Mental Health Commission of Canada
Commission de la santé mentale du Canada

Vancouver Peer Reference Group Report on Peer Support for Homelessness and Mental Health

Mental Health Commission of Canada At Home/Chez Soi Project

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VANCOUVER PEER REFERENCE GROUP

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CONTRIBUTORS

Peer Reference Group members:
Barb Bawlf, Debbie Sesula, Arianna Kennedy, Jeff Ashborn, Sandra Dawson, John Massam

Report authors:
Sandra Dawson, John Massam and Melissa Stephens on behalf of the Vancouver PRG

Peer Coordinator:
Althea Crawford (until May 2012)

Past members of the Peer Reference Group or Working Group for PWLE:
Mike Pratt, Ron Warbrick, Julia Weisser, Branwen Willow

Vancouver Site Coordinator:
Catharine Hume

Administrative Assistant:
Melissa Stephens

Thank you to all the participants who took the survey.

EXECUTIVE SUMMARY

In 2009, the Mental Health Commission of Canada (MHCC) invited a number of people who identified as People with Lived Experience (PWLE) of mental health issues, addiction, and/or homelessness, to join a working group to develop a Peer Reference Group (PRG) for the Vancouver site of the MHCC's At Home/Chez Soi (At Home) project. The main role of the PRG would be to inform and advise the local Project Team (decision-making body) about issues of importance to people with lived experience, and to guide the involvement of people with lived experience across the Vancouver project. Shortly into the process, the Site Coordinator, with the help of the working group, developed a Peer Coordinator job description and hiring process, and hired a part-time Peer Coordinator. The working group became the PRG in July 2010.

After developing a Terms of Reference (TOR) (see Appendix I), the PRG had initial discussions about areas of importance for PWLE within At Home. One key issue was the role of peer support in a recovery-based model of care. Members acknowledged that the vulnerable population recruited to At Home had traditionally not been engaged in the mental health system and consequently had likely had minimal access to peer support. They saw the value in reviewing what peer support is available for this population throughout Vancouver. Specifically, the PRG wanted to gauge the depth and breadth of the formal training provided to peer support workers in the mental health system, and the fit between this training and the specific needs of participants in At Home. The PRG noted that many participants had experienced substance use or dependence, mental and physical health issues, extended periods of homelessness, and lifetime trauma and abuse histories. The PRG then decided to review current formal peer support training available in Vancouver and the range of agencies providing peer support to the high-risk PWLE.

The "Discipline Summary of Peer Support Work" written by the Peer Support Workers Communities of Practice (PSWCoP) (see Appendix II) from all sites of At Home, helped the PRG to clarify definitions of peer support work, the necessary criteria for Peer Support Workers (PSW), and best practices. Necessary criteria include lived experience of not only mental health issues, but wellness and recovery to draw upon in practice, in-depth knowledge of the recovery and peer support movements, experiential knowledge of community mental health services as a resource, and advocacy that is person-directed.

The PRG realized that there were certain issues unique to the At Home participant population that "formal" mental health peer support trainings offered in Vancouver may not address. Two PRG members currently overseeing mental health peer training programs for their respective agencies, Vancouver Coastal Health (VCH) and Coast Mental Health (Coast), offered to compare and contrast their curricula and present it to the PRG to assist in identifying the breadth of formal trainings offered. This review formed a basis for identifying missing curriculum components. After comparing the trainings, most PRG members agreed that both curricula needed more depth around harm reduction, suicide risk, and trauma-informed care, and that they should add issues of homelessness, rehousing, and issues unique to street sex work.

The PRG identified other non-profit agencies offering peer support to the participant population, such as Aboriginal Front Door Society and Lifeskills. The Peer Coordinator connected with a number of these agencies to learn more about the peer services and the peer support training they offered. There appeared to be limited, if any, formal training, not because training was not seen as important, but because of the challenge of securing resources. The Peer Initiatives Coordinator for Vancouver Coastal Health Addictions attended a PRG meeting to share her perspective on peer support work based on her experience. A PSW attended as well and spoke about peer support at the Grandview Woodland Harm Reduction Kiosk (the Kiosk).

