



**REPORT ON  
HEALTHRIGHT PEER  
ADVOCACY AND  
SUPPORT SERVICE TRIAL  
MARCH-DECEMBER 2007**

**REPORT ON HEALTHRIGHT  
PEER ADVOCACY AND  
SUPPORT SERVICE TRIAL 2007**



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## HEALTHRIGHT PEER SUPPORT

So what is Peer Support all about?  
The need to get healthy is what we will shout  
A better diet, GPs and exercise  
Is where a happier healthier life really lies  
We started with 6, then 5 then four  
Then extra hours we were given more  
Out and about participants by our side  
Don't stay at home don't run and hide  
Peer support is here to help you along  
With extra support you can't go wrong  
We will share our stories if that's what you need  
Because a life experience is the best indeed  
So move forward into a future bright  
Peer support will guide you right  
So now HealthRight Peers are finished and done  
The real hard work has just begun  
So jump up and yell as loud as you can say  
Peer Support is here to stay

Stephanie Ransome  
Peer Supporter  
Rockingham  
December 2007

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## **INTRODUCTION**

The physical health of people living with mental illness has been a concern for at least three decades, particularly since the move away from institutional care to community based care (Jones, Badger, Knopke, & Coggins, 1983; Lando, Williams, Williams, & Sturgis, 2006; Phelan, Stradins, & Morrison, 2001; Werneke et al., 2006). Several authors have written about this issue particularly in relation to those people described as living with 'severe' or 'chronic' mental illnesses (Bobes et al., 2007; Connolly & Kelly, 2005; S. Davidson, Judd, Jolley, Hocking, & Thompson, 2000; Howard, El-Mallakh, Rayens, & Clark, 2007). It has been established that mortality rates from preventable causes are higher among people living with schizophrenia than in the general population (Sartorius, 2007). Several factors that may account for this discrepancy have been identified, including metabolic syndrome, cardiovascular disease, carbohydrate and lipid metabolic disorders, the increased likelihood of suicide, abdominal obesity and life style (Bobes et al, 2007). Osborn (2001) also notes that psychotropic medications contribute to iatrogenic physical health problems.

This issue was highlighted in Western Australia when The Duty to Care Report (Lawrence, Holman, & Jablensky, 2001) was published. One of the key findings of that report was that the overall mortality rate, from preventable causes, of people living with mental illness was two and half times greater than that of the general population. In particular the authors found that the greatest number of excess deaths of people living with mental illness was due to ischaemic heart disease. The report also highlighted that physical illness in general is often not diagnosed, not treated properly or treated at much later stages in people living with mental illness.

Lack of attention to physical health issues of people living with mental illness is compounded by the fractured nature of health delivery systems, inadequate screening for physical health problems in mental health services and the lack of collaboration between mental health services and primary health care services (Garden, 2005; Jones et al, 1983; Meadows, 1998)

It has been recognised that there is a correlation between physical health and mental health (Werneke, et al, 2006). That is improving the physical health of a person can lead to improvements in their mental health. The challenge that faces health delivery systems is to integrate the health management of people living with mental illness such that adequate attention is given to their physical health needs (Phelan et al, 2001).

### **Peer Support as an Intervention**

The UWA Duty to Care Report sparked a keen interest in addressing the physical health needs of people with long term mental illness and the outcome was the Department of Health funded *HealthRight* project managed by UWA which included in its plan:

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- The trial of a Peer Advocacy and Support Service model to be conducted to provide practical support for consumers and their carers in making and attending appointments with GPs and other health professionals.

The work of Margaret Cook and Ginger Gordy must be acknowledged, for without their valuable contributions to the deliberations of the HealthRight Advisory Group this trial may not have taken place.

## PROJECT AIM

The overall objective for the project was, on a trial basis, to support a selected sample of adults with severe and enduring mental illness to recognise the importance of attending to physical health needs and to assist them, through peer support, to take the necessary steps to do so.

### Inclusion Criteria:

- Patients with severe and enduring mental illness;
- Aged 18 – 65;
- Currently receiving mental health treatment in one of the designated population groupings;
- Able to give informed consent;
- Mental health sufficiently stable to allow participation in the program;
- Interested in dealing with physical health issues.

