). Retrieved May 27, 2008 from PsychInfo.

^{iv} Lawn, S., Smith, A., and Hunter, K. (2007). Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. *Journal of Mental Health* (2007: 1 – 11). Retrieved May 8, 2008 from Canadian Research Knowledge Network.

^v Goering, P., Durbin, J., Sheldon, C.T., Ochocka, J., Nelson, G., and Krupa, T. (2006). Who Uses Consumer-Run Organizations? *American Journal of Orthopsychiatry* (76:3, 367-373). Retrieved May 8, 2008 from PsychInfo.

^{vi} Forchuk, C., Reynolds, W., Sharkey, S., Martin, M.L., and Jensen, E. (2007). Transitional Discharge Based on Therapeutic Relationships: State of the Art. *Archives of Psychiatric Nursing* (21:2, 80-86). Retrieved May 27, 2008 from Elsevier.

^{vii} Sells, D., Davidson, L., Jewell, C., Falzer, P., and Rowe, M. (2006). The Treatment Relationship in Peer-Based and Regular Case Management for Clients with Severe Mental Illness. *Psychiatric Services* (57:8, 1179-1184). Retrieved May 27, 2008 at: <http://www.psychservices.psychiatryonline.org/cgi/content/abstract/57/8/1179>

^{viii} Gates, L. B. and Akabas, S. H. (2007). Developing Strategies to Integrate Peer Providers into the Staff of Mental Health Agencies. *Administration and Policy in Mental Health*, 34:293-306. Retrieved May 29, 2008 from PsychInfo database.

^{ix} Chinman, M., Young, A. S., Hassell, J., and Davidson, L. (2006). Toward the Implementation of Mental Health Consumer Provider Services. *Journal of Behavioral Health Services and Research*, 33:2, April 2006.. Retrieved May 29, 2008 from PsychInfo.

^x Moll, S. and Sherman, D. CCDS Small Grants Program: Psychiatric Disability and Peer Support Final Report (2007). Internal Report of MHRC (available upon request).