PEER SUPPORT SHOWS PROMISE IN HELPING PERSONS LIVING WITH MENTAL ILLNESS ADDRESS THEIR PHYSICAL HEALTH NEEDS

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ABSTRACT

The physical health of individuals with long-term mental illnesses has long been of concern. In Western Australia, the overall mortality rate from preventable causes of people living with mental illness was reported to be 2.5 times greater than that of the general population. A trial peer support service was initiated to assist people with mental illness to attend to their physical health needs. This paper presents the planning, implementation, and results of this collaborative initiative involving non-government agencies, the public mental health service, consumers of mental health services, and the University of Western Australia.

The physical health of people living with mental illness has long been of concern, especially since the shift from institutional to community-based care (Jones, Badger, Knopke, & Coggins, 1983; Lando, Williams, Williams, & Sturgis, 2006; Phelan, Stradins, & Morrison, 2001; Werneke et al., 2006). Physical health has particularly been an issue with respect to individuals described as living with "severe" or "chronic" mental illnesses (Bobes et al., 2007; Connolly & Kelly, 2005; Davidson, Judd, Jolley, Hocking, & Thompson, 2000; Howard, El-Mallakh, Rayens, & Clark, 2007); for example, mortality rates from preventable causes are higher among people living with schizophrenia than in the general population (Sartorius, 2007). Regardless of the type of mental illness, the physical health of people living with mental illness is likely to be poorer than that of matched controls in the general population (Lawrence, Holman, & Jablensky, 2001; Mackin, Bishop, & Watkinson, 2007; Tarrant, 2006).

Factors contributing to the poor physical health of individuals with mental illnesses include metabolic syndrome, cardiovascular disease, carbohydrate and lipid metabolic disorders, the increased likelihood of suicide, abdominal obesity, poor nutrition, smoking, and physical inactivity (Bobes et al., 2007). Osborn (2001) also notes that psychotropic medications contribute to iatrogenic physical health problems.

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Individuals with mental illnesses face complex challenges that can affect their physical health such as stigma, social deprivation, lack of economic opportunity, the fractured nature of health delivery systems, and the lack of collaboration between mental health services and primary health care services (Davidson et al., 2000; Garden, 2005; Jones et al., 1983; Meadows et al., 2001; Robson & Gray, 2007). The nature and consequences of mental illness can also be a factor (Leucht, Burkard, Henderson, Maj, & Sartorius, 2007); for example, individuals living with schizophrenia may be less able to spontaneously report physical symptoms, may have a high pain tolerance or reduced pain sensitivity, and may have cognitive deficits that impair communication (Robson & Gray, 2007). When symptoms of physical disease are reported, they may be dismissed as part of the mental illness (Beecroft et al., 2001). Taken together, these factors pose substantial barriers to the already poor coordination and delivery of primary health care services for this population (Beecroft et al., 2001; Garden, 2005; Jones et al., 1983; Meadows et al., 2001).

The physical health of people living with mental illness was highlighted in Western Australia's *Duty to Care* report (Lawrence et al., 2001). One of the key findings was that the overall mortality rate from preventable causes of individuals living with mental illness was 2.5 times greater than that of the general population. The report also found that physical illness in general is often not diagnosed, not treated appropriately, or treated at much later stages in individuals living with mental illness.

The *Duty to Care* report (Lawrence et al., 2001) sparked a keen interest in addressing the physical health of people living with mental illness through peer support. Peer support is "based on the belief that people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations" (Davidson, Chinman, Sells, & Rowe, 2006, p. 443). In the context of mental health, a peer supporter is an individual with the lived experience of mental illness who supports another individual with a lived experience of mental illness (Solomon, 2004).

Despite a strong body of evidence that mutual support is beneficial and widely accepted, this resource has been either underutilized or ignored in the mental health field (Davidson et al., 1999). The biggest obstacle is a perceived lack of credibility: the perception that peer supporters have little useful to offer because they have a mental illness. Yet research has shown that 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).

