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DEVELOPMENT OF A PEER SUPPORT STRATEGY FOR THE SOUTH WEST LHIN (SWLHIN)

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EXECUTIVE SUMMARY

Peer support was identified as one of the mental health and addiction system improvement initiatives for the South West Local Health Integration Network (SWLHIN). This report discusses a proposed peer support strategy and the processes undertaken in its development including the literature review, environmental scan, values and guiding principles, vision and outcomes and areas of focus for the strategy. Additionally, implementation considerations are outlined as well as a draft logic model to support evaluation planning.

DEFINITION AND PEER SUPPORT EFFECTIVENESS

There are many definitions for peer support and various models of peer support ranging from informal peer support to formal and intentional peer support as well as clinical models that include peer support. The Mental Health Commission of Canada (2010) defined intentional peer support as *"any organized support provided by and for people with mental health problems".* There is sufficient evidence to make a case for peer support as an effective intervention for people experiencing mental health and addiction challenges. In addition, there is research support for the role of consumer survivor initiatives (CSIs) in providing mental health and addiction interventions either in situations where there are consumer-led services or where consumers provide intervention as an adjunct to traditional services. The findings show that peer support services impact on a range of measures such as less time in hospital; reducing hospitalization, use of psychiatric medications, use of outpatient services, physician visits, and cost of services; easing transition to community, reducing social isolation, and improving training; and improving employment and therefore income.

PROMISING PRACTICES

There is a good literature base to support a range of promising practices for peer support. The following are key highlights:

- Have a clear role description and responsibilities in order to avoid role confusion. This is particularly important when working with health professionals in the community or facility based care. A peer support role could include direct support such as emotional support and role modeling; educational support such as skills in problem solving; individual and system advocacy such as getting access to resources and improving the system; as well as providing information and referrals to peers who are being supported.
- Establish a range of peer support models and options to meet the diverse needs of different target groups including approaches to support those who have difficulty getting out of the home or getting to specific locations (e.g. providing telephone and online peer support) as well as having access in the diverse locations where people live and work – e.g. community settings, clinical settings, work place, etc.
- Recruit peers who have the appropriate skills and attitudes to take on the role of a peer supporter.
- Provide orientation and training based on established standards for training.

- Develop clear understanding of the role of the mental health professional in relation to working with a peer supporter.
- Establish a range of organizational supports for the peer supporter such as instituting the role of a paid peer support coordinator to facilitate and assist peer-to-peer relationships and other needs that may emerge; suitable matching of peer supporters to those who require the support; appropriate level of supervision; improving staff attitudes towards peer supporters; managing stressors that accompany organizational change; as well as identify and encourage champions (non-peer staff who help to raise awareness of peer support role and work).
- Institute appropriate mechanisms to value and endorse peer supporters – consider what financial and non-financial recognitions can be implemented.
- Consider and address ways to sustain peer support programs such as outreach activities, partnerships with mental health and social service organizations, integrate peer support in the continuum of care, establish infrastructure supports, etc.

GAPS IN PEER SUPPORT RESEARCH

There are various areas of peer support research where there are gaps and need further exploration. This includes structures for peer support such as peer support networks, telephone support and supports for family members; organizational support such as the effectiveness of peer support champions; role of mental health professionals in how to encourage collaboration between professionals and peer supporters, including models of peer support within clinical practice environments; and access to peer support services to different target groups across different age groups, ethnicities, workplaces, etc.

ENVIRONMENTAL SCAN

Majority of the SWLHIN peer support models used by CSIs were based on an informal peer support model. In addition, some of the programs also reported formal/intentional peer support model. However, since intentional peer support was often reported in the absence of formal matching it may be possible that this term was used more broadly than intended in the literature. In the SWLHIN, the models had greater alignment to the friendship models. Most of the beneficiaries of peer support were identified through word of mouth, outreach and community referrals. In some instances, referrals were made by mental health professionals where linkages were established – majority of these linkages which were not formalized. The exception was the Transitional Discharge Model (TDM) research study which provided formal interactions and relationships between some of the consumer survivor organizations and mental health care professionals and service organizations. In other jurisdictions in Ontario, there are additional clinical models that integrate the peer supporter as part of the interdisciplinary team; these models include inpatient mental health programs and Assertive Community Treatment (ACT) teams.

PEER SUPPORT STRATEGY – VALUES AND PRINCIPLES

A set of values and principles were developed and organized under the following headings: personal characteristics, recovery and healing, partnerships, quality, capability, inclusivity and diversity, and integration. These values and principles support the design and decisions about peer support work.

VISION AND OUTCOMES

The vision for the peer support strategy emerged from interviews and discussions with stakeholders in the region:

> *"Peer support is an essential and valued component of a client-centered, recovery oriented system of mental health and addiction care."*

The key outcomes desired by the stakeholders included:

- ✓ Region wide acceptance of peer support as a valid and effective intervention
- ✓ Availability of peer support where ever individuals are in their recovery journey including locations such as the community, hospital, outpatients, work and school as well as where ever they live – urban, rural or remote locations
- ✓ Appropriate and sustainable funding to support implementation of models based on promising practices
- ✓ CSIs and mental health providers working in a true partnership – as true partners peer supporters are part of the planning and ongoing oversight of mental health and addiction programs
- ✓ Standards for peer support practices are linked with accountability
- ✓ Continuous support and improvement of existing peer support programs while filling the gaps with new models where these are needed, such as models that include partnership with clinical agencies. Expand mandates of existing programs where appropriate and feasible to address gaps
- ✓ Peer support programs – no matter where they exist – in CSI or in mental health care teams – are part of a peer support network of sharing and learning.

AREAS OF FOCUS

Four areas of focus were established:

1. **Improve Existing Models of Peer Support**: Support strengthening of informal and formal consumer-led peer support models in SWLHIN including expansion of formal peer support access to patients/clients in the clinical settings such as in the hospital and community. In clinical settings, a partnership model (i.e. between CSIs and mental health care organizations) is recommended. The presence of paid peers in roles such as case managers, coordinators and counsellors is encouraged but not central to this peer support strategy.
2. **Promote Standards for Peer Support Training and Investments in People**: Establish LHIN-wide standards for peer support training based on promising practices. Allocate resources to support CSIs strengthen their investments in people.
3. **Establish Linkages and Integration Processes between Peer Support Offered by CSIs and the Mental Health Care System**: Establish well defined and effective processes to link and integrate the two solitudes (CSIs and mental health care system).
4. **Enhance Governance and Infrastructure of CSIs**: CSIs can leverage each other's strengths and assets and establish an effective network for sharing information, resources and expertise as

well as working together on specific activities. A central office is recommended as well as new investments to support CSIs on common administrative requirements and other functions.

ENABLERS

To support the implementation and evaluation of the peer support strategy, there are key enablers that could be leveraged. These include:

- ✓ Commitment and continual engagement from all stakeholders
- ✓ Multi-stakeholder steering committee to provide oversight to the implementation of the peer support strategy
- ✓ Project management support from a neutral party with specific skills and credibility with both the CSIs and the mental health services
- ✓ Change management framework
- ✓ Funding for planning and implementing of specific components of the strategic investments
- ✓ Two to three year timeframe for full implementation of the peer support strategy
- ✓ Evaluation at mid-point in the implementation plan for accountability and readjustment of strategy and work plan as required.

IMPLEMENTATION AND EVALUATION CONSIDERATION

Implementation considerations are provided as well as a draft logic model to support the evaluation of the peer support strategy for the SWLHIN.

1.0 INTRODUCTION

The South West Local Integration Network (SWLHIN) launched an initiative to renew its peer support strategy in 2014-2015 focusing on peer support in relation to mental health and addiction. Previously, the SWLHIN had commissioned a report on community capacity development for mental health and addiction services. The 2014 report identified peer support as one of several key areas requiring system improvement. The development of this project related to a peer support strategy was a direct result of this recommendation. The goal was to strengthen peer support infrastructure and integration within the LHIN. Two high-level directives for this project were: 1) to enhance practice standardization, training, system advocacy and adoption of peer support as a key component of and embedded in service delivery; and, 2) for local consumer support initiatives (CSIs) to augment the local service delivery, facilitate stronger linkages between CSIs and other services, maximize resources for direct care and minimize administrative duties.

