Catherine House Inc.

Recovery Program
Peer Support Program Evaluation

Report 2

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INTRODUCTION and Development of the Peer Support Program

The Recovery Program is the result of a partnership agreement between government and non government organisations for the delivery of an intensive and comprehensive model of service to mental health consumers with a psychiatric disability and for whom recurring homelessness is an ongoing issue. The residential service operates 24 hours, 7 days a week, for 12 clients, 7 residents on-site with an additional 5 clients living in individual transitional houses in the inner city. A vital other component to the program is the Outreach Service delivered to over 30 consumers who have exited the residential service.

The Rehabilitation and Recovery Model provides the framework for the service which provides intensive support, across all of life domains while promoting hope, choice, empowerment and respect. It is a unique service in South Australia, which also addresses the lack of safe, affordable, alternative accommodation facilities for women with varying housing needs. As an integrated and inclusive service, the Recovery Program is committed to working in collaborative partnerships with consumers, families, program partners, other agencies and services to best meet the client needs.

The implementation of the Peer Work and Consumer Participation Project began by an education and awareness raising process. In 2007 and 2009, Paul Grima, an experienced Victorian Consumer Consultant and Peer Support Educator visited the organisation and conducted training to educate and raise awareness of staff and consumers on the consumer perspective and the roles of Consumer Representatives, Consumer Consultants and Peer Support Workers. He was involved in development discussions regarding the implementation of the Consumer Participation Pilot Project and the Peer Support Program within the organisation.

His visit presented both staff and clients with a unique opportunity to hear first hand how he had effectively used his personal experience with mental illness to enable positive system change to mental health service providers in his region and thereby enhancing the lives of consumers. For consumers the training reinforced the message that, leading a positive, satisfying life is quite within their grasp. Feedback expressed from consumers included that they found this training empowering and motivating. The training offered valuable information and guidance on the different ways that the organisation could proceed with planning and implementation of the consumer and peer roles within the program and wider agencies.

Research tells us that participation in Peer Support/Consumer Participation enhances empowerment and recovery. It has been demonstrated that the involvement of all parties in Peer Support has been positively associated with the indicators of recovery and empowerment.

The Recovery Program works with Consumers to support, encourage, promote, and enable this process. Patrick Corrigan described the benefits of Peer Support on both the Peer Worker and the Consumer receiving the support. He explains the process of the "helper principle" and asserts:

> …people feel better about themselves not only when they receive support and resources from peers but also when they are able to give and be of assistance to others. This kind of help can boost the self-esteem of participants, which in turn can suppress self-stigma that might worsen a person's experience of mental illness (2006, p 1493).

Lori Ashcraft and William Anthony provide training to organisations on the recovery approach. They believe that recovery principles include peer support, and assert that it is a most effective way to develop and sustain an organisational culture that remains focused and committed to recovery practices. There are many benefits to employing Peer Workers, these include; the ability that peers have to engage with consumers that historically have been difficult for staff to engage; peers provide living proof that recovery is possible; and Peer Workers can free up professional staff to concentrate on other tasks. Peer Workers are required to accept the boundaries and ethics of the organisation, however, they are free to share their own experience of recovery and this is a great asset. Peer Workers can enhance and expand on what professional staff have been doing and should be made welcome as a part of the team, and included in decision making as they have first hand knowledge of how decisions affect consumers (2007).

Studies have demonstrated that problems can occur with the introduction of Peer Workers to an organisation regarding differing attitudes to recovery, role conflict and confusion, lack of policies and practices around confidentiality, poorly defined job structure and lack of support. These issues have undermined integration of the Peer Workers into the organisations. Therefore, it was important to address these possible issues when the organisation was developing a Peer Worker Program and integrating it into the organisation (Gates & Akabas, 2007, p293).

The Recovery Program and the organisation already have a history of employing ex-consumers of the services it provides, and to date this has been a successful process. Employed ex-consumers have been welcomed as staff members in various roles and the organisational culture warrants that all staff are treated equally and each staff person is a valued and respected team member. However, the employment of ex-consumers as Peer Support Workers was a completely new initiative. The Recovery Program endeavoured to incorporate research findings into the implementation of the Peer Worker

Program to ensure a supportive and integrative process occurred when Peer Workers were introduced and inducted into the organisation.