Australia's National Mental Health Plan 2003–2008 (Australian Health Ministers, 2003) supports a recovery orientation in mental health service delivery and is committed to the implementation of mechanisms to facilitate the involvement of consumers and caregivers at all levels within mental health services. There is evidence to suggest that consumers and caregivers now have a voice as consultants and advocates in a wide range of mental health services across Australia (Browne & Courtney, 2006; Connor, 1999), and there is increasing commentary on consumer participation in training and employment in the areas of consultancy, representation, and advocacy (Craze & Petrovski, 2006; Happell &

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Roper, 2006; Jackson, 2006; Kidd, Kenny, & Endacott, 2007; Kroschel, 2005). The evidence on peer support initiatives in Australia is harder to find, although a 3-month pilot evaluating the effect of peer support on client functioning after discharge from hospital and on readmission rates in a South Australian mental health service reported positive results with respect to consumer satisfaction and cost effectiveness (Lawn, Smith, & Hunter, 2006). Peer support services are now part of mental health delivery systems in a number of countries, particularly in the United States (Bracke, Christiaens, & Verhaeghe, 2008; Bradstreet, 2006; Chinman, Weingarten, Stayner, & Davidson, 2001; Dixon et al., 1994; Gates & Akabas, 2007).

THE PEER ADVOCACY AND SUPPORT SERVICE (PASS)

Program Development

In response to the *Duty to Care* report (Lawrence et al., 2001), the West Australian Department of Health convened an advisory group that included strong consumer representation. Based on the group's recommendations, the department funded a project named HealthRight with the following objectives:

- to provide practical support for consumers and their caregivers in making and attending appointments with general practitioners (GPs) and other health professionals,
- to increase the proportion of people with mental illness who regularly see a GP about their physical health needs,
- to ensure that consumers admitted to mental health services have their physical health needs thoroughly assessed,
- to increase the ability of medical professionals to respond to the unique issues involved in providing total health care to people with mental illness,
- to implement systems in mental health services to identify the absence of a GP and to promote links,
- to raise the awareness of all stakeholders, and
- to implement systems to increase effective interagency collaboration.

One component of HealthRight was the trial of a Peer Advocacy and Support Service (PASS). It was proposed that through the support of a peer, consumers of mental health services could be encouraged to set realistic goals regarding their physical health. Further, peer supporters could work with both consumers of mental health services and service providers—by liaising with case managers, general practitioners, and other allied health professionals—to improve the physical health of people living with mental illness.

The overall aim of the trial project was, through peer support, to assist a selected sample of adults with severe and enduring mental illnesses in recognizing the importance of attending to physical health needs and in taking the necessary steps to do so. The peer supporters would be individuals who had experienced mental illness and understood the difficulties faced in the recovery journey. The trial

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population ("participants") would be individuals interested in and able to take some responsibility for their physical health and able to give informed consent. Consumers of mental health services were integrally involved in the development, management, and evaluation of the trial.

Focus group discussions were held with government and non-government organizations (NGOs) as well as with mental health care professionals. Consultation with three major stakeholder groups followed to assess needs; identify resources; consider delivery models, partners, and pilot sites; and inform the development of the project. The three stakeholder groups were (a) mental health consumers who had been involved in either giving or receiving peer support, (b) NGOs already providing community-based services to people with mental illness, and (c) mental health service providers.

Pursuant to the consultation process, two NGOs and three health services (two public mental health services and a Street Doctor service) agreed to become partners in the trial; a description of the partners is presented in Appendix A. Once the partners were selected, a reference group was formed consisting of a representative from each participating service, HealthRight project workers, and four consumer advocates. The group met frequently over an 18-month period. They defined the roles and responsibilities of project workers, NGOs, mental health services, and peer supporters (see Table 1); identified and addressed problems and potential problems; and oversaw and reviewed all aspects of the trial, including the development of resources, the training program, documentation, evaluation strategy, and implementation. It was in this reference group that much of the collaborative effort took place.