## PROJECT DEVELOPMENT

### Identifying project issues

The first step taken was the identification of two people who had been clients of mental health services as leaders and champions for the project. Initial meetings with them identified the following issues:

- The project was being developed within an academic university environment and it was important to identify and work with supportive collaborative community-based partners.
- It was hoped that the trial could be run through an existing non-government organisation where there was infrastructure to support the Peer Supporters and through which the project could be sustained in the future should on-going funding become available.
- There were no consumers of mental health services trained as Peer Supporters in Western Australia. Training and resources would, therefore, need to be developed.
- Service providers including GPs needed to be involved in the project.
- Consumer leaders stressed the importance of ensuring that the service did not become a “self-help” group, but rather that it should be concerned with practical

support and assistance for consumers of mental health services who would be required to take some responsibility for their own care. The Peer Supporters would need to have experienced mental illness and understand the difficulties faced in the recovery journey.

- Although the project was concerned specifically with providing support to people with mental illness in the area of dealing with their physical health needs, other needs would arise, and there needed to be a structure in place whereby these needs were dealt with by the appropriate agency or support service.

It was agreed that initial consultation to identify the most suitable service delivery model would need to be held with two major stakeholder groups:-

**1. Mental Health Consumers who had been involved in either giving or receiving peer support.** The aim of this consultation was to brainstorm what the likely needs of consumers of mental health services would be and what kinds of barriers and problems had been encountered in giving and receiving support. A focus group was held with 6 consumers of mental health services all of whom had been involved with assisting other mental health consumers.

The project was explained to them and a brainstorming session was facilitated where ideas were given on the development of the project/resources. Advice was received on possible barriers and problems which could arise and suggestions were made on overcoming these problems. The general consensus was that ultimately the project should belong to consumers.

**Barriers identified included:**

- Doing more than is required;
- Access to services when they are needed e.g. immediate appointments with GPs;
- Boundaries – the blur between social contact and work responsibilities;
- Clouding by own experiences;
- Age, gender, culture and sexuality;
- Keeping within the mandate;
- Being excluded and feeling powerless when rights are ignored;
- Concerns regarding legal issues such as clients over-dosing.

**Process requirements for the trial were identified as follows:**

- Action plan;
- Definition of mutual roles and responsibilities, rules of engagement and sign-off;
- Resource development and finding information on relevant health issues such as optical care, dental care, nutrition, sleep management, podiatry, quitting smoking, stress management and exercise;
- Identification of appropriate and willing GPs for clients;

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- Protocols in place for difficult situations – back up plans and contingencies, including travelling in cars with clients, clients not taking medications, not answering door, drug and alcohol issues, safety, children involved; when client goes to hospital – use WRAP action plan idea, mutual agreement and sign-off;
- Professional development/debriefing/supervision;
- Value and respect for supporters and supporters self-care;
- Development of shared care/care planning protocols with services including follow up, record keeping, continuity of care, lines of communication and case management;
- Contact with agencies who will provide the required/promised service – development of support networks/interagency support;
- Development of consumer confidence;
- Consent/disclosure/privacy/legal issues/insurance;
- First aid requirements;
- Goal setting/achievements;
- In house support networks and structures;
- Team leadership and the team approach;
- Complaints protocol;
- Definition of the research;
- Costs, grants and refunds;
- Stand-in peer support workers and back-up;
- Development of workshops for Peer Supporters and for targeted clients.

**2. Non Government Organisations** already providing community-based services to people with mental illness whose knowledge and expertise could potentially contribute to the project. This contribution could include incorporating peer support into an existing service, participation in training and resource development, provision of supervision and office accommodation for the Peer Supporters and provision of back-up support for consumer needs which were unrelated to physical health needs. A meeting was held with invited representatives from Ruah Community Services, The Hills Community Support Group, Richmond Fellowship, Lorikeet Clubhouse, and Grow. Perth Home Care services, The Mental Illness Fellowship and the Uniting Church Rainbow Project were also invited and were unable to attend. At this meeting the project was explained and participating organisations were asked for advice on NGO involvement in the trial and whether any one of them would be interested.

**The important outcomes of this phase of the project were to define:**

- who the collaborative partners would be;
- where the trial sites would be;
- how to conduct the trial;
- what information was required by all stakeholders.

### **Identification of Collaborative Partners**

Arising out of the initial consultation two non-government agencies agreed to become collaborative partners in the trial:-

1. Ruah Community Services
2. The Hills Community Support Group Rainbow Project

Once these two agencies had agreed to participate in the trial a .6 FTE project assistant/ research officer was employed specifically to assist in the development of the training program and related resources, and to carry out an evaluation of the trial. Ethics approval was obtained from the University of Western Australia Human Research Ethics Committee for the trial procedure and for the associated questionnaires for clinicians, Peer Supporters and participants in the trial.