St. Joseph's Health Care, London, was selected as the lead organization to manage the project. St. Joseph's was charged to work with South West Alliance Network (SWAN) and the South West Addiction and Mental Health Coalition to ensure all key stakeholders (both providers and individuals with lived experience) were fully engaged and regularly consulted over the course of this project. A consultant team was identified to support the project and to make recommendations based on best practice models.

There were several key assumptions that were made at the outset of the project:

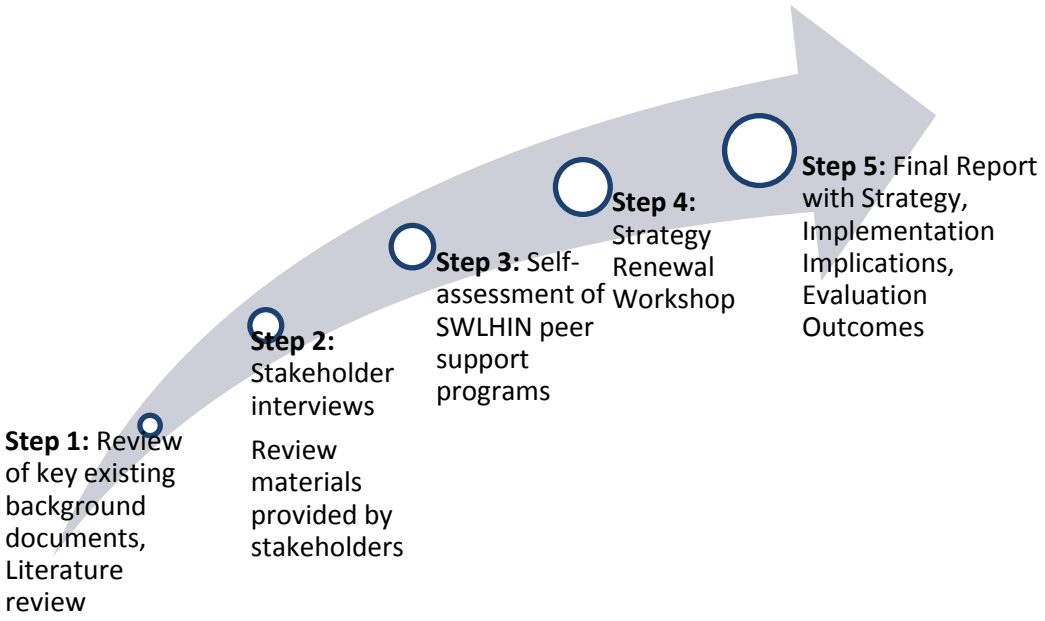
- Peer support is an essential part of the mental health & addiction continuum of care and the delivery of models of care based on best practices is expected for people receiving the service
- Peer support initiatives need to maximize the skill and ability of those providing peer support through a strengthened and sustainable peer support infrastructure

2.0 WHAT IS THIS REPORT ABOUT?

The peer support strategy initiative, thus far, had five steps as shown in Figure 1 below: 1) review of background documentation and literature review; 2) stakeholder interviews and review of materials provided by stakeholders; 3) assessment of existing peer support programs in the SWLHIN; 4) peer support strategy development workshop; 4) preparation of SWLHIN peer support strategy report. This report is the culminating report of these five steps and as such, integrates the findings from all steps of the work. Specifically, the objectives of the report are to:

a) Present the highlights of the literature and environmental scan
b) Discuss the input from key stakeholders
c) Describe the recommended peer support strategy for the SWLHIN
d) Provide some initial suggestions on the implementation and evaluation in order to assist the SWLHIN in planning the next stage of implementing the peer support strategy.

Figure 1: Key Steps towards Renewal of Peer Support Strategy



3.0 Literature Review

3.1 Peer Support – What is it?

From a broadest perspective, "*peer support is a naturally occurring, mutually beneficial support process, where people who share a common experience meet as equals, sharing skills, strengths and hope; learning from each other how to cope, thrive and flourish*"[1]. Viewing peer support from an intentional mechanism to assist those living with or affected by mental illness, "*peer support (formalized) begins when persons with lived experience who have received specialized training, assume unique, designated roles within the mental health system, to support an individual's expressed wishes*"[2].

The Mental Health Commission of Canada (2010) defined intentional peer support as *"any **organized** support provided by and for people with mental health problems".* The MHCC further elaborates that

> *"Peer support initiatives [are] the **programs, networks, agencies or services** that provide peer support. They can be:*
>
> - *Funded OR unfunded.*
> - *Use volunteers OR paid staff OR both.*
> - *Operate out of psychiatric consumer/survivor run organizations OR other agencies.*
> - *Delivered by a group of peers OR by an individual peer in a team of professionals.*
> - *A primary activity of the initiative OR a secondary benefit e.g. in a consumer/survivor business." (O'Hagan et al, 2010 p.41).*

[1] OPDI (2015)
[2] OPDI (2015)

Peer supporters[3] and peer operated services have been recognized as best practices in the United States where it is included in the Medicaid program and supported by the peer support worker bill. Similarly, in the United Kingdom, a formalized role of Recovery College has been established to train peer supporters; and in Ontario, the peer supporter is mandated in Assertive Community Teams (ACT) within community mental health care teams (Walker & Bryant, 2013).

3.2 PEER SUPPORT – EFFECTIVENESS

3.2.1 PEER SUPPORT INTERVENTIONS

Peer support plays an important role in recovery. The MHCC in its review of the literature and their report *Making the Case for Peer Support"*, concludes that peer support is effective; it works and can save money. The report notes that a research base supports peer support in reducing hospitalization and distress symptoms, improves social support and overall improves people's quality of life (O'Hagan et al, 2010).

Pitt et al (2013) conducted a systematic review and included 11 controlled trials which involved past or present consumers of mental health services who were employed as providers of mental health services. The studies where consumers (peers) who provided services as opposed to professionals found that there were no significant differences in the two groups in most outcomes studies but did find that the peer intervention studies had slightly less use of crisis and emergency services. The peer supporters spent more in-person time with the clients. In the studies where peer supporters were an adjunct to professional care, they found there were no differences. None of the studies indicated any harm to clients. The researchers concluded that "*employing past or present consumers of mental health services as providers of mental health services achieves psychosocial, mental health symptom and service use outcomes that are no better or worse than those achieved by professional staff in providing care*" (p. 23).

Repper and Carter (2011) conducted a systematic review and included peer support interventions that were professionally led as opposed to consumer led initiatives. They found that paid peer supporters were associated with reductions in hospital admissions and readmissions among those who received peer support as well as improvements in factors that provided recovery. Improvements were found in scores in empowerment, self-esteem, confidence, social functioning (e.g. coping and problem solving skills); accessing greater social supports, community integration; reports of feeling greater acceptance, understanding, being liked and feelings of hope (e.g. belief in a better future). The authors concluded that peer supporters

> *"Appear to be able to do more successfully than professionally qualified staff is promote hope and belief in the possibility of recover; empowerment and increased self-esteem, self-efficacy and self-management of difficulties and social inclusion, engagement and increased social networks. It is these outcomes that people with lived experience have associated with their own recovery; indeed these have been proposed as the central tenets of recovery: hope, control/agency and opportunity" (p. 400).*

[3] The term "peer supporter" will be used in this report to denote both volunteer (unpaid) and paid peers who provide support to other peers. The term peer support worker will be used only where it is relevant to the context.