Each stakeholder had an opportunity to present issues and concerns. For example, representatives from the mental health services were apprehensive about having current clients working as peer supporters and maintaining confidentiality. NGOs were concerned that peer supporters not be exposed to negative attitudes from clinic staff, that they have adequate supervision, and that duty to care responsibilities be respected. Consumers raised concerns about involving family caregivers where appropriate, ensuring that peer supporters received comprehensive training, and having clearly defined roles and responsibilities. Issues were discussed until an acceptable solution for each stakeholder group was reached.

Strategies developed to achieve the project's objectives included liaising with local Divisions of General Practice to find "mental health–friendly" GPs, encouraging consumers and GPs to allow peer supporters into consultations, increasing awareness among mental health clinicians to be cognizant of the physical health needs of their clients, and encouraging case managers and GPs to more effectively communicate with each other for the benefit of consumers.

The project was managed by members of the University of Western Australia's School of Psychiatry and Clinical Neurosciences. Their role was to monitor the overall project budget, supervise the evaluation component of the trial, provide administrative support for the project workers, and to apply for approval from the Human Research Ethics Committee.

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Measures

Clinicians were asked to complete a pre- and posttrial questionnaire designed to evaluate their attitudes toward peer support and their clients' health. Participant questionnaires pre- and posttrial assessed physical health needs, health behaviours, and their relationship with the peer supporter. Peer supporters completed a posttrial questionnaire evaluating their activities and relationship with each participant as well as their ability to work with referring case managers. Many of the questions used a 5-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*) with additional space for narrative comments. The evaluation was approved by the university's Human Research Ethics Committee. Standard information and consent forms were attached to all questionnaires; refusal to complete questionnaires did not affect care or preclude participation in the trial.

Recruitment and Training of Peer Supporters

There were no trained, paid peer supporters in Western Australia, and therefore a training program was developed to meet the needs identified by the key stakeholders (see Appendix B). The training opportunity was advertised in existing consumer networks, and interested individuals were invited to apply on a first-come, first-served basis. Class size was limited to 15 due to the structure of the program. Training commenced in February 2007. A total of 25 people began the course, and all but two completed the training.

The training was conducted in a workshop format and was generally interactive. Sessions took place 1 day per week for 3 weeks, facilitated by project workers, employees of a participating NGO, and invited guest speakers (a mental health nurse, a GP, and a well-respected consumer consultant). The training encompassed both an orientation to HealthRight objectives and a description of the anticipated role of peer supporters. Each trainee was supplied with a manual that included a complete set of workshop presentations. The training was free of charge.

A job description for peer supporters was developed based on the roles and responsibilities defined by the reference group (see Table 1), and selection criteria were identified. During the course, trainees were invited to apply for the six available peer supporter positions, and applications were received from 14 individuals. Peer supporters were selected on the basis of observed interpersonal skills, written job applications, and structured interviews. A peer supporter could be an ex-consumer of a participating mental health service; however, if a peer supporter was a current client of that service, his or her care was transferred elsewhere.

Orientation of Staff of Referring Services

Two presentations were made to all staff of participating health services. The first presentation, 4 months prior to trial commencement, outlined the background of the project and the development of the peer support service as well as the potential benefits of peer support for clinicians and their clients. Opportunities were given for feedback and comments. Clinicians at the two public mental health sites expressed concern about client confidentiality (Would peer supporters understand the need to respect

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client confidentiality?) and decompensation (Would peer supporters become unwell due to the pressure of working with consumers?). Clinicians were reassured that confidentiality would be a component of the training and that there were supports in place to monitor peer supporters; a peer supporter who became unwell would be treated in the same manner as an employee who became unwell.

The second presentation, made just prior to trial commencement, consisted of information about procedures (see Appendix C) and documentation. It was stressed that at no time would it be appropriate for peer supporters to view clinicians' files, and that peer supporters' case notes would be secured at the NGO offices. At this presentation, complete sets of all documents, a resource book and kit, and the content of the training program were provided to the services; pretrial clinician questionnaires were distributed; and peer supporter introductions were made.