Peer Workers in an organisation can work towards addressing social isolation and loneliness of the consumers it supports. Peer Workers can provide social support that offers understanding, reduces stigma, encourages hope and provide recreational opportunities for consumers (Rivera et al, 2007). A Peer Worker can provide practical help and support with day to day living issues, thereby taking pressure off existing professional staff, someone who is in addition to what already exists, not in place of anyone.

Baptist Care (SA) Inc (BC(SA)), formerly The Baptist Community Services of South Australia (BCSSA), developed a tool kit for both government and non-government organisations to use when employing Peer Workers (2007). It provides a thorough description of the benefits of employing Peer Workers, and the training and support that they are funded to provide. It outlines the importance of organisations to prepare, train, and support Peer Workers, as well as the importance of developing a detailed job specification in conjunction with peers, consumers, other organisations and stakeholders to ensure it is a collaborative and informed process. BC(SA) provided training and support for the Peer Workers and for the organisation.

The Program Manager consulted regularly with the Senior Project Officer and the Mentor Coordinator of the BCS (SA) Inc. Peer Support Project as well as the Peer Support Coordinator of the Mental Illness Fellowship of South Australia (MIFSA) to discuss the development and implementation of the Peer Support Program within the organisation. There was a commitment to ensuring that the Program was thoroughly and professionally undertaken right from the initial stages. BC(SA) and MIFSA agreed to offer support, including assistance in offering ongoing support and training to consumers, recruitment of Peer Workers and consultation regarding the development of job specifications, systems development, and individual mentoring to Peer Workers and access to peer meetings.

Aims of Evaluation

The aims of this evaluation are as follows:

1. To document the features of the Peer Support Work Program from the perspectives of the clients, the Peer Workers and the staff at Catherine House.
2. To document if the above goals of successful implementation and outcomes were achieved.
3. To uncover any areas that requires addressing and improving regarding the services provided by the Peer Workers.
4. To uncover any areas that requires addressing and improving regarding the working roles of the Peer Workers.

Features of the Peer Support Program

The two Peer Workers who are employed at Catherine House have completed the Introduction to 'Peer Work Course' facilitated by the Peer Work Project as mentioned above.

There are two Catherine House Recovery Program case workers who supervise the Peer Workers. They provide on-the-job support and follow up on how roles are going, provide feedback and support informally during Peer Worker's shifts, as well as formally when required. The Peer Workers also receive professional supervision from the Program Manager.

The Catherine House Peer Workers are responsible for using an individual lived experience of mental illness to provide support, guidance and hope, to clients in the residential and outreach service. They also provide practical help and support with day to day living issues (i.e. cleaning, cooking, shopping, physical and recreational activities). Further, they co-facilitate group activities with case workers and provide individual support to link clients with community activities and community resources (i.e. transport health services).

METHODS

An information sheet and consent form was sent out by mail to each client of the Peer Work Program who were clients of the Catherine House Recovery and Outreach programs, after receiving approval from the Assistant Director.

The information sheet detailed that Catherine House was aiming to review the services provided by the Peer Workers, and looking to see how the program may be improved after operating since August 2009.
A booking sheet was created to record client's interview times over a two day period, this was organised to help conduct the majority of the client interviews. Four questionnaires were created to suit clients, Peer Workers, staff, and stakeholders, which would be used as the basic proforma for all of the interviews. The discussion questions centred on what the Peer Work Program looked like the advantages and disadvantages of the program and the structural issues within the Peer Work Program. Initially, eleven clients were approached to participate.

The data was collected by one interviewer, who conducted face to face interviews with five clients of the Peer Work Program, one by telephone and another by email. When approached by telephone five clients declined to participate. The face to face interviews were held in a lounge area of a Catherine House property. A sign was placed on the door to prevent disruption and to indicate a meeting was taking place.

The clients were informed of the opportunity to have a support person during the course of the interview, to stop the interview at any time and to refuse to answer any questions they were uncomfortable with. It was emphasised that their responses were confidential and that in the preparation of a report, care would be taken not to identify any individual. With the client's permission, answers were recorded by hand. The clients interviewed by telephone and email also received similar instructions. All clients who participated in the interviews also signed a consent form agreeing to their participation.