3.2.1 Role of Consumer Survivor Initiatives

In addition, it is important to note that the role of CSIs in providing mental health intervention has also been supported in the literature. Doughty and Tse (2011) conducted a systematic review which included 29 controlled studies comparing mental health services that included a consumer-led mental health service component or consumer-led mental service alone and traditional mental health services (with no consumer involvement in the service delivery). The review conducted that *"overall consumer-led services reported equally positive outcomes for their clients as traditional services, particularly for practical outcomes such as employment or living arrangements, and in reducing hospitalizations and thus the cost of services*" (p. 252).

A joint report by Canadian Mental Health Association, Ontario; Centre for Addiction and Mental Health; Ontario Federation of Community Mental Health and Addiction Programs; and the Ontario Peer Development Initiative summarized the following key findings based on their review of the literature on CSIs:

- ✓ Reducing social isolation which is a significant factor in relapse
- ✓ Less time in hospital
- ✓ Fewer crisis services
- ✓ Reduce use of psychiatric medications
- ✓ Reduce use of outpatient services and physician visits
- ✓ Discharged patients learn by example from their peers – ease transition to community living
- ✓ Increase consumer voice in institutional environments – e.g. Patient Councils
- ✓ Receive employment and training
- ✓ Earn additional income to supplement or replace benefits
- ✓ Contribute back through paying income tax.

3.3 Peer Support Promising Practices

A literature review was conducted in order to better understand best practices in the use of peer support as an intervention to support people with mental illness.

3.3.1 Peer Supporters

A major theme regarding peer support is related to the role of the peer supporter. Peer supporters have commented on feeling powerless in the mental health system, likely due to lack of credentials or professionalism, and poorly defined place within the health care system (Basset et al., 2010). Literature has consistently identified the need for clarifying the role of peer supporters. There is no structure or system set in place that clearly defines the role, responsibilities and job description of a peer supporter (Ahmed et al., 2012; Campbell & Leaver, 2003; Daniels et al., 2011; Duckworth & Halpern, 2014; Kemp & Henderson, 2012; Mahlke et al., 2014, Miyamoto & Sono, 2012; O'Hagan & Trust, 2011; Pitt et al., 2013; Repper & Carter, 2011; Repper, 2013; Walker & Bryant, 2013). Peer supporters occupy challenging roles including being expected to create mutual and flexible relationships, the desire to retain professional practice and being expected to be change agents (changing the culture and fostering openness) (Berry et al., 2011). In addition, it was found that role confusion arose more frequently when agencies recruited

peers from within their client pool (Gates & Akabas, 2007). Due to these challenges, it has be suggested that peer support job descriptions should be written in conjunction with managers, HR staff and peer supporters to ensure role clarity and accuracy (Daniels et al., 2011). A peer support role could encompass: direct peer support (emotional, role modeling), education (skills development such as communication, problem solving), recovery, daily life skills, individual advocacy (attended meetings, advocate for other services), systemic advocacy (providing feedback, consultation, input on policy), provision of information and referrals as needed (Bell et al., 2014).

3.3.2 Peer Support Models

Peer support models range from informal relationships, formalized or intentional peer support, peer support in the workplace or even in the community at large. Venues for peer support include in person, as well as online and telephone support. In formalized relations, there have been instances where there was poor matching of peers to consumers within the peer support model (Coatsworth-Puspoky et al., 2006; Repper, 2013). Looking at the community model, there is general a lack of community awareness on the importance of peer support in mental health (Krumm et al., 2013). Based on literature, it has been suggested that having at least 2 peer staff for any new program is important so that they have each other's support (Davidson et al., 2012; Repper, 2013). In a formal peer support model, the expectation of the peer is to help others, build peer support into our systems, and make it "ordinary" (Fulton and Windfield, 2011).

Regarding an online support model, studies have shown there to be poor computer literacy rates among consumers (Campbell 2014; Moock, 2014), poor confidentiality and increased liability (Moock, 2014). Perhaps incorporating social media into a peer support model may be impactful (Naslund et al., 2008). However, this type of peer support may require further research to determine benefits, impacts and structure for best practice.

3.3.3 Recruitment of Peer Supporters

Once the peer support role and model are defined, it is important to have a recruitment process in place. Without a structured recruitment process, there will likely be a lack of qualified individuals to provide service for to support others (O'Hagan & Trust, 2011). Literature has stressed the importance of having a formalized recruitment process including interviews to ensure the right candidates are selected (Repper 2013). Selection criteria should include: knowing and being able to connect with people, guidance and planning skills, negotiating and advocating skills, organizing and setting up, managing and improving, reflecting and developing (Fulton & Windfield, 2011). Furthermore, it is recommended to increase the number of peer supporters recruited to ensure sustainability for those lost to relapse, illness etc. (Holmes et al., 2013).

3.3.4 Orientation and Training

Once peer supporters are recruited, determining an appropriate training and orientation structure is the next step. When such procedures are in place, these processes allow for standardization of the peer support role (Basset et al., 2010). A few studies have found there to be a need for a credited or certified program that peer supporters can take to prepare them for their role, however this is not always available or possible (Campbell & Leaver, 2003; Duckworth & Halpern, 2014). Training for peer

supporters is important, but managers and all non-peer staff should be trained as well, in particular on the principles and importance of peer support activities (Bell et al., 2014; Daniels et al., 2011; Walker & Bryant, 2013). Training topics can include: exploring peer support, personal recovery plans, confidentiality, information sharing, exploring boundaries and disclosure, developing listening skills, promoting social inclusion, responding to distressing situations (Simpson et al., 2014). Providing training on disclosure (i.e. knowing how much information to share and when to share it) is a useful skill for a peer supporter (Basset et al., 2010, Berry et al., 2011, Kemp & Henderson 2012, O'Hagan & Trust 2011, Repper & Carter 2011). Creation of a peer support manual or handbook for orientation and training is important, especially in regards to standardizing the process and for sustainability (Kemp & Henderson 2012). Allocating one staff member per peer for the orientation process is important to help provide tips about routines and daily procedures (Repper 2013). Not only providing training at the outset of a program, but also providing ongoing training and monitoring for peer supporters to ensure their work is of high quality is recommended (Tse et al., 2014).

3.3.5 Role of Mental Health Professional

Defining the role of the mental health professional and the non-peer staff in the peer support model is important. At times, there is prejudice and discrimination from non-peer staff towards peer supporters for various reasons (Walker & Bryant, 2013). Negative attitudes towards peer supporters have been identified among non-peer workers (Cleary et. al 2011, Davis, 2013); these include territoriality, defensiveness, stereotyping, and stigma (Jacobson et. al, 2012). Therefore, providing non-peer staff with training on the importance of the role is helpful to mitigate this issue (Basset et al., 2010, Repper & Carter 2011). Building awareness of issues among peer supporters and non-peer staff may sensitize people and help to open dialogue about ways to address these issues (Moll et. al, 2009). It is also recommended that a focus be placed on collaboration with mental health professionals and with partnerships with organizations across the mental health system (Basset et al, 2010; Van Voorhees et al., 2012; Simpson 2013; Simpson et al., 2014). The role of mental health professionals should include but not be limited to: sharing strategies, challenges and successes, developing skills, knowledge and expertise and creating confidence in peer supporters (Repper 2013).

3.3.6 Organizational Supports

The overall structure of a peer support model may be a challenge without having the right organizational supports in place. Organizational support is a pillar for success of the model, along with peer support network and managerial support (Berry et al., 2011, Singer 2011). The literature has noted the following challenges: poor supervision from staff, due to a variety of reasons including lack of value placed on peer support, poor knowledge of its benefits (Bell et al., 2014, Kemp & Henderson 2012, Repper 2013); poor staff attitudes towards peer supporters (Oldknow et al., 2014); and, organizational changes that put strain and stress on peer supporters (Berry et al., 2011). As a result it is recommended that having a peer support coordinator along with a program facilitator are important to ensure peer supporters have the assistance they need to carry out their roles effectively (Simpson et al., 2014). Another type of support could include the use of peer support champions, who are non-peer staff that work to raise awareness about the peer support work and role, and provide support as needed (Berry et al., 2011).