Resources Developed

A resource kit was produced for all trainees, which included existing brochures and information on a range of issues such as smoking cessation, guidelines for physical activity and dietary requirements, breast cancer and screening, alcohol guidelines, healthy eating, and National Prescribing Service information on medicines and help lines. This kit was the major resource for peer supporters to obtain health-related information for participants.

In addition, a comprehensive guide to health information, services, and resources in the trial area was produced for use by all stakeholders. Mental health–friendly GP-reviewed brochures were developed on making the most of GP visits and on suggested health checks for men and for women. A "passport" was designed for participants to record all health-related information, such as medications and dosages, the telephone numbers of their GP and allied health providers, and appointment details.

Documentation produced for the trial included a referral 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, and a confidentiality agreement form to be signed by peer supporters working with the public mental health clinics.

Trial Implementation

A 6-month trial period was planned (March to September 2007). Two peer supporters (one male, one female) were placed at each of the three participating trial sites. Even though it had not been explicitly planned to refer participants to a peer supporter of the same gender, in most cases that is what happened. Since the peer support was a trial and numbers were small, no data were collected to further explore whether gender allocation had an impact.

The roles and responsibilities of HealthRight project workers, NGOs, health services, and peer supporters in the trial are presented in Table 1. The three health services involved in the trial identified and referred appropriate participants. The NGO supervisor discussed and reviewed each referral with the referring case manager before assigning the referral to a peer supporter. Compatibility and suitability issues were dealt with at that point.

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Table 1

Roles and Responsibilities of Collaborative Partners in Peer Support

HealthRight project workers and non-government agencies	Health services	Peer supporters
• Develop training program and resources • Train interested consumers of mental health services • Select 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, paid, and supervised by the two non-government agencies • Collect evaluation data • Present service providers with relevant information and coordinate referrals to the peer supporters • Obtain or develop resources and information aimed at raising awareness of the need to attend to physical health needs • Locate allied services where necessary • Write a full report to the Department of Health on conclusion of the trial	• Identify suitable participants and make referrals • Arrange first meetings between peer supporters and referred clients • Work with peer supporters, caregivers and families, GPs, and allied health professionals in 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 maintain responsibility for the management of prescribed medications • Meet regularly with peer supporters to monitor progress	• Set health-related goals with participants • Encourage and assist participants to find and consult GPs • Encourage and support participants to locate and utilize allied health professionals and health-related services • Assist participants to make health-related appointments • Provide participants with information, resources, and support in attending appointments • If necessary, advocate on behalf of participants • Maintain contact with the key mental health professionals and ensure communication of relevant information • Disengage when appropriate to encourage independence • Maintain appropriate records and documentation to ensure accountability, to comply with legal responsibilities, and to assist the evaluation process

At the two public mental health service sites, the role of the peer supporters was to assist participants to make and attend GP appointments, and to address other physical health issues as required. Peer supporters working with the Street Doctor service, where the physical needs of participants were already being met, assisted participants with lifestyle issues such as locating physical health activities and quitting smoking. Although the peer support service was designed to assist people with mentally illness to attend to their physical health, it was acknowledged that other issues would arise and that there needed to be a structure in place whereby assistance could be provided to ensure that these needs were dealt with by the appropriate agency or support service.

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Initially, peer supporters had daily contact with their NGO supervisor. As the trial progressed and they became more confident in their role, supervision occurred every 2 weeks. Telephone support was made available to peer supporters during working hours, if required. Each referring agency allocated a non-physician health professional who provided support on a day-to-day basis, for example, by providing peer supporters with information about clinic procedures or advice regarding clinical matters outside the scope of their training. Peer supporters also liaised with case managers at the referring agencies to keep them abreast of progress made. A HealthRight project worker facilitated monthly support meetings for all the peer supporters, allowing for the exchange of ideas and experiences.

The aim was for each peer supporter to work with five consumers for a total of 15 hours per week over a 6-month period. It was anticipated that while some consumers may not need 6 months of support to address issues of primary health care needs, they would need sufficient time to develop relationships with peer supporters that might facilitate such lifestyle changes as sustained improvements in nutrition, increased physical activity, and smoking cessation.