Other interviews were also conducted with two Catherine House staff who supervised the Peer Workers, two Peer Workers who were the original workers during the program and three stakeholders of the program by face to face, telephone and email.

Two researchers analysed the data that had been collected in the interviews. One researcher was involved in the Recovery Program and one worked at Catherine House but was external to the Program. They both compiled the information contained in the interviews, sorted this information and developed the themes which are outlined in the discussion section.

RESULTS

Stakeholders

The stakeholders commented that they continued to support and assist the program as they believed the concept and value of Peer Work was understood and valued across Catherine House. They commended the staff for their research into Peer Work and persistence to begin the program, in particular management who continued to find ways to get the position started. Paul Grima, Consumer Consultant and Peer Work Educator spoke of the high level of consultation that was undertaken to begin the program to insure it would operate effectively (e.g. How peer workers would be accepted in the workplace, training needed by peer workers).

MIFSA commented that the model/process that was undertaken by Catherine House was used as an example to other organisations when talking about creating Peer Worker positions. They pointed to the clear role and plan implementation as key factors in the success of the Catherine House Peer Work Program.

BC(SA) acknowledged that staff at Catherine House had open communication with Peer Workers, which was essential for them to learn such skills as developing professional boundaries. BC(SA) also recognised that Catherine House had Ulysses Agreements in place, so that supervising staff were aware of early warning signs that would suggest Peer Workers were unwell, which assists both parties to determine if Peer Workers were unable to fulfil their duties and commitments to clients.

Overall, the stakeholders highlighted the benefits the program had for clients, staff and Peer Workers. In particular they claimed that the process empowered Peer Workers, and allowed them to define how they wanted to be seen in the workplace as they took on a professional role.

The stakeholders also reported the benefits that the Catherine House Peer Workers experienced by receiving mentoring from MIFSA and Baptist Community services as another outlet for support. The Peer Workers were also able to access the further training workshops MIFSA ran including, group mentoring towards employment, and physical health workshops.

1. What does the Peer Support Program look like?

Clients

Clients listed a wide variety of activities that they had undertaken with the Peer Workers. Some activities were undertaken within Catherine House at Sagamartha, the Education and Employment Program, and these included: computing, beading, card making and jewellery making. Other activities were external to Catherine House and included: going out for coffee, the use of public transport, shopping, accessing the Mary Magdalene Centre, accessing MIFSA services, and joining a local gym. In addition, other activities involved supporting the client in her own accommodation; unpacking and setting up a home, tidying and sorting household items and registering a car.

Most clients felt that they participated in the Peer Support Program to gain practical help with activities that they needed to perform. Their motivation was to gain support to undertake these activities.

Staff

The staff said that their role in the Peer Support Program was threefold. Their first role was to identify which clients would benefit from their involvement. Their second role was to match clients with the appropriate Peer Worker. Their third role was to support the Peer Workers and provide the workers with supervision.

The staff involved with the Peer Support Program noted some key features of the program. Time and effort was spent matching clients with specific Peer Workers. For each client, the program offered goal-defined, time limited support, while providing flexibility depending on the needs of each client. A care plan was developed for each client that addressed the goals which were broad encompassing specific, practical activities like shopping, through to broad goals such as improving social engagement. A unique feature of the program was the collaboration of the Peer Workers with the case workers for each participating client.

Peer Support Workers

Each Peer Worker works for 6 hours per week, and has 2 concurrent clients. The Peer Workers listed their usual activities with clients as; accompanying clients to appointments, supporting clients with housework, taking clients out for coffee and assisting with shopping. Furthermore, the Peer Workers listed many other roles including: supporting clients during crises, providing clients with written resources, co-facilitating a self-care workshop and facilitating Salem's voice meetings (a consumer-only meeting) in the absence of consumer representatives, and the development of a client newsletter. The Peer Workers felt that they provided a bridge between the case workers and the clients. They achieved this by contributing a lived experience of mental illness, by using open and honest communication and by providing the clients with support.

The Peer Workers provided details of their work and duties. A portion of their time was spent in administrative tasks including organising contacts external to Catherine House, communicating with their supervisor (a member of Catherine House staff) and communicating with case workers. Another important role involved direct contact with clients, while developing care plans, undertaking activities, re-assessing client goals and re-organising services for clients during a crisis. Peer Workers also noted that some time was spent travelling to and from the client's homes.