3.3.7 VALUE/RECOGNITION OF PEER SUPPORT

Creating a sustainable peer support model for mental health users can be a challenge in itself. Determining whether to pay peer supporters is an important area to explore. Research shows that there is poor value placed on peer supporters who are not paid (Bell et al., 2014; Fulton & Windfield, 2011), however there is always a concern if funding exists (Campbell & Leaver, 2003; Daniels et al., 2011, Humm & Simpson, 2014). In order for peer supporters to feel valued, formal recognition is important (Bell et al., 2014, Berry et al., 2011; Fulton & Windfield, 2011). Paying peer supporters would help legitimize the role in the eyes of the health care system and show them respect (Duckworth & Halpern, 2014; Holmes et al., 2013; Miyamoto & Sono, 2012). Loosing staff to relapse or illness has also been a concern with regards to sustainability (Singer 2011). As a result, emphasis should be placed on self-management strategies to prevent relapse of peer supporters (Schrank et al., 2012). Other challenges around sustainability include poor working conditions, work overload issues (Mahlke et al., 2014) and travel constraints for part-time peer supporters that work across large regions (Becker et al., 2012).

3.3.8 SUSTAINABILITY

As a result of sustainability challenges, recommendations from the literature include:

- Integrating peer support into the continuum of care, make it be known and accepted means for assisting people with recovery in mental health (Campbell & Leaver, 2003; Oldknow et al., 2014)
- Disseminating success stories for peer support activities to keep hope alive, to help others understand importance of this support (Davidson et al., 2012)
- Creation of peer support manual or handbook for orientation and training (Kemp & Henderson 2012)
- Promote collaboration between agencies such as mental health services, social services, child services to integrate peer support into the system (Krumm et al., 2013, Walker & Bryant, 2013)
- A clearly identified meeting space for peer supporters to discuss ideas, issues, areas of stress and problem solving techniques (Mahlke et al., 2014)
- Increasing the number of peer supporters overall throughout organizations to ensure availability when needed (Morley et al., 2013; Pitt et al., 2013)
- Focusing on ongoing development of the peer role – providing continuous training opportunities and creating a wider system change to integrate peer supporters into the system (Repper 2013).

3.4 GAPS IN THE PEER SUPPORT RESEARCH

There are various areas of peer support research where there are gaps and need to be further explored.

Structure

- A better understanding of how a peer support network can assist the formalized peer support model (Bell et al., 2014)
- Determining whether online peer support is effective (Meilling, 2011; Ahmed, 2012; Van Voorhees et al., 2012)
- Determining whether telephone peer support is effective (Dennis and Brown, 2014)

- Understanding the family role as a peer supporter and it's effectiveness (Basset et al., 2010; Cavaleri et al., 2011)

Organizational Support

- The need to further research whether peer support champions can be utilized as an effective organizational support piece (Berry et al., 2011)

Role of Mental Health Professionals

- The need to better know how to encourage collaboration between mental health professionals and peer supporters

Access to Peer Support Services

- The need to address access to peer support services across all populations, ages, ethnicities, demographics, etc. (Almeida et al., 2011, Jones et al., 2014)
- There is a limited number of peer support services for children across the province (Canadian Mental Health Association, 2007)
- There is a lack of workplace strategies to support a peer support model (Mahlke et al., 2014)

3.5 Analysis of Literature Review and Environmental Scan

There is ample support to demonstrate the effectiveness of peer support in the research literature (Davidson et al., 2012; Repper & Carter, 2011; Repper, 2013). There are however many different peer support models and components/practices of peer support models. These various components have not been studied individually but rather as part of the peer support model. Therefore, it is difficult to identify "best practices" based on the research literature on specific components of the peer support programs – e.g. recruitment approaches, organizational supports, monitoring and evaluation, etc. Due to the nature of the research evidence for specific components of the peer support models, the authors have chosen to use the term "promising practices" to identify the peer support practices that are recommended in the literature.

The literature review and environmental scan was used to identify a list of peer support models. A refined list of the models was then analyzed using the information gathered in the literature. The analysis of the models was further used to develop a tool that was used by peer support programs in the SWLHIN to conduct a review and assessment of their own initiatives in peer support in the context of mental health. This was referred as the *Peer Support Self-Assessment Tool*. The self-assessment tool includes the nine headings. Specific promising practices were further identified under each of these headings.

4.0 SWLHIN ENVIRONMENTAL SCAN

4.1 OVERVIEW

Majority of the SWLHIN peer support models used by CSIs were based on an informal peer support model or a walk-in center (see Table 2). In addition, some of the programs also used formal/intentional peer support model. However, since intentional peer support was often reported in the absence of formal matching it may be possible that this term was used more broadly than intended in the literature. The table below (see Table 1) from the MHCC denotes a continuum from friendship to clinical care. In the SWLHIN, the models had greater alignment to the friendship models. In addition, most of the beneficiaries of peer support were identified through word of mouth, outreach and community referrals. In some instances, referrals were made by mental health professionals where some linkages were established – majority of which were not formalized. The Transitional Discharge Model (TDM) research study provided interactions between some of the consumer survivor organizations and mental health care professionals and service organizations.

Table 1: Spectrum of Peer Support Models

Friendship  **Clinical Care**	**Informal Peer Support** – naturally occurring, voluntary, reciprocal relationships with peers one-on-one or possibly in a community
	Clubhouse/Walk-in-Centre – mainly psychosocial and social recreational focus with peer support naturally occurring among participants
	Self-Help, Mutual Peer Support – consumer operated/run organization and activities, voluntary, naturally occurring, reciprocal relationships with peers in community settings
	Formalized/Intentional Peer Support – consumer run peer support services within community settings (group or one-on-one) focusing on issues such as education, employment, MH systems navigation, systemic/ individual advocacy, housing, food security, internet, transportation, recovery education, anti-discrimination work, etc.
	Workplace Peer Support – workplace based programs where employees with lived experience are selected and prepared to provide peer support to other employees within their workplace
	Community Clinical Setting Peer Support – peer supporters are selected to provide support to patients/clients that utilize clinical services, e.g. outpatient, A.C.T. teams, case management, counselling
	Clinical/convention MH system-based Peer Support – clinical setting, inpatient/outpatient, institutional peer support, multidisciplinary groups, recovery centres, or rehabilitation centres crisis response, crisis management, emergency rooms, acute wards

The major gaps were in the workplace and clinical settings (e.g. community or hospital); although with the advent of the introduction of the Transitional Discharge Model studies, several programs were involved in a partnership model between CSIs and professional services in hospitals. However, since the

peer support was funded through the Council of Academic Hospitals of Ontario on a 2-year grant there is a risk of losing this without ongoing funding, and support for expansion to other sites is not in place.

Table 2: Peer Support Programs in the SWLHIN and Types of Models Employed

Peer Support Program	Informal Model	Walk In Centre / Activity Centre	Clubhouse Model	Self-Help, Mutual	Formalized / Intentional PEER SUPPORT	Workplace Model	Family Model	Community Clinical Setting Model	Clinical / Conventional MH System Based Model
1	Yes	No	No	No	Yes	No	Yes	No	No
2	Yes	Yes	Somewhat	Somewhat	Somewhat	Yes	No	No	No
3	Yes	Yes	Yes	Yes	No	Yes	No	No	No
4	Yes	Yes	No	Somewhat	Somewhat	No	No	No	No
5	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes
6	Yes	Yes	Yes	Yes	Yes	No	No	Somewhat	No
7	Yes	No	No	No	Yes	No	No	No	No
8	No	No	No	No	Yes	No	No	No	No

4.2 Gaps Identified from Environmental Scan

The following summarizes the key gaps identified in the environmental scan (i.e. interviews with the stakeholders and review of documents):

- Little activities where mental health professionals' are involved or working with peer supporters/volunteers
- Few formal or informal partnerships between CSIs and mental health service organizations
- Lack of clinical models with peer supporters involvement (both in community and in hospital)
- Lack of models for families and work place, special populations (e.g. ethno-specific)
- Challenges due to distance, transportation, location
- Inconsistencies in training, human resource plans, matching peers to peer supporters and risk management
- Inadequate monitoring and evaluation
- Lack of sustainable funding.