Unfortunately, at one public mental health service site, referrals were not forthcoming, and in June 2007 the service was withdrawn from this site. (Clinician data from this site were excluded from any analysis.) The two peer supporters who had been assigned to that site found employment elsewhere. Due to positive results in the two remaining sites, the trial was extended until December 2007.

Results

Participants. Thirty-two clients were referred to the trial as participants, 25 of whom elected to receive peer support (13 males, 12 females, mean age = 43 years). Clients choosing not to receive support did not wish to embark on increased physical activity or weight loss programs. Twelve of the 25 participants already had a general practitioner, mainly through the Street Doctor service. Peer supporters helped 9 participants find a GP by liaising with clinic staff and the local Division of General Practice. The remaining 4 participants either attended a group practice or did not want to find a GP, despite recommendations. Increased physical activity (walking regularly with the peer supporter) was reported by 20 participants. Other reported lifestyle changes associated with the peer support project included linking with a community exercise facility (11 participants), weight loss (8), encouragement to change dietary habits and eat healthier foods (7), and support to stop smoking (5). Some participants made more than one lifestyle change during the course of the trial.

Peer supporters. All peer supporters reported improvements in their confidence and self-esteem. Two peer supporters noted better mental and physical health as a result of the trial; one reported significantly reduced cigarette consumption. Two commented on how personally rewarding it was to work as a peer supporter, and two reported feeling like a peer with professional health care workers.

Clinicians. On the pretrial questionnaire, clinicians expressed concern that even though the issue of confidentiality would be addressed in training, peer supporters would not understand the importance of maintaining confidentiality. From written responses to the confidentiality question at the conclusion of the trial, however, it was clear that this was no longer a concern for clinicians who had worked directly with peer supporters. As one clinician commented, “The peer support workers in our

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service displayed a high level of professionalism and were respectful maintaining confidentiality and were clear on their roles and responsibilities." There was no comparable change in attitude among clinicians who had worked at pilot sites but, for reasons beyond the control of the project, workers had not had direct contact with peer supporters.

The other major concern that clinicians had expressed pretrial was that the mental health of peer supporters might suffer due to a number of factors including exposure to negative attitudes of clinic staff, work-related stress, potential problems caused by "difficult" clients, inadequate support, and the challenge of maintaining appropriate boundaries. At posttrial, these concerns were not raised. Clinicians reported that they observed benefits for their clients including improved physical health resulting in better mental health; greater awareness of the importance of attending to physical health, which promoted recovery; development of a more holistic approach; and reduced demand on clinical services.

DISCUSSION AND CONCLUSION

Early results of this trial are encouraging and exceeded expectations. The peer support contact has involved far more than assisting participants with access to GPs, as illustrated by the lifestyle changes some participants were able to make. Unexpectedly, as a direct result of HealthRight, several staff members also reported positive lifestyle changes including smoking cessation and initiation of exercise programs. Identified facilitators of and barriers to the success of peer support in this trial are outlined in Appendix D.

In the public mental health clinic where the trial was successful, staff at the highest levels were keen to implement a peer support service. Prior to the trial, they had carried out extensive research and consultation with all stakeholders; in their culture and attitudes, the clinic staff were ready for the service. (Lack of funding had prevented them from implementing a program.) The presence of high-management level "champions" was seen to be critical to the success of the trial.

The NGOs that housed the peer supporters welcomed them as part of their staff and incorporated them into their teams. The inclusion of the peer supporters as part of the NGO culture was also seen as critical to the success of the trial, and an acknowledgement and clear understanding of the benefits of peer support by the staff at both NGOs and two of the health services were key factors in the trial's success.

Stakeholders agreed on several reasons for failure at one site. The impetus and enthusiasm for the trial were lost at a critical time when the champion of the service was transferred and the head of service simultaneously went on leave. At this site, administrative support was inadequate (e.g., computer access was denied, telephone messages could not be left, and peer supporters were prohibited in the open-plan office where clinicians worked). As well, peer supporters were not considered part of the clinic team and were excluded from staff meetings.