2. Perceptions of Peer Worker Program

Clients

The clients perceived many benefits from their relationship with their Peer Workers. They said that the Peer Worker provided them with company and companionship, reassurance and support, reduced their anxiety and improved their confidence and self-esteem. Their relationship was assisted by the shared experiences with mental health issues. One client said that their Peer Worker was understanding and not overly judgemental, but relatively strict. In addition, the provision of a Peer Worker provided stability for one client who had to change case worker.

Clients disliked cancellations from Peer Workers due to illness and sometimes felt that more time was needed both in terms of meetings and in the overall duration of the program.

There was quite a difference between the clients in how they perceived their relationship with their Peer Worker. For some it represented a friendship, while for others, they saw it as a continuation of their other professional relationships.

Suggested Improvements

The clients made suggestions for improvements to the Peer Support Program. These included having more Peer Workers, and more time in both activities and in the duration of their involvement with the program. One client wanted success with the program to acknowledge any setbacks in the client's progress. Another client wanted more clarification of the client- Peer Worker relationship, in particular the boundaries of the client- Peer Worker relationship. The challenges to this relationship existed around the confidentiality of information and what could or couldn't be disclosed by the Peer Worker to case workers.

Comments specifically about the programs broad goals

Improving life management skills – Some clients undertook activities which they believed improved their life management skills including cooking and cleaning. Another client believed that her Peer Worker modelled good life management skills by looking after her (the Peer Workers) own health.

Improving communication and social skills – Peer Workers improved client's communication and social skills by talking about how to speak with people, providing advice on being assertive, privacy of personal information, and by modelling good social skills with others.

Improving the client's social network – Involvement with Sagamartha played a large role in improving client's social networks. In this environment, clients were able to practice their improved social skills and form associations by attending functions and meeting for coffee. One client who undertook computer training at an agency external to Catherine House did not find the staff there as helpful.

Improved management of stress and emotions – Several clients felt that the Peer Workers helped reduce their stress by being available to talk, providing advice and reassurance. The Peer Workers had a unique understanding of the impact of their illness on both the client and their family. One client did not feel that the program changed how she related to stress.

Increased awareness of mental health issues – Clients said that their Peer Worker talked about self-awareness of mental health and subsequently self-management. Peer Workers facilitated access to a psychiatrist and referral to other mental health professionals. Peer Workers educated one client in the use of Dialectical Behavioural Therapy (DBT) and advocated its use during hospitalisations during illness.

Reduced stigma about mental health – Clients talked about the Peer Workers really understanding the stigma associated with mental illness, through their own experiences. Despite the Peer Workers

advocating for the right for mental health consumers to be heard, to be treated in the same way as others, one client still felt stigmatised, while another said she didn't feel any different.

Positive and hopeful about life – In most cases, clients felt that by working with a Peer Worker, they were able to achieve more things, in terms of activities such as shopping, than previously. Furthermore, one client was herself working on becoming a Peer Worker.

Improving self-efficacy – While most clients felt that their self-efficacy had improved, they also felt that there was more room for improvement, particularly given on going mental health issues. They also felt that while participating in the various activities improved their self-efficacy, more time was needed before substantial improvements could be made.

Improved links with community resources – The Peer Workers facilitated access to a range of community resources including the Mary Magdelene Centre and Sagamartha, help with food vouchers and other written resources. As stated above, one client was encouraged to participate in DBT by her Peer Worker.

Staff

What is working/not working?

The staff commented that at times establishing the reliability of the Peer Workers was an issue due to the Peer Workers own mental health. The staff reported that the workers were unavailable due to poor health at unpredictable times when clients had expected them, meaning they were unable to fulfil their commitments. Thus, they believed it was important to hire Peer Workers who were able to manage their mental health at times of illness.

They claimed that the enthusiasm shown by the Peer Workers initiated hope in the clients. Furthermore, their ability to establish rapport and a bond with the client was essential in building a trusting working relationship.

Efficiency

The staff claimed that the program worked well for the majority of clients who chose to participate. They claimed their choice to actively engage with their Peer Worker was a factor in program outcomes. Furthermore, the clients ability to actively engage was affected by their health; for instance during times of illness it was difficult for the clients to achieve their goals.