4.3 Examples of Peer Support Models

4.3.1 Informal Models

Drop-in Center/Activity Center – Phoenix Survivors Perth County

Phoenix Survivors Perth County is a member-run support organization for persons coping with mental health issues in Perth County. The Drop-In Centre in Stratford, which serves Stratford and Perth County, provides peer support, leisure and recreational programs, social activities, educational workshops and employment opportunities. As well, peer support groups meet weekly in Perth County for leisure activities. Phoenix is where people find others who have undergone similar challenges in life. Together members share their concerns and ideas. Phoenix is a vehicle through which people can improve the quality of their lives through their own actions. Volunteering and joining groups/ committees allows

members to feel wanted and needed, and, allows them to contribute as they can. This leads to a greater sense of self-worth and empowerment and a more rewarding life.

Coffee Socials – CONNECT for Mental Health

CONNECT for Mental Health is a not-for-profit peer support organization run by and for individuals who have been affected by mental illness. It offers one-to-one support as well as group support to individuals 18 years and older. "*Coffee Socials*" run weekly and held at different locations. These socials provide an opportunity for those affected by mental illness to gain emotional support from individuals who have "been there", connect, socialize, and enjoy an evening out in the community.

4.3.2 Formal Models

WarmLine – Psychiatric Survivors of Elgin

The WarmLine is a peer support run, friendly phone line, through which consumers of mental health services receive support, share concerns and generally have a peer who understands their perspective and is willing to listen and talk with them. The WarmLine serves as a diversion from 'hot lines' or "crisis lines" and even emergency services. Callers speak with trained peer supporters who provides empathetic listening and conversation via the telephone, working 6 hours per shift, from 6pm-12am daily. There are two types of calls; incoming and outreach calls. This service grew out of the expressed need of members to have support available when the offices are closed. These members felt unsafe calling the crisis team. The warm line operates with a different person receiving calls each day.

Psychiatric Survivors Network of Elgin functions as a drop-in-setting enabling it to promote positive social interaction and provide a safe, friendly and confidential support. The organization also facilitates education and awareness related to mental health issues and concerns. In addition, it acts as a liaison with the community at large to eliminate the public's perception of psychiatric survivors as being burdens to society, unemployable through sensitization, education, and public awareness of mental illness.

Transitional Discharge Model – London Health Sciences Centre and St. Joseph's Health Care, London

Peer supporters are part of a formal discharge program that addresses the vulnerable period of discharge for people who receive mental health services in an inpatient hospital unit. The model includes two components: peer support from a previous mental health consumer who has been trained using the OPDI training program and who is living successfully in the community; and, continued staff support from a professional staff person from the hospital until the person has established therapeutic relationship with a provider in the community. This model was part of several research studies and has been adopted in a large number of hospitals in Ontario.

Peer supporters are recruited by the CSI partners (Can-Voice and CONNECT for Mental Health). They are asked to make a one year commitment. A Peer Support Coordinator based at the hospital coordinates and supports the peer supporters including ongoing training, matching, problem solving, etc. A dedicated space is provided at the hospital for the coordinator and for peer supporters for office space, meetings, etc. The peer supporter continues to meet the patient after discharge at locations of mutual agreement such as a coffee shop, mall, etc.

4.3.3 Clinical Models

Crisis Centre – Canadian Mental Health Middlesex

Canadian Mental Health Middlesex provides short-term, community-based, crisis counselling with a focus on developing coping skills, crisis prevention planning, peer support, links to psychiatric assessment and referrals to community agencies. Can-Voice has partnered with the crisis service and assigns peer supporters who are integrated with the program. Can-Voice is a member run peer support, self-help organization for the education and empowerment of consumers/survivors of the mental health system. The organization is funded/sponsored by SWLHIN.

ACT Team – Canadian Mental Health Association, Peel

The ACT Team is a multi-disciplinary team that includes addictions, vocational and peer support, nurses, support workers, a social worker, an occupational therapist, and psychiatrists. Team members provide individual and family assistance, as well as advocacy around accessing community resources and services, to individuals experiencing serious mental health concerns. In close collaboration with the client's Community Support Worker, the peer supporter provides practical support including: mentoring, support in life transitions, skills development, and promotes self-advocacy. They co-facilitate WRAP and Pathways to Recovery groups, as well as participate in inter-agency groups, events and committees. The peer supporter is a paid staff member of the program and is accountable to the manager and is required to maintain specific documentation as part of the team.

Interprofessional Team - Ontario Shores Centre for Mental Health Sciences (Ontario Shores)

The peer supporter (called the Peer Support Specialist by the organization) is a member of the inter-professional team, responsible for providing support to clients and their families within the recovery model framework. The peer supporter works with clients in one-on-one and/or group situations to promote shared journey philosophy. They promote Ontario Shores programs, services and community resources, supports clients in navigating mental health services (organizational and community), supports clients with their discharge planning and recovery process, identifies service gaps, and participates in program planning and advocacy efforts to enhance necessary client related services, organizes and leads individual and group social/recreational activities to increase socialization and provide skill-building opportunities. The peer supporter is a paid staff member at the hospital and is accountable through documentation of their services in the Electronic Health Record and to the manager of a specific program.

5.0 SWLHIN Peer Support Strategy

The peer support strategy framework includes four components: 1) values and principles; 2) vision and outcomes; 3) areas of focus; and, 4) key enablers. See Figure 2 below.

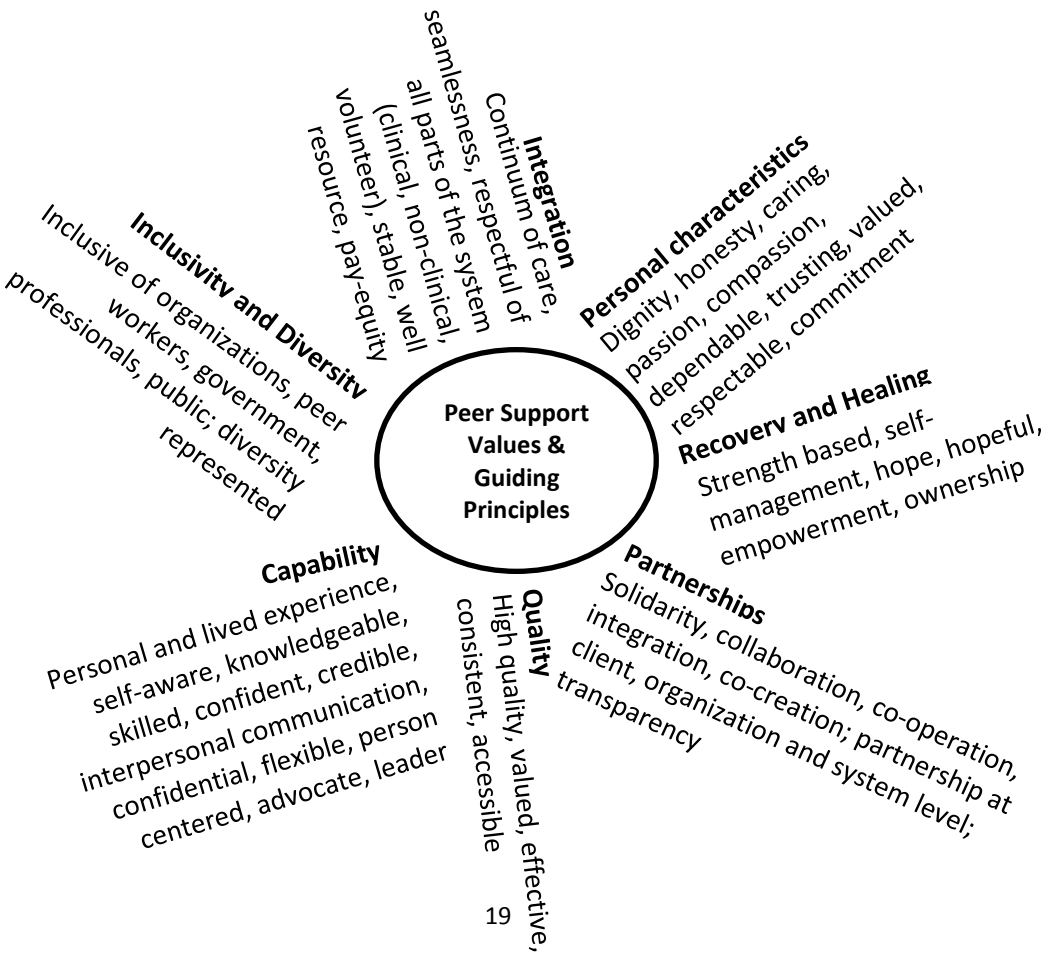
Figure 2: Peer Support Strategic Framework