### **Identification of Trial Sites**

During the project development phase three different sites were identified for the trial by virtue of the fact that staff at those sites requested to be included. These participating sites were:

1. Mirrabooka Community Mental Health Services.
2. Rockingham Kwinana Adult Mental Health Service.
3. The Perth and Hills Division of General Practice Street Doctor Service, Midland.

The emphasis in both of the public mental health service sites would be to assist clients to make and attend GP appointments. Peer Supporters placed in these sites would be employed and managed by Ruah Community Services who already worked in these geographical areas. The Peer Supporters who would work with the Street Doctor Service would assist patients to attend to lifestyle issues such as locating physical health activities and quitting smoking, and they would be employed and managed by the Hills Community Support Group Rainbow Project based in this area.

### **Determination of Trial Processes**

A reference group was established for the trial. Membership comprised key staff of the collaborative non-government agencies and the services whose clients would be supported, the HealthRight project officer and a number of consumers of mental health services, including the two consumer leaders. This group debated and agreed the roles of all concerned and memoranda of understanding were drawn up between the collaborative partners.

## **Determination of Information Required**

The required information was identified through:

- The focus group attended by consumers of mental health services (described above);
- Reference Group meetings;
- Management meetings with Ruah Community Services and the Hills Community Support Group Rainbow Project;
- Discussions with participating Mental Health Services and the Street Doctor Service.

## **ROLES AND RESPONSIBILITIES**

### **1. The agreed role of HealthRight and the non-government agencies was to:**

- Develop a training program and resources for the trial;
- Train a group of consumers of mental health services who would be invited to attend the training through the formal consumer networks. They would be trained to work with participants, and where appropriate their carers and families, assisting them to access GP and other services where they could take action on issues affecting their health;
- Select from that group six Peer Supporters through a formal recruitment process (two people for each of the three sites);
- Draw up contracts for the selected Peer Supporters who would be employed and supervised by the two non-government agencies and funded by the HealthRight project budget;
- Collect evaluation data using the approved questionnaires;
- Present service providers with information on the trial and the processes involved;
- Co-ordinate referrals to the Peer Supporters;
- Bring to the project resources and information aimed at raising awareness of the need to attend to physical health needs and to locate allied services where necessary;
- Facilitate regular meetings between Peer Supporters working in all three trial sites;
- Write a full report to the Department of Health on conclusion of the trial.

**2. The agreed role of the three participating health services was to:**

- Identify clients suitable for the trial and make referrals to the Peer Supporter co-ordinator;
- Provide for first meetings at the Mental Health Services between Peer Supporters and referred clients;
- Work with Peer Supporters, carers and families, GPs and allied health professionals in organising and developing shared care plans for the clients concerned;
- make available a nominated support person for the resolution of day to day problems and work issues;
- continue case management of the patients concerned and, with relevant GP involvement, maintain responsibility for the management of prescribed medications;
- meet at least once a month and more frequently if necessary with the Peer Supporters to discuss progress of referred clients.

**3. The agreed role of the Peer Supporters was to:**

- Set health related goals with participants in the trial and to help and step back discouraging dependency;
- Encourage and assist the participants who did not have a regular GP to find a GP;
- Encourage and support participants to locate and access allied health professionals and health related services to improve their overall physical health and well-being;
- Assist participants to make health related appointments and where necessary accompany participants to the appointment/s;
- Provide participants with information, resources and support to assist them to ask relevant questions to meet their physical health needs;
- Provide education on the rights and responsibilities of participants in their dealings with health care providers;
- If necessary advocate on behalf of participants regarding their physical health needs;
- Maintain contact with the key mental health professionals and assist participants to communicate relevant physical health related information;
- Maintain appropriate records and documentation to ensure accountability, to comply with legal responsibilities and to assist the evaluation process;
- Attend project meetings and supervision as required.

The trial would be conducted over a six month period and the aim would be for each Peer Supporter to work with 5 participants in that time.

## **DEVELOPMENT OF TRAINING PROGRAM**

**Information sessions** were developed for each of the following groups:

1. Mirrabooka Mental Health Teams;
2. Rockingham Kwinana Mental Health Teams.

In these information sessions the following was presented:

Introduction to Duty to Care/HealthRight and the evolution of PASS  
Peer Support – what it is  
The anticipated benefits to all of PASS  
Referrals and the target patient population (patients without GPs and/or little attention to physical health/ must want to attend to physical health needs)  
PASS evaluation/research  
Intro to what the Peer Supporters will do and their involvement in the recovery process  
Use of resources/handing over of information kit  
Support and supervision of Peer Supporters

At a second session the trained and selected Peer Supporters were introduced and pre-trial questionnaires handed out for completion by clinicians. The same information was presented to the Street Doctor in Midland.