It is suggested that the clinic culture at that site was not yet ready to accept the notion of peer support. In hindsight it would have been better to spend more time with clinic management and staff to facilitate the necessary cultural and attitudinal changes toward peer support. As the project progressed, it became evident that the peer supporters at the successful NGO sites were receiving positive feedback

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and support and were incorporated into the working teams within those settings, attending staff meetings and working in close proximity to other staff members.

Although the majority of clinicians were concerned about confidentiality pretrial, those who worked directly with peer supporters reported a change in attitude posttrial. This suggests that clinician attitudes toward peer supporters may change only if clinicians have the opportunity to interact with them directly. Clinicians at the site where the trial failed did not have the opportunity to work directly with peer supporters; this may have contributed to the lack of referrals and the subsequent withdrawal of the peer support service at that site.

Having only two project workers (only one of whom was full-time) limited the overall scope of the HealthRight project. Limitations of the peer support trial itself were the small number of participants and the lack of a control group and non-randomized sample population. Participants completed their questionnaires with the support of the peer supporters; it is acknowledged that this was not ideal due to the potential influence of "the experimenter effect." The evaluation was conducted this way due to strong concern by the NGOs that participants would be apprehensive about dealing with an unfamiliar person.

Since the end of the trial period, one of the participating NGOs has employed peer supporters in all its community teams, although the focus is no longer primarily on physical health. One of these peer supporters was part of the trial. HealthRight has extended its funding to two of the participating partners, who both continue to employ a HealthRight peer supporter. The remaining peer supporter now works full-time at another NGO. The state Department of Health has provided ongoing funding for the next 3 years to cover the costs of continuing the service in one public mental health service and one NGO. Funding has also been made available to develop more peer support training, to facilitate the spread of additional peer support services into other settings, and to conduct further research. These developments suggest that peer support is now considered to be a viable enhancement to mental health services in Western Australia. Future research might add to our understanding of how peer support can facilitate behaviour change and of mechanisms that facilitate cultural change in public mental health settings.

RÉSUMÉ

La santé physique des individus vivant avec un problème de santé mentale chronique est depuis longtemps un sujet de préoccupation. En Australie-Occidentale, par exemple, on a évalué, chez les personnes ayant un problème de santé mentale, le taux de décès relié à des causes évitables. Les résultats ont montré que ce taux était 2,5 fois plus élevé que dans la population en général. On a donc mis sur pied un projet pilote de soutien par les pairs pour aider les personnes ayant un problème de santé mentale à répondre à leurs besoins en matière de santé physique. Dans cet article, nous décrivons comment ce projet (impliquant la collaboration de partenaires non gouvernementaux, du système de santé public, des bénéficiaires de soins de santé mentale et la University of Western Australia) a été planifié et mis en place, et nous présentons les résultats qu'il a permis d'obtenir.

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APPENDIX A

Description of Participating Partners

Ruah Community Services is committed to working in partnership with citizens marginalized by mainstream society to enable them to overcome their disadvantages, improve the quality of their lives, enhance their spirit, and participate more fully in the community. Ruah's mandate includes working with people in their mental health recovery journey and assisting them to reduce the impact of poverty and find pathways to mainstream opportunities. Ruah became the major NGO partner and agreed to assist in developing resources, training peer supporters, and documenting the trial.

The *Hills Community Support Group (HCSG) Rainbow Program* was the other participating NGO. HCSG provides low-cost, long-term housing for adults with severe and persistent psychiatric disability. Support includes social and living skills development, recreational and vocational support, and assistance with access to community facilities and resources. HCSG did not play a role in resource development or training.

Two of the health services were *public adult mental health outpatient clinics*. In Western Australia, adult mental health services provide long-term access to psychiatric treatment for public patients including case management, medication review, and allied health services. The role of these services in the trial was to identify and refer clients willing to address their physical health needs.

Street Doctor is an innovative, mobile medical service providing primary health care services to street-based populations in northeastern Perth. This program focuses on the physical, psychological, and social needs of populations that do not regularly utilize mainstream services.