5.1 Values and Guiding Principles

We all hold a set of core values that motivate us individually in our personal and professional lives. In the context of peer support, there are core beliefs, values and principles that create a specific ethos of good will that is unique and shapes the intentions, thoughts and actions of those who are involved and committed to peer support. These core values and principles are the bedrock upon which a solid peer support strategy must be build.

The following are values and principles identified by stakeholders at the stakeholder engagement workshop. These align with core principles of peer support programs described in the literature and in the environmental scan. See Figure 3 below.

Figure 3: Values and Guiding Principles



5.2 VISION AND OUTCOMES

The literature, environmental scan and stakeholders align and give credence to the following essential vision of peer support in the context of mental health and addiction. This vision statement is in alignment with Ontario's 10 year mental health strategy:

South West LHIN Peer Support Vision

Peer support is an essential and valued component of a client-centered, recovery oriented system of mental health and addiction care.

Ontario Mental Health Strategy Vision

An Ontario where every person enjoys good mental health and well-being throughout their lifetime, and where all Ontarians with mental illness or addictions can recover and participate in welcoming, supportive communities.

The following are key hopes, aspirations and outcomes that stakeholders wish to achieve:

- ✓ **Region wide acceptance** of peer support as a valid and effective intervention
- ✓ **Availability of peer support where ever individuals are** in their recovery journey – community, hospital, outpatients, work and school as well as where ever they live in the region – urban, rural or remote locations
- ✓ **Appropriate and sustainable funding** to support implementation of models based on promising practices
- ✓ **CSIs and Mental Health providers** working in a **true partnership** – as true partners peer supporters are part of the planning and ongoing oversight of mental health and addiction programs
- ✓ **Standards** for peer support practices are linked with accountability
- ✓ Continuous support and improvement of **existing peer support programs** while filling the gaps with **new models** where these are needed, such as models that **include partnership with clinical agencies.** Expand mandates of existing programs where appropriate and feasible to address gaps
- ✓ Peer support programs – no matter where they exist – in CSI or in mental health care teams – are part of a **peer support network of sharing and learning.**

5.3 Areas of Focus and Goals

Stakeholders reflected on a set of promising practices identified through the literature (see section 3.3) and assessed their own peer support programs against these practices. The findings from the self-reflections or self-assessments of these programs were presented at an in-person stakeholder meeting. Through discussions and an exercise to rank priorities, the following four areas of focus were identified for the peer support strategy:

- Models of peer support
- Standards in training and investments in people
- Linkages and integrated processes with the mental health care system
- Governance and infrastructure support.

Each of the areas of focus is further elaborated below with recommended actions or activities. These four areas are not mutually exclusive; therefore, some of the action/activities may support the achievement of one or more goals.

5.3.1 Focus Area #1: Goal is to Improve Existing Models of Peer Support in the SWLHIN

Use the identified promising practices to support the strengthening of informal and formal consumer-led peer support models in SWLHIN. Expand formal peer support access to patients/clients in clinical settings in hospitals and in the community.

In clinical settings, a partnership model (i.e. between CSIs and mental health care organizations) is recommended. The presence of paid peers in roles such as case managers, coordinators and counsellors is encouraged but not central to this peer support strategy.

The SWLHIN is a large region with extensive diversity in urban, rural and remote locations and distances between places. The evolution of peer support programs in this region has responded to the needs of the local communities and because resources have been few, these programs have largely been informal. It is important to continue to support these informal models while investing and strengthening the activities that are formalized and intentional. For example, in formal peer support, there needs to be processes established based on promising practices – processes such as recruitment, training, matching, documentation, monitoring, supervision, recognition and compensation, etc.

In order to provide adjunct support to those individuals who are served in the mental health care system, the formal/intentional models need to be expanded by establishing formalized partnerships with mental health service organizations in the community and in hospitals/facility based care. The nature of these partnerships will need to be established by the local organizations in each county. The LHIN could provide incentives for such partnerships by funding resources for facilitation of these processes, joint peer supporter/professional training sessions, as well as resources for coordination, monitoring and evaluation.

Peer support provided by consumer-led organizations is recommended regardless of the setting in which peer support is provided. A mix of volunteer and paid peer supporters will provide greater capacity and have greater sustainability. Paid peer supporters can act as mentors to volunteer peer supporters as well as provide support in supervision, debriefing and self-care. Paid peer supporters are not coordinators – one or more full time coordinators will need to continue (depending on the size of the peer support activities and size of the CSI).

A recent study by OPDI and the Self-Help Alliance (2014) concluded that peer supporters who are paid in Ontario are underpaid (Taylor Newberry Consulting, 2014). Majority (70%) were paid by the hour which ranged from $11.50/hour to $42.70/hour with an average of $21.00/hour. Annual salaries for peer supporters were significantly different between those employed by CSIs versus non-CSIs ($22,000 vs. $35,548). This also shows that these workers were likely working part time or variable hours. About 43% of the sample was not satisfied with their income and more than half of the sample (52%) indicated their pay was not equal to others who did similar work but were in non-peer positions. These findings indicate that the SWLHIN will need to establish equitable compensation for peer support positions. This study can provide some benchmarking data.

5.3.2 Focus Area #2: Goal is to Promote Standards for Peer Support Training and Investments in People

Establish LHIN-wide standards for peer support training based on promising practices.

Allocate resources to support CSIs to strengthen their investments in people (peer supporters, staff and management).

There was wide spread recognition that peer supporters in the SWLHIN peer support programs received a wide variation of training programs ranging from OPDI (level 1 and 2) training for a few individuals to in-house training/orientation programs that cover basic information. Although some in-house training programs are comprehensive, majority of the programs did not meet the content areas established by Mental Health Commission of Canada (see Appendix A).

In addition to standards for training, there were other practices where there were significant gaps, that is, the agency did not meet the identified promising practices and had wide variation in practices. The following practices were not met by many of the peer support programs:

- Written role description for the peer supporter
- Risk management considerations (e.g. police check, references or other similar processes)
- Human resource plan review and updated on an annual basis based on the need for the community for peer support, the current capacity and reflection of actual and/or anticipated turnover of peer supporters.
- Annual performance appraisal with peer supporter development plan.
- Peer supporters making consistent commitment to the activities of peer support.

- Recognition and compensation strategies that was appropriate and implemented in an equitable manner.
- Reimbursement policy for all out-of-pocket expenses such as transportation, training programs, coffee cards, etc.
- Accommodations and support services to promote equitable treatment and accessibility.
- Self-care supports such as regular review of workload and other demands; training and coaching on self-care; opportunities to debrief; socialize and connect with other peer supporters.