### **Development of Resources**

A resource kit was produced for all trainees which included existing information brochures on a range of issues such as: a guide to quitting smoking, physical activity guidelines, information on breast cancer and screening, alcohol guidelines and information on alcohol, anxiety and depression, tips for safer health care, food for health, National Prescribing Service information on medicines and help lines, a guide on diabetes and psychotic disorders and health consumer council advocacy information.

In addition a HealthRight resource book - *A Guide to Health Information, Services and Resources in Perth* - was produced for use by all stakeholders. GP reviewed brochures were also developed on: *GPs - Everybody Needs One* explaining how to find a GP/making the most of GP visits/ what to consider when choosing a GP, and *Health Checks for Men* and *Health Checks for Women*. (These resources are available on the HealthRight web site). A HealthRight passport was also produced for use by participants and treating health professionals. This document includes space for personal details, a medical summary, contact details of treating health professionals, a medication list and dose required an appointment diary and health notes.

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Documentation produced for the trial included:

- a formal **referral and information** form,
- a **goal setting sheet** for Peer Supporters to complete with participants,
- a **consent form** for signature by participants agreeing to the sharing of information with their case managers and GPs,
- a **Peer Supporter job description**, and
- a template for Peer Supporters to use in making **contact notes** on their activities with participants.

### **Training Needs of Peer Supporters**

Identified training needs for Peer Supporters are listed in **Table 1**. A three day training program was developed to cover these topics and attention was given to all of these identified needs.

An additional orientation session was developed for those people who were selected to fill the 6 Peer Support positions created for the trial. Information presented in the orientation training was:

Orientation to the employing NGO – policies, procedures and protocols;  
Supervision at workplaces and meeting dates for peer supervision;  
How referrals would be actioned;  
Refresher training on the use of resources and data base;  
Evaluation of the trial and the role of the Peer Supporters in completing required documentation.

**Table1: Training needs for Peer Supporters as identified by key stakeholders**

1. What peer support is and roles and responsibilities of supporters – mediator, supporter, buddy;
2. Communication and negotiating skills/listening skills and dealing with spouse and carer influences;
3. Setting boundaries;
4. Recognition and dealing with social exclusion of mentally ill;
5. Disclosure protocols and transparency;
6. Confidentiality, legal issues and integrity;
7. Dealing with difficult/risk situations and ethical issues;
8. Rights of supporters and of clients – duty of care and accountability;
9. Protocols on shared care, case management and family support;
10. Team approach/own needs/support/debriefing;
11. Supporters self-care, awareness of potential self-triggers and taking time out;
12. Use of resources developed for the trial;
13. Training for GPs on the project and the needs of consumers;
14. Access to related services such as optical care/nutrition/dental care/sleep/stress management/ exercise;
15. Need for a holistic approach;
16. Assertiveness/empowerment;
17. Assisting clients to navigate the health system.

## **TRIAL IMPLEMENTATION**

Preparation for the trial was completed between July and December 2006. The reference group was set up and had monthly meetings during this time. In this preparation phase evaluation questionnaires were finalised and ethics approval obtained. The training program, presentations to participating services and peer support resources were developed in collaboration with Ruah Community Services who dedicated time of two employees to assist with this development work.

Expressions of interest were sought through consumer networks from potential Peer Supporters to attend the training program.

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### **Training**

In February 2007 two groups of people underwent the Peer Supporter training, one in Perth and one in Rockingham Kwinana. The training was conducted over a three week period on one day per week in each centre. A total of 23 people completed the training (25 had commenced the course).

The two presentations described above were made to the staff of the public mental health services involved in the trial in February/March 2007. Presentations were also made to the staff of the Street Doctor Service at this time.

### **Recruitment of Peer Supporters**

On the second training day formal application packages were given to those participants who expressed an interest in applying for the Peer Supporter positions. Applicants for the 6 positions were required to complete a written job application and to answer specific selection criteria. Applications for the Peer Supporter positions were received from 14 of the trainees and all applicants were granted interviews. Standardised structured interviews were conducted in the three employing areas (Mirrabooka, Midland and Rockingham Kwinana). Interview panels were comprised of the relevant future supervisor of the Peer Supporter, a representative of the referring health service with whom they would be working, and the project officer who had assisted with the development of the training program and resources and who would be undertaking the research component of the project (she also undertook the role of consumer representative).