In all cases observed, the Peer Workers offered a unique support in being able to empathise and connect to clients, from the platform and perspective of lived experience of mental illness. The staff claimed to have observed the Peer Workers model hope, courage, resilience, and owning responsibility for driving

ones own recovery. They have seen clients respond positively to this authenticity of Peer Worker's perspective.

In some cases, Peer Workers have achieved a connection with clients and corresponding positive client outcomes which were not achieved by other workers. The staff assess this as attributable to the lived experience which Peer Workers provide, and to which some clients respond by deconstructing existing barriers which they maintain with professionals.

Furthermore, the staff observed that supporting clients offered Peer Workers many opportunities to develop their skill set and professional identity. Based on their observations and times of supervising Peer Workers, the staff believe they have utilised all opportunities for professional development. The staff believe peer support to be a valuable adjunct to case management and the Peer Workers are valuable members of the Recovery Program Staff.

3. How Peer Workers understand their role

The staff commented that Peer Workers understanding of their roles and duties has evolved, and they have improved as they have learned on the job. They have claimed that the workers have adjusted well to the workplace environment and they have received supervision to assist them in this process. The staff members commented that the Peer Workers have developed the ability to be honest and firm in their interactions with clients; skills they did not have previously.

4. How the Peer Support Program and Peer Work is received by clients

The clients are active participants in the Peer Worker Program, although their motivation to actively participate in the program dictates the outcomes they may achieve. The staff aim to choose clients for the program that are most in need of assistance and who will most benefit from the help of a Peer Worker. Initially staff reported some resistance from clients in embracing the program; however it has been embraced over time.

Suggested Improvements

The staff reported that it was helpful if Peer Workers were flexible in terms of understanding that clients had different needs and goals to achieve. They also believed Peer Workers ability to be flexible in terms of availability and hours able to work were beneficial. Overall, they have suggested that more funding is needed for the program, and that funding for supervision would be useful. The supervising staff reported that the Peer Workers required ongoing and regular supervision (formal weekly and informal more often) to assist with fulfilling their duties to clients and understanding the organisations expectations.

Perceived benefits to Catherine House

The staff claimed that the Peer Worker Program was effective as it assisted client outcomes and these were achieved in a shorter amount of time due to the availability and support of the Peer Workers and the unique service they had to offer and this made the program more cost effective.

Comments on quality improvement standards

The Peer Worker Program has been operating for approximately 18 months; staff have reported that the program has improved and has been guided by Catherine House policy and procedures.

How much time do you spend supervising the peer support worker?

The staff reported that they provided both formal and informal supervision to Peer Workers. Formal supervision often consisted of suggesting practice tools and techniques to improve Peer Worker's practice. Informal supervision may have consisted of vibrant discussions, offering of opinions and shared collaborative support. The staff and Peer Workers also communicated by email and telephone when they were unable to meet face to face. The staff reported that they spent approximately 1 hour per week supervising the Peer Workers. However, they desired more supervision time, which was not always able to occur, as they were often not available due to other work commitments.

Future directions

The staff reported the need for more Peer Workers and for more hours to be created for them to do their work. Currently there are 30 outreach clients and two Peer Workers, so there is a low Peer Worker to client ratio.

Peer Support Worker

How did the Peer Support Workers fulfill their obligations?

Both Peer Support Workers found their initial work to be challenging for a range of reasons. For both Peer Workers it meant revisiting their own stories which they found emotional, however, this process also validated the significance of many events in their lives and their own ability to recover. During orientation into the role, participation in case meetings, while initially intimidating, became easier over time with support and encouragement from the supervisor. Connection with the Peer Work Network through MIFSA provided additional support, particularly with the development of a plan in the event that the Peer Workers became unwell themselves. This included an improved understanding of how this might occur.

The Peer Workers have needed to adapt to differing needs and abilities of clients, in terms of level of understanding, mental health of the client, and their level of engagement with the community. The Peer Workers thought that an important part of their role involved modelling appropriate behaviour, including

grooming and maintaining their own health. The Peer Workers were very aware of maintaining confidentiality, encouraging their clients to discuss issues, without exploiting the client or the information. This was a challenge for the Peer Workers who had to establish boundaries, particularly around discussions involving personal matters.