5.3.3 Focus Area #3: Goal is to Establish Linkages and Integration Processes between Peer Support Offered by Consumer Survivor Initiatives and the Mental Health Care System

Establish well defined and effective processes to link and integrate CSIs and mental health care system.

Ensure CSIs are able to continue their autonomy with an accountability framework.

CSIs and peer support in particular had roots in a world where people were disempowered and had distrust of the formal mental health care system. Stakeholders continue to call for greater balance of powers when working with health care providers – they call for increased trust, comfort and greater bonds of communication. As peers join the circle of care (formally or informally), they need mechanisms that support individuals while maintaining confidentiality and appropriate policies and procedures for sharing and disclosing information. Peer supporters desire to build rapport, relationships and collaborative arrangements with health care professionals as well as services providers in the community such as social services in order to better support clients/patients/community members.

In moving towards collaboration, linkages and integration, Cheung and Smith (2009) caution that the need to maintain autonomous CSIs. They state,

> *"Collaborative autonomy is a necessary precondition for any future policy interventions which truly aspire toward equality and dignity, reflective of the experiential knowledge derived from people with lived experience. Owing to the historical subordination and stigmatization of service users, whether in 'mental health' or 'addictions', the notion of autonomy is central to restoring equilibrium in the power balance between service users and providers. Here, the establishment, development and enhancement of autonomous peer/consumer-run organizations can serve to reintroduce the voices of service users in all aspects of the policies and programs that affect their everyday lives, voices that have been silenced, overlooked and unacknowledged for too long by systemic barriers and persistent social stigmas" (p. 2).*

5.3.4 Focus Area #4: Goal is to Enhance Governance and Infrastructure of the CSIs

CSIs can leverage each other's strengths and assets and establish an effective network for sharing information, resources and expertise as well as working together on specific activities.

A central office infrastructure needs to be established with new investments to support CSIs on common administrative requirements.

Revive the structure of SWAN based on agreed upon functions (form follows function).

There are a number of ongoing activities where CSIs do not have capacity or can develop sustainable expertise. There are opportunities for the CSIs to come together and share resources to create economies of scale, efficiencies and optimize limited resources. In order to successfully harness these resources, it will be important for CSIs to jointly decide which areas they wish to work on together and which functions are better left with individual CSIs. Based on these decisions, the structure of the renewed SWAN governance could be designed. It is important that the form of governance follows the functions that the CSIs need from the network. The following are an initial list of areas for potential joint activity through the network:

- Creating a common brand and website with the ability for each CSI to manage their own webpages
- Develop a region wide marketing and communications plan including specific materials such as brochures, posters, etc.
- Common tracking tools for activities and indicators – using online tools that can be aggregated would be ideal
- Common client satisfaction tools and annual evaluation reports
- Standard budget and expenditure templates
- Common Human Resource tools including such things as attendance, annual performance appraisals, job descriptions, and orientation manuals

In additional to sharing the above functions, the CSIs need additional resources to establish and operate a shared central office. This office would need staff such as a manager and assistant (s) to support a range of administrative and support activities. It is important to note that the funding for a central office will need to be additional investments and not consolidation of existing resources. The need to consolidate functions with additional resources was previously called for in a provincial report by Reville (2006). CSI managers need to be direct their attention and focus on supporting peers, conducting outreach, working with mental health system partners, etc. The following are some examples of administrative/support activities that could be centralized:

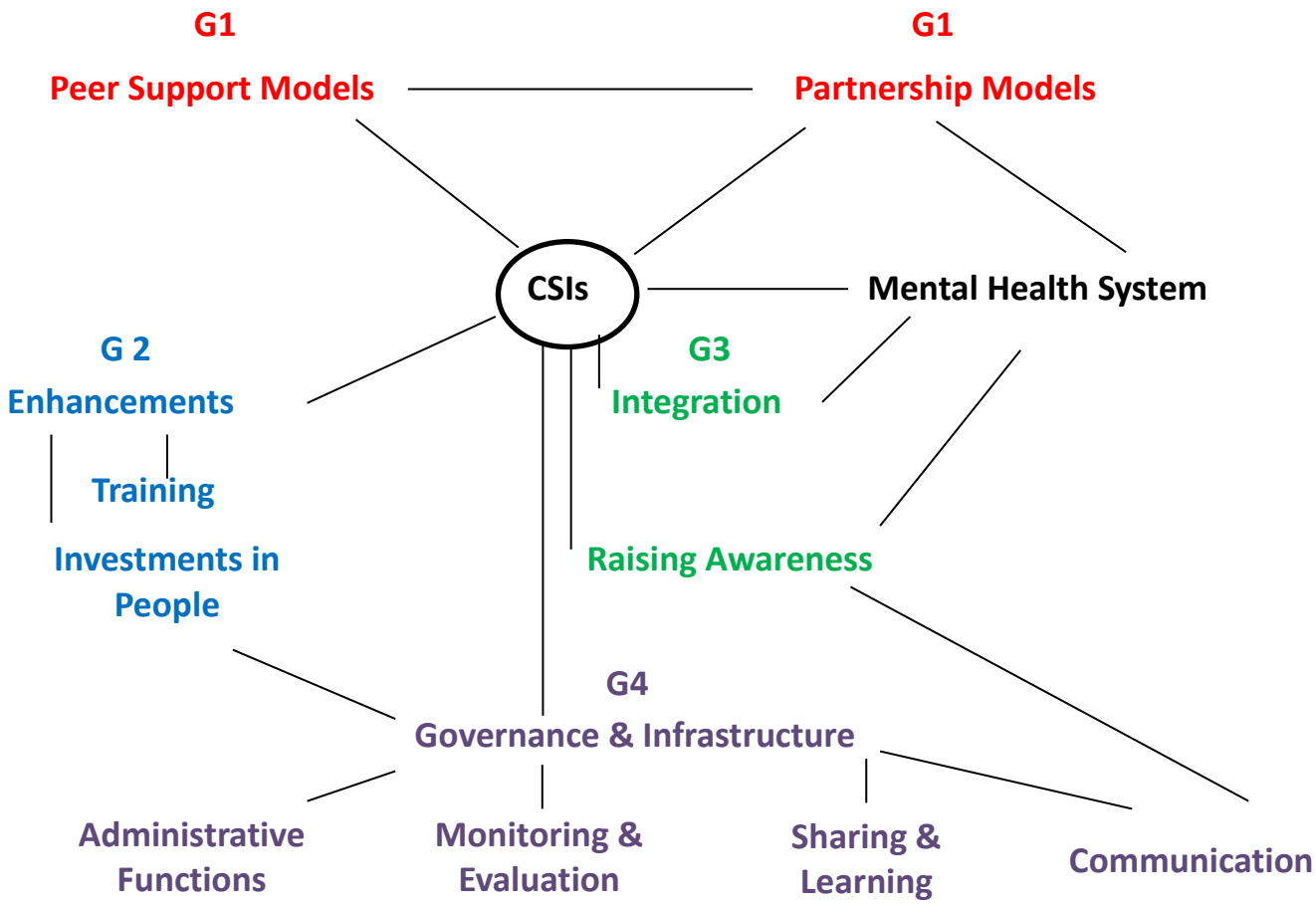
- Information technology (e.g. website; contracts for cell phones, conference lines, etc.)
- Human resource management (reference and police checks; tracking mandatory training requirements, performance appraisals, etc.)
- Finance (e.g. preparing quarterly variance reports, annual reports, etc.)

- Quality monitoring (e.g. tracking specific indicators; preparing reports; supporting quality improvement initiatives, etc.)

5.3.5 Connections between the Four Focus Areas

Figure 4 below depicts the connections between the four areas of focus discussed above and the main action or activities related to each goal. Each area of focus/goal/activities is colour coded. The figure depicts the four goals (G1 to G2) – each connected to CSIs.