Six Peer Supporters were selected and placed – two in each of the participating trial sites. In Midland they were accommodated in the offices of the Hills Community Support Group Rainbow Project and in Rockingham Kwinana in the offices of Ruah Community Services. In Mirrabooka they were accommodated in the Community Mental Health Clinic, supervised by Ruah Community Services. They commenced work in late March 2007.

Peer Supporters were employed from March 2007 on six month contracts as casual employees at SACS Level 3 by the NGOs where they were placed/supervised. They were contracted for 15 hours per week. As the trial evolved it was decided to continue the contracts of the four Peer Supporters employed in Rockingham Kwinana and Midland until December 2007, as results were good and all were keen to continue with the work.

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**Sustainability**

A seminar on the PASS trial was jointly hosted by Ruah Community Services and HealthRight in November 2007 for invited guests. The intention was to share what had been achieved in the trial and to discuss ways in which the HealthRight project goals could be continued and the peer support service sustained. Invitations were extended to representatives from organisations that had been successful in obtaining funding for the federally funded Personal Helpers and Mentors initiative and others who were interested in introducing peer support. Representatives attended from the Richmond Fellowship, Community First in Rockingham, the Mental Illness Fellowship, Lorikeet Centre, Uniting Care West and from all organisations participating in the trial. The day was successful and employment opportunities were made available to all four Peer Supporters – all of whom made presentations on their experiences in the trial.

In addition in December 2007 the Mental Health Division in the Department of Health undertook to make available additional funding to continue the trial project until June 2008, at which time decisions will be made regarding the future of Peer Support as an operational service. Having completed their formal contracted time in December in the trial, Ruah Community Services decided they would not continue their involvement for the addition 6 month period and they have implemented peer support in the organisation to enable them to provide support to their own clients. The trial is, therefore continuing in Rockingham Kwinana with the Peer Supporters based within the Mental Health Services, supervised within the services and overseen by HealthRight. In the Midland area the trial will continue in the same way as it has done until now. During this six month period the evaluation process will continue, and a presentation will be made to the Department of Health on the recommended course of action for future continuation of the service.

**RESULTS**

The trial was very successful with the Perth and Hills Division of GPs Street Doctor Service (Midland) and with the Rockingham Kwinana Mental Health Service. In Mirrabooka referrals were not made. After what was considered a sufficient length of time, during which the two Peer Supporters concerned investigated relevant services in the Mirrabooka area, discussions were held with Joondalup Community Mental Health and arrangements were made to relocate the two Peer Supporters to that service. One of the Peer Supporters resigned and left the project soon after. Referrals were slow and the second Peer Supporter obtained alternative employment and also left. It was decided that because this service was being offered on a trial basis, it would not at this time be continued in Joondalup.

Instead Peer Supporters were offered additional hours in Rockingham Kwinana where referrals were heaviest and where additional time was needed, and the contracts of all four remaining Peer Supporters were extended until December 2007.

**Statistical results showed:**

- 9 of the 23 people who participated in the trial were supported to find a GP;
- 37.5% of the participants were diagnosed with previously unknown health problems during the trial;
- 6 people had given up smoking or were quitting smoking by the end of the trial;
- 11 reported that they were eating more fruit and vegetables;
- 9 reported that they were losing weight;
- 13 reported that they were exercising more frequently (Peer Supporters walked with 20 of the participants as part of their work); and
- 12 were introduced to community exercise facilities such as Curves Gym and the Ruah walking group.

Of additional interest were the following results:

**Trial Participants**

- The mean length of time that participants had had contact with mental health services was 11.3 years.
- Physical health is not routinely asked about or dealt with in the mental health services.
- 27.7% of participants only go to the GP when they are ill which indicates that routine health checks are not being done on those people.
- The most common reasons for not going to a GP or to allied health professionals are cost and transport.
- 14% of participants reported in the pre-trial questionnaire that they never did any exercise and 57% said they did sometimes/some days. Only 9.5% exercised everyday.
- Only 23.8% reported that they eat fruit and vegetables everyday.
- 42.9% of the participants reported that they would be more likely to make GP visits if someone went with them.
- Questions on lifestyle issues clearly showed that participants would be far more likely to make changes with support from someone – 33.3% said they would be more likely to stop smoking, 71.4% would exercise more, and 57% would lose weight with support from someone. The trial results showed this to be true.
- Of those participants who completed post trial questionnaires, 87.6% felt that they would trust their GPs to help them to look after their physical health. Going to a GP as part of the trial resulted in 37.5% of participants being diagnosed with previously unknown health problems and 52.9% of the participants were continuing to receive treatment from a GP as the trial ended in December.