5. What is working, what is not working?

Both of the Peer Workers discussed the high level of flexibility of the Program to respond to the individual demands and needs of the clients, and the focus on client goals and the collaboration with the clients' case workers. The Peer Workers felt that time was needed to establish their relationship with the clients' case workers. Gradually the individual roles of the Peer Workers and the case workers were developed and this reduced the initial isolation felt by the Peer Workers.

Training in Peer Worker skills was important to the Peer Worker. The 6 week peer workshop, which was completed before the Peer Workers applied for the position, was helpful in developing the confidence to undertake the role as well as skills to manage crises. Furthermore, the emphasis of the training on maintaining their own health and the cessation of work when the Peer Workers became unwell was vital.
"Being able to walk with a client on (her) own personal journey in positive steps of recovery is (a) surreal feeling" (Peer Worker).

Suggested improvements

Despite being given clear guidelines from the organisation on appointment, during induction and ongoing supervision, the Peer Workers felt that their relationship with their clients was unclear. This lack of understanding by the Peer Workers meant that boundaries were developed through trial and error.

Peer Workers felt a lack of time to complete both the work directly involving clients and the administrative aspects of the position. This and the development of time management skills was regularly addressed in supervision meetings, and Peer Workers were informed that it was not necessary to take on so many tasks. They also felt that time for the Peer Workers to meet would have been beneficial for them.

Overall, it appears that the Peer Workers may have found aspects of their role difficult as they had a lack of experience in a professional role and this may have meant they found it difficult to adapt to a professional environment at Catherine House.

Benefits to Catherine House

Both Peer Workers felt that the Program was an important part of the jigsaw that made up all of the aspects of recovery for the Catherine House clients. One Peer Worker also commented on her ability to share with the broader community the positive aspects of the Program which she felt would contribute to efforts to reduce the stigma of mental illness.

Meeting program goals and objectives for clients

Life management skills –The Peer Worker provides confidence so that the client can develop and take charge of their own progress.

DISCUSSION

Main Findings

The majority of the interviewed clients found their involvement with the Peer Support Program to be a positive experience. Most reported that their involvement resulted in improved outcomes in terms of life management skills, communication and social skills, managing stress, feeling positive and hopeful, and improving self-efficacy. Generally, the greater their involvement with the Program resulted in a higher level of reported benefits. Clients discussed a wide variety of activities that they enjoyed completing with the Peer Workers such as social outings for coffee and shopping, budgeting advice, attending the Education and Employment Program, computing, cooking, going to the library, card making and beading.

The interviewed case workers and the Peer Workers perceived many benefits from the Program, for both the clients, and the Peer Workers themselves. The Program, however, was also challenged by a number of factors including the volume of work voluntarily taken up by the Peer Workers (which was increased as the Peer Workers chose to take up a high workload themselves) and the supervising staff members, the health of the Peer Workers and the ambiguity or unclear boundaries in the relationship between clients and Peer Workers.

Lived experience of mental illness

Both the clients and the Peer Workers discussed the value of the Peer Workers *lived experience* of *mental illness.* Clients found that working with a Peer Worker allowed them to have c*ompanionship* at a time when they felt isolated. A client mentioned that she felt she was able to open up to her Peer Worker as she understood where the client was coming from. Another mentioned that her Peer Worker was able to help her *improve her confidence and self esteem*. As when the client became anxious her Peer Worker provided reassurance and guidance (i.e. advised her on deep breathing strategies and supported her in taking part in a DBT course).

The case workers that supervised the Peer Worker spoke of the Peer Worker's ability to model hope, courage, resilience and owning of responsibility for driving ones recovery to their clients. As a result the clients responded to the authenticity of the Peer Workers perspective. The case workers claimed the Peer Workers connection to clients and the resulting positive client outcomes have not been achieved by case workers. They attributed this success to the lived experience connection which the Peer Workers provide, and to which clients responded by deconstructing existing barriers which they maintained with 'professionals'.