Figure 4: Connections between the Priority Areas of Focus for the SWLHIN Peer Support Strategy



5.4 Enablers

In order to successfully implement the peer support strategy for the SWLHIN, the following enablers will be required:

- ✓ Commitment and continual engagement from all stakeholders
- ✓ Multi-stakeholder steering committee to provide oversight to the implementation of the peer support strategy
- ✓ Project management support from a neutral party with specific skills and credibility with both the CSIs and the mental health services
- ✓ Change management framework
- ✓ Funding for planning and implementing the peer support strategy and for specific components of the strategic investments
- ✓ Two-three year timeframe for full implementation of the peer support strategy
- ✓ Evaluation at mid-point in the implementation plan for accountability and readjustment of strategy and work plan as required.

6.0 IMPLEMENTATION CONSIDERATIONS FOR THE PEER SUPPORT STRATEGY

The following draft action plan is preliminary and will require further refinement and feedback from stakeholders. Appropriate resourcing of external, neutral facilitators will be critical to help organize, convene, engage, negotiate and navigate the various interests while maintaining focus on the common vision. The stakeholders must see themselves in the driver's seat and trust that there will be practical benefits for their respective organizations while striving for the common good.

#	Area of Focus	Implementation Considerations	Resources
1	**Models of Peer Support**	Each CSI to develop **a CSI specific plan** to strengthen their existing programs using promising practices. Share plans with **Community of Practice** in order to share and learn from one another. SWLHIN to share/signal to the mental health sector the LHIN-wide peer support strategy, the value of peer support as an effective intervention and the importance of mental health organizations **to partner** with CSIs that provide peer support programs and services. Provide **incentives for partnership** development between CSIs and mental health care organizations. Establish **fair and equitable compensation framework** for peer supporters and support its implementation across CSIs and mental health care system.	Consultant/Facilitator support Establish Community of Practice SWLHIN communication plan tools and strategies SWLHIN planning and allocation of resources Contract short term consultant and/or allocate task to SWLHIN staff
2	**Standards in Training and Investments in People**	Establish a **cross CSI working group** to address standards for training and other aspects of peer support practices. **Allocate resources** to support facilitation and project management support. Mandate would include: • Develop, adopt and/or adapt core competencies for peer support • Develop, adopt and/or adapt competencies that are specific to CSI approaches and uniqueness • Build value proposition and budget for training program for current and ongoing training of peer supporters • Provide oversight/monitoring of the implementation of the training SWLHIN to provide **funding support** to train peer supporters, staff and managers.	Consultant/Facilitator support Training budget for peer supporters including costs for travel and accommodation/food

#	Area of Focus	Implementation Considerations	Resources
		CSI working group to gather, review and/or develop tools to facilitate implementation of promising practices related to **human resource practices**. Group can develop 1-3 priorities for each year. Develop and/or access existing **management development** program for CSI managers and coordinators	Consultant/facilitator support to develop a template for these discussions and processes Training budget for CSI managers and coordinators including costs for travel, accommodation and food
3	**Linkages, Networks and Integrated Processes**	Establish working groups of CSI representatives and mental health organizations (hospital and community) with mandate to: • Develop and implement a **communication plan and tools** to raise awareness of peer support within respective organizations • Develop and implement **local plans to integrate processes** – specific processes could include referrals, joint training, communication protocols, etc. • **Communities of Practice** – across the LHIN – in-person, virtual Suggest five initial working groups – Middlesex, Oxford, Grey Bruce, Elgin Norfolk, Huron Perth	Consultant/facilitator to support each established working group for the first year with plan to develop trust and momentum to continue without external support Budget for meetings, travel, marketing materials, etc.
4	**Governance and Infrastructure Enhancement**	Conduct **SWAN revival retreat** for CSI boards and leadership to address an agreed upon set of objectives: • **Review peer support strategy** and suggested areas for governance and infrastructure enhancement • Determine what **value SWAN can provide** on the functioning of the CSIs (e.g. what resources can be shared, what functions can be pooled) • Establish a **governance structure** that can support the functions of SWAN (form follows function) • Decide what **types of resources** will required Develop a **detailed implementation plan** – suggest it will take at minimum 2 years to transition • Year 1 - pooling specific functions such as reporting functions, monitoring a small set of indicators • Year 2 – managing budgets and expenses, prepare reports.	Consultant/facilitator to organize and facilitate retreat and help develop SWAN's renewed structure, mandate and business plan for year 1 as well as help put the resources in place by year 2. Budget for 2 day retreat, monthly conference calls and quarterly full day meetings Budget for central office manager and staff

7.0 Evaluation Considerations for the Peer Support Strategy

7.1 Logic Model

The following logic model is a preliminary draft to assist in the monitoring and evaluation of the peer support strategy as it is implemented. A detailed evaluation plan should be developed once the implementation plans are finalized.

	Vision: Peer support is an essential and valued component of a client centered, recovery oriented system of mental health and addiction care.			
	Models of Peer Support	**Standard for Training and Investments in People**	**Linkages and Integrated Processes for the Mental Health Care System**	**Government and Infrastructure Enhancement**
Outcomes – long term	Peer support available across SWLHIN and accessible in any mental health and addiction setting Sustainable and appropriate levels of funding Models of peer support based on promising practices that are tailored to meet specific target populations Strong partnerships between CSIs and mental health and addiction systems (formal MOUs)			
Outcomes – short term	CSIs and MH organizations establish working processes	Peer supporters trained using established standards Trained staff and managers	Development of communication strategy (e.g. web, brochures) to facilitate outreach, referrals and information	Revitalized SWAN to support community based CSIs
Outputs	• Applications for partnership funding • Peer support compensation framework	• Agreed upon core competencies • Standards for training • Identified training programs for staff and managers	Common communication strategy, plan and tools	Revised Terms of Reference Established central office with appropriate staff and tools
Activities	• Communication plan and tools for peer support strategy • Establish incentive plan for partnership development • Develop peer support compensation framework	• Establish working group • Consensus on competencies and training standards • Develop tools, processes, structures to address priority areas on human resource practices • Management training	• Establish working groups in five locations between peer support agencies and the formal mental health system • Partner with organizations such as MindyourMind with peer related communication expertise	• Retreat Meeting of CSIs and other identified key stakeholders • Develop terms and activities of SWAN • Hiring of key personnel (director and administrative support)
Inputs	Contracted consultant Partnership funding	Consultant/Facilitator Training budget OPDI Meeting supports	Financial support for partners Meeting support Budget for technical supports – website, communication tools	Consultants/Facilitator Meeting support Budget for central office

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APPENDIX A: MENTAL HEALTH COMMISSION OF CANADA TRAINING PROGRAM GUIDELINES

Mental Health Commission of Canada Training Program Guidelines
Fundamental principles of peer support
i. Lived experience, hope and recovery
ii. Self-determination and how to foster it
iii. Peer support values, ethics and principles of practice
iv. Trauma informed practice
v. Applying peer support principles in diverse environments
Social and historical context of peer support
vi. The historical context of peer support
vii. Prejudice, discrimination and stigma
viii. Diversity and social inclusion
ix. Social determinants of health
Concepts and methods that promote effective peer-to-peer effectiveness
x. Interpersonal communication principles and methods
xi. Building supportive relationships
xii. The process of recovery and change
xiii. Building resilience through self-care and wellness plans
xiv. Limits and boundaries
xv. Crisis situations and strategies
xvi. Connecting with community resources / reintegration
xvii. Awareness of possible symptoms and potential side effects of medication
xviii. How to prepare peer when relationship needs to be terminated
Training programs provided to peer support volunteers/workers include a **variety of delivery mechanisms** including opportunities to practice and learn from experiences. This may include verbal/written information; interactivity through small groups discussions, exercises, role-play; journaling; videos, etc. The training is accessible physically and intellectually.
A plan for **ongoing training** of peer support volunteers/workers including system for maintaining a **training record** for each peer support volunteer/worker.