## **Peer Supporters**

- Where participants were ready to work on their physical health Peer Supporters were able to establish good working relationships with them and together they achieved excellent results.
- There were some cultural issues in the mental health services which hindered open communication at times.
- In the overwhelming majority of cases both participants and Peer Supporters believed that the service had been very helpful to participants.
- Written comments on the benefits to the Peer Supporters themselves included:
  - “I have gotten so much out of working with all of these people. Each of them has inspired me in so many ways and brightening up my day. I have grown in confidence and my ability to advocate for others and to support them in their own life journeys.”
  - “I am so proud of my wellness and I use this daily in a positive way to each and everyone I work with. Relationship building has been quick as they all love the fact that I really understand them, because I have been there.”
  - “It feels so good to be able to give back to others for all of the hard work people put into me. I have always had so much respect for health care workers, but now I have a new kind of respect for them as I now know what it is like on the ‘other side of the trench’.”
  - “This work has shown me just how responsible we need to be when working with consumers as we are dealing with their lives, hearts, souls. We need to give these people the respect they rightfully deserve.”
  - “Many of the people I have worked with were in the ‘too hard basket’, but being able to work closely with them has shown that they just needed someone to care and give them a voice and to listen . All this has made me grow and see that peer support is so important.”
  - “This project has given me the opportunity to assist participants in not only improving there physical health, but also improve there mental health and increase personal confidence and self esteem. My confidence, self esteem and physical health has also improved during the project.”
  - “It has been a good experience working in the supportive and structured environment of Ruah in Rockingham.”
  - “Increased confidence; better routine; more contact with people.”
  - “Overall improved mental health as a result of being able to help others achieve goals makes me see myself as a worthwhile person.”
  - “I have joined a gym and attend every day.”

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“Increased ability to take on more, i.e. to plan: I am doing an art course and fitting this and work hours into my weekly routine.”

“I am talking one to one with health professionals such as The Street Doctor, and seeing myself as a peer were once I might have thought of such people as “above me.”

“There is much more I could say like “it has made me wiser” but I don’t know how to prove that.”

“It has been one of the most rewarding experiences of my life.”

### **Clinicians**

- Post trial clinician questionnaires revealed that clinicians were less concerned about Peer Supporters maintaining confidentiality after the trial than they had been prior to commencement of the trial. This suggests that client confidentiality was well maintained by Peer Supporters and that the pre-test sentiments were unfounded.
- Most clinicians had positive attitudes towards peer support and the benefits of it to their clients.
- The relevant questions showed that physical health issues are not routinely attended to in the mental health services.

### **Feedback on Service from Dr Sue Jackson (Perth and Hills Division of GPs Street Doctor)**

The individuals referred from the GP access project (part of the primary healthcare networks street doctor program) are all individuals with chronic mental health problems living in the community.

It is well known that this patient population tend to make poor use of medical and allied health services and are also prone to having high lifestyle risk factors such as smoking, drug use, low exercise and poor diet which all contribute towards a high risk of both diabetes and cardiovascular disease.

Several of the drugs used to treat mental illness may cause weight gain – when this is coupled with the isolation that often occurs following either hospital admission or recurring episodes of mental illness it makes it difficult for these individuals now lacking social and community support to make positive lifestyle changes. Generally these individuals also have reduced family and community support which often presents additional barriers to entering exercise programs, giving up smoking and/or changing dietary habits.

Most of the patients that we have referred to the peer support program to date have exhibited multiple lifestyle related pathologies in addition to their underlying mental illness. Several patients exhibited BMIs in excess of 30, and three showed other factors

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associated with increased risk of coronary artery disease. Due to their existing mental health problems management of further medical conditions becomes increasingly complex both in terms of the effect on the individual and interactions between medications this then dramatically increases the cost of management.

The peer support program has proved very effective in smoking cessation, weight reduction, dietary change and exercise – all patients who have engaged and continued the program have shown measurable results and have managed to make significant lifestyle changes. These changes also have improved self esteem and life skills which then enables participants to improve their access to and utilization of existing services. Continuation of this program would enable us to investigate the effect the program has on recurrence rates and hospitalization for mental illness episodes.

Although it is too early to quantify it would appear that use of peer support programs may reduce long term health costs in this population. This is particularly significant as this group of individuals have been traditionally hard to engage both in terms of ongoing medical care and preventive care.