Volume of work

The clients that had taken part in the program mentioned that they would have liked to have a Peer Worker support them for a longer period of time, and for more hours, as often their activities (i.e. computing) were cut short due to time restrictions; they would have liked more time to be allocated to the hours of the peer work service they received. Further, the Peer Workers also expressed a desire for increased hours of support as they claimed time restraints limited their ability to complete tasks with clients. This was due to the transport time needed to drive to client's homes, and other administrative duties that they were required to perform in the support time. This often meant that they were working outside of paid hours, which was not encouraged or approved by management. Further, the case workers claimed that more hours were needed for supervision of Peer Workers, as under supervision they performed well, and issues such as their health would be addressed and managed, helping them to fulfil their commitments to clients.

Health of the Peer Support Workers

The Peer Workers spoke of their work as providing them with a healthy social connection in the community which allowed them to have insight into the importance of their personal wellness. Their work with clients was a protective mechanism as it constantly reminded them that they also needed to manage their own mental health and take active steps (i.e. Ulysses Agreement, supervision, mentoring) to reach their self development and professional development goals. A Peer Worker claimed her lived experience allowed her to have an insight into clients struggle with their health, which gave her the opportunity to relate honestly her own experiences, often building trust and rapport with clients. She placed great importance on the feedback received from case workers, which allowed her to gain knowledge and improve in her services to clients. Further, the Peer Workers also claimed self reflection was important in maintaining a connection with clients, and that it was important to remember how it was when they were experiencing crisis, which allowed them to provide words of support to clients and educate other staff, which would plant the seeds for growth in clients.

Challenges to the relationship between the Peer Workers and their clients

While the clients were positive about the relationship with their Peer Workers, there was also some ambiguity about the nature of this relationship. Both groups felt their role was to support the client; however, it was unclear about whether this relationship was a friendship or a professional one. The challenge this posed was around issues of disclosure of information derived from the relationship. It quickly became apparent that clear boundaries were required so that misunderstandings did not occur.

During the program, clients had an improved understanding of others and their needs. Some clients were initially irritated about inconveniences in the Program such as lateness or illness of their Peer Worker. However, over time there was an increased understanding that the Peer Worker also had health issues and other needs which needed to be managed at the same time as their own.

In summary

The Catherine House Peer Support Program has many benefits to clients, staff and Peer Workers, central being the lived experience that the Peer Workers bring to their work, which clearly is the foundation of their ability to build trust and rapport with their clients, and important in achieving good client outcomes. Peer Workers integrated well into the Catherine House staff group and were welcomed as part of the Recovery Program team.

Recommendations

Based on the findings, it is highly recommended that Peer Workers are included in the Recovery Program staffing model. In order for this to be a successful change to the current staffing structure, Peer Workers are in need of further training and professional supervision that will directly address their understanding of the expectations of their Peer Worker role, and professional boundaries. As indicated, the Peer Workers have undertaken extra duties against the directive of management.

Further, clients have misunderstood the professional boundaries of the service that Peer Workers provided or perhaps Peer Workers did not make this clear at the beginning of the client-Peer Worker relationship. This suggests that there is a need for professional development training and supervision that addresses Peer Workers need to manage workload, set boundaries and to learn how to address their role with clients. Peer Workers and staff can also provide further information to clients, such as a handout that outlines the professional services that Peer Workers offer and also the limits to these services.

There is also a need for Catherine House supervisors to establish a relationship with peer supervisors at MIFSA to ensure a congruent approach to supervision with Peer Workers is in place. This will assist the training and implementation of peer worker roles, responsibilities and expectations.

Further, more funding is needed for the Peer Worker Program, which will increase the hours of Peer Support. As the Peer Workers have claimed to be completing two to three extra hours of work per week, more support hours would be ideal. The Peer Workers have recommended their roles and duties are completed and expanded to two to three days per week over six hour shifts.

Currently funding does not cover supervision of Peer Workers. This study has demonstrated that Peer Workers performed well under supervision. Therefore, a recommendation is to fund supervision by Catherine House staff. The Peer Workers have requested the following supervision arrangements; with the Manager of Transitional Programs (once a month for one hour), with the staff member/case worker who supervises them (every two weeks for one hour), and with their Peer Mentor from the Peer Worker Project at MIFSA (every month for one hour).

With extensive training, that aims to develop a professional outlook and boundaries, the Peer Workers will have a better understanding of their roles and responsibilities, which will help to improve the duties they undertake with clients. Further, an increase in funding for both Peer Worker hours and professional supervision will help to improve the quality of the Peer Worker Program at Catherine House.

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