APPENDIX B

Training Needs for Peer Supporters as Identified by Key Stakeholders

- What peer support is and the roles and responsibilities of supporters—mediator, supporter, buddy
- Communication and negotiating skills/listening skills, and dealing with clients' spouse and caregiver influences
- Setting boundaries
- Recognition of and dealing with social exclusion of mentally ill
- Disclosure protocols and transparency
- Confidentiality, legal issues, and integrity
- Dealing with difficult/risk situations and ethical issues
- Rights of supporters and of clients—duty of care and accountability
- Protocols for shared care, case management, and family support
- Team approach, debriefing methods and opportunities
- Working as part of a team while ensuring that own needs are met/need for support and how it will be given
- Supporters' self-care, awareness of potential self-triggers, and taking time out
- Use of resources developed for the trial
- Training for GPs on the project and the needs of consumers
- Access to related services such as optical care, nutrition, dental care, sleep, stress management, exercise
- Need for a holistic approach
- Assertiveness and empowerment
- Assisting clients to navigate the health system

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APPENDIX C

HealthRight Procedural Flow Chart

1. Mental health services case manager/street doctor identifies suitable participant.
2. Case manager/street doctor discusses the project with the potential participant and provides a copy of the pamphlet, "What Is the HealthRight Peer Advocacy and Support Service?"
3. If the potential participant is in agreement, the case manager fills in the referral form and the potential participant signs the referral. Referral is posted (not faxed) to coordinator of Peer Advocacy and Support Service (PASS).
4. PASS coordinator contacts case manager/street doctor to clarify any issues or safety concerns.
5. If the referral is assessed as appropriate, the PASS coordinator allocates the referral to a peer supporter.
6. Peer supporter contacts case manager/street doctor to discuss referral and to negotiate time and place for case manager to introduce participant to the peer supporter.
7. Introductory meeting takes place (case manager/street doctor, participant, and peer supporter). Peer supporter and participant arrange their next appointment.
8. Participant and peer supporter meet and complete goal-setting plan. Copy is provided to case manager/street doctor.
9. Participant signature is required on interagency consent form that identifies any agencies with which there is likely to be an exchange of information.
10. Peer supporters document all contacts with participants and stakeholders. Files should be secure at all times.
11. Initial goal-setting plan should be reviewed by peer supporter and participant on a regular basis. Updates should be passed on to the case manager/street doctor.
12. Peer supporter arranges to meet with case manager/street doctor on a monthly basis or more often if necessary, to discuss the progress to date. The participant should always be included in the meeting.
13. A formal review of the work is undertaken on completion of the support service.

APPENDIX D

Identified Facilitators of and Barriers to Success of Peer Support Service

Factors Contributing to Success

- Peer supporters were provided with office accommodation by the collaborating non-government agencies, were made welcome by the other employees in those offices, and were included in team meetings and office activities.
- "Champions" for the service included high-level clinical staff—a psychiatrist/head of clinical services in the mental health service and the GP Street Doctor—and both indicated their full support of the non-medical model component of their patients' recovery throughout the trial.
- Peer supporters received professional supervision and had regular, sometimes daily, contact with their supervisors and with the contact persons in the referring services.
- All stakeholders were made aware of the successful outcomes of the peer support work.
- Peer supporters took time in the initial phase of the implementation to find out about services in the geographical areas where they worked and dealt with a variety of participant needs in addition to assisting them to deal with their physical health.

Barriers to Success

- Insufficient training of clinical staff on the benefits of peer support
- No "champion" for the service within the clinic
- Staff changes and absences at the time of project set-up in the clinic
- Insecurity on the part of clinic staff on the issue of confidentiality
- Lack of clear understanding of the role of peer supporters
- Insufficient logistical preparation (e.g., computer access, message taking at reception)
- Reluctance on the part of clinic staff to advertise and promote the service in waiting areas and on notice boards
- Inability to make the cultural changes required to accommodate consumers of mental health services as staff members

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