**Reasons for Success**

The reasons that the trial was successful include:

- Peer Supporters who were accommodated by the collaborating non-government agencies were made welcome by those services and were included in team meetings and office activities.
- The “champions” for the service included high level clinical staff – a psychiatrist/ head of clinical services in Rockingham Kwinana and the GP Street Doctor. Both indicated throughout the trial that they were fully supportive of the non-medical model component of their patients’ recovery.
- Peer Supporters were paid an acceptable market rate for the work they did which gave them credibility and made them feel part of the work force in which they were placed.
- Peer Supporters were given access to professional supervision and had regular, sometimes daily contact with their supervisors and with the contact persons in the referring services. In Rockingham Kwinana one of the senior members of the referring team had .5 of her time allocated to community work and networking which tied in closely with the peer support service. This role was invaluable to the success of the project.
- Peer Supporters took time in the initial phase of the implementation to find out about related services in the geographical areas where they were working and they dealt with a variety of participant needs in addition to assisting them to deal with their physical health.

In addition to this information the following was reported in discussion with the various stakeholder groups:

### **Additional Positive Outcomes**

1. Meaningful partnerships were developed between the HealthRight project, Ruah Community Services, the Hills Community Support Group, the Perth and Hills Division of GPs Street Doctor Service and the Rockingham Kwinana Mental Health Services. This allowed for all to benefit from the experience and expertise brought by each group, and the work load was shared.
2. The development of a comprehensive training program has enabled participating organisations to incorporate peer support into their own establishments with much of the ground work completed. Ruah Community Services has now developed its own draft Peer Support training package for future use. Valuable experience was gained by presenting the initial program to a large group of consumers of mental health services and also gave this group of people the opportunity to learn new skills and to spread the word on both peer support and the HealthRight message.
3. The HealthRight principles and philosophy have been introduced into all participating organisations and will continue after the completion of the project. Development of related resources has assisted with this process.
4. Other organisations have benefited from the development of the HealthRight resources which have been distributed to any interested parties, to all Community Mental Health GP Liaison Officers, and they have been included on the HealthRight web site. For example, Graylands Hospital and Hawthorn House have requested supplies of the HealthRight passports.
5. Two of the Peer Supporters trained and employed in the trial have secured further more permanent employment as Peer Supporters, one with Ruah Community Services and one with the Richmond Fellowship.
6. Ruah Community Services reported that although they had been working for some time on integrating peer support into their services, the trial was a contributing factor in speeding up the introduction of the service into their work teams and it assisted in clarifying these roles.
7. Ruah also reported that pre-existing physical health and wellbeing activities were boosted in number and spirit due to the inclusion of HealthRight participants.
8. All stakeholders benefited from the learning and insight in the challenges and issues experienced in implementing the trial.
9. The trial was a very successful exercise in trust building across the participating organisations, and all recognised the high value of peer support through the hands on experience.

10. The HealthRight health promotion campaign has been developed alongside the trial peer support service, and publicity has incorporated all activities. This has resulted in a great deal of interest in the peer support service and information on PASS in the West Australian Health Supplement in October 2007 resulted in a number of calls from members of the public requesting the service for family members, including people living in the Mirrabooka area. Health promotion resources have been used by participants in the peer support trial – e.g. HealthRight backpacks and T shirts, pedometers, water bottles, information cards and brochures.

### **Barriers to Peer Support in the Field of Mental Health**

Davidson et al (1999) in a review of peer support literature comment that even though there is a strong body of evidence that mutual support in other fields has been found to be beneficial and widely accepted, in the mental health field it is a resource that is either underutilised or ignored. They note that the biggest obstacle in the mental health field is a perceived lack of credibility - that Peer Supporters have little useful to offer because they have a mental illness. Peer support programs can be successful when mental health clinicians are educated about the benefits of peer support and recovery (Hutchinson et al., 2006), issues of confidentiality and boundaries are addressed (Mowbray et al., 1996), the role of the Peer Supporter is clearly defined (Dixon, Krauss, & Lehman, 1994), and adequate supervision and support mechanisms are structured into the program (Fox & Hilton, 1994).

Although there was an attempt to ensure that all these issues were adequately dealt with, the reasons for the failure of the trial in the Mirrabooka setting was seen to be because:

- Staff did not have the same level of commitment to the service as was apparent in Rockingham Kwinana. Although presentations had been made to them the positive benefits of the service had not been adequately discussed and it was reported that staff did not feel that they had been sufficiently involved in the set-up process. In the sites where the service was successful there had been prior acknowledgement by the clinical staff of the benefits of peer support and in the Rockingham Kwinana setting previous attempts had been made to acquire funding for such a service. Consumers of mental health services had been consulted and involved in these funding applications.
- The GP Liaison Officer who had requested that the Mirrabooka Clinic be included in the trial and who was the champion of peer support in the Clinic was promoted and re-located at the time the trial was due to commence. She had been an active member of the Reference Group, she presented one of the training modules to the trainee Peer Supporters and without her involvement there was no “champion” for the trial in Mirrabooka. The clinic head of service was also on leave at the time the trial commenced.

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- Confidentiality was a concern in the Mirrabooka setting and although Peer Supporters signed a confidentiality agreement, they were precluded from entering the open plan office space where clinicians worked. This site was the only one where the Peer Supporters were situated within the referring service. It was reported that possibly the service would have been more successful if Peer Supporters were housed away from the referring service whilst the cultural changes were taking place.
- The two Peer Supporters working in the Mirrabooka setting did not feel part of the team and did not feel that they were welcome in the service.
- It was reported that some of the patients who were asked whether they would like to participate in the trial declined because they felt that they were there to attend to their mental health and not their physical health.
- It was also reported that some of the patients who had been identified prior to the trial as possible participants because they did not have GPs, were found to have GPs and did not, therefore, require the service.
- Housekeeping issues such as use of computers, telephone messages and reception of clients had not been adequately ironed out prior to the commencement of the trial.

## **RECOMMENDATIONS**

Based on the successes and the barriers experienced in this trial the following recommendations are put forward for consideration:

### **1. Continuation of Peer Support in Rockingham Kwinana and in Midland**

Peer support has proved itself in these two areas and it is recommended that it be continued as an operational function within these two sites. Peer Supporters should continue to be paid market rates for the work they do. During the period ending June 2008, during which time the funding has been extended to continue the trial in its existing format, it is recommended that the services involved hold discussion with the relevant officials from the Mental Health Division to decide how best to continue the service. Issues for discussion include:

- Numbers of Peer Supporters to be employed
- Employment conditions
- Expansion of the service in Midland into Swan District Mental Health Services.

## **2. Expansion of Peer Support State-Wide**

In terms of the State Mental Health Plan and the work being undertaken on the development of the alternative workforce policies it is recommended that consideration be given to the employment of Peer Supporters in Adult Community Mental Health Clinics state-wide. HealthRight has focused on peer support to assist people to attend to their physical health needs. This work has proved successful and it is recommended that future Peer Supporters work not only in this area but that they be employed to assist clients of the Mental Health Services to attend to health, social, employment and any other needs they might have.

## **3. Development of Peer Support Culture**

The experiences of trying to introduce peer support into a Clinic where there was no “champion” has highlighted the need to spend more time initially working with clinic staff to deal with the cultural issues and concerns they might have and to ensure that they are fully involved in, and committed to the introduction of the service.

It is recommended that future expansion of peer support into new sites be preceded by training of staff and full involvement of all in the introduction of the service. Management at all levels of the service must be committed and involved. A second attempt at introducing the service in Mirrabooka is recommended as is a return to Joondalup Adult Mental Health.

## **4. Management of Future Peer Support Service**

Although the trial was highly successful, management of it was multi-layered and participating NGO's were not able to involve their own clientele as participants in the trial. Ruah Community Services has withdrawn from the final extended phase of the trial because they have honoured their agreement to participate until December 2007, and because they are now implementing their own version of peer support. This in itself is an extremely positive outcome of the trial, and highlights the need for the employing services to have the autonomy to define the roles of Peer Supporters employed by them and to maximise the service for their own clientele.

It is therefore recommended that the employment of Peer Supporters becomes the funding responsibility of the Mental Health Division and that decisions on placement of Peer Supporters and management of the service as a whole be made in discussion with relevant non-government and public mental health services.

## **CONCLUSION**

The PASS trial has been highly successful and all stakeholders have benefited from the service. Certain barriers were experienced and the learning from this was that the concept is new and previously untried, and to be successful in all situations requires further training and development.

The successes have confirmed that collaboration can work and that positive working relationships can be developed across a number of organisations.

The future of peer support looks bright and should not be allowed to come to an end with the conclusion of the HealthRight trial. Consumers of Mental Health Services have benefited from both giving and receiving the service and the time is right for the implementation of on-going peer support work. A policy for future management of such a service must be decided and roles and responsibilities defined.

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