To get an idea of how peer support was playing out in the At Home project, the PRG held discussions with PSW and Peer Specialists (PS) from the three service arms of the Vancouver site: the Integrated Case Management (ICM) team, Assertive Case Management (ACT) team, and the Bosman Hotel Community. The PSW and PS explained their roles, and answered questions related to their experience of working as a peer within their service teams. They observed that they were able to connect with participants in a way that other clinicians or workers on the team could not by being able to share what it is like to live with a mental illness and addiction. They can "cut through" clinical jargon and ground the conversation in the participant's humanity. This benefits the clients and the team. Both the PS from the At Home project and their colleagues affirmed the value of having peers fully integrated into the team.

Finally, the PRG saw the opportunity and value of surveying At Home participants about their experiences of peer support. The Peer Coordinator, along with the PRG, designed and implemented a survey of peer supports utilized by participants with the intent of better understanding participant experiences of peer support both prior to and after entering At Home.

Forty-five participants completed the survey. The implementation of the survey revealed that even when provided with a definition at the beginning of the survey, many participants were confused about what peer support was and who was offering it. Although some of the participants who completed the survey received professional, formalized peer support services from PSW, such as those trained by VCH and Coast, or those employed by At Home, many more identified peer support as coming from places like a baseball team and food or meal programs. The survey collected information about what participants found helpful and not helpful in the services received, and their suggestions for improvements.

Several respondents said that peer support was more helpful coming from someone with similar experiences to themselves, particularly in terms of helping them connect to resources within the community, to adjust to "coming inside," and helping them to deal with substance use and mental health issues. People would like to see more funding for peer support services, more training of peer support workers, and they think peer support should pay well. They felt that peer support is more helpful when it is consistent and received on a regular basis.

The survey responses are consistent with findings and key recommendations in *Making the Case for Peer Support*[1], a report commissioned by the MHCC, capturing the peer support experiences of over 600 people with lived experience of mental health issues, and reviewing Canadian and international literature around the role of peer support in mental health. The report's recommendations included developing guidelines for funding peer support, creating guidelines to support the development of peer support, including curricula for peer support workers leading to a formal qualification, options for affordable training opportunities and education guidelines for peer support and its values for the non-peer workforce.[2]

The PRG learned also of the newly-formed Peer Support Accreditation and Certification (Canada) (PSACC), a non-profit organization coming from the MHCC's Peer Project, led by Stéphane Grenier. PSACC will create national certification and accreditation services in accordance with nationally endorsed standards of practice for mental health peer supporters. The PRG recommends that PSACC ensure that the vulnerable, high-risk population of people, such as those recruited to At Home, be considered in the process of developing the certification and accreditation, as this population is often neglected within the mental health system.

[1] O'Hagan, Mary [et al.]. *Making the Case for Peer Support: Report to the Mental Health Commission of Canada, Mental Health Peer Support Project Committee*. Mental Health Commission of Canada, 2010. www.mentalhealthcommission.ca
[2] Ibid. 10-11

The survey of peer support asked an additional question about whether participants would use online peer support. One-third of respondents answered yes, one-third no, and one-third maybe. This suggests that participants are, at least, curious about accessing online peer support services. Recent research, such as Guadagno, et al., in "The Homeless Use Facebook?! Similarities of social network use between college students and homeless young adults,"[3] suggests that marginalized populations, including young adults who are homeless, access the internet and social media more often than at first thought. Agencies offering peer support may wish to explore online service delivery.

In concluding its role in 2013, the PRG makes the following recommendations with respect to peer support training for people experiencing mental health issues, homelessness and/or transitioning from homelessness, and/or addiction:

1. The specific needs of people with lived experience of mental illness, addiction, and/or homelessness can be addressed by developing training specific to the population as an adjunct to existing trainings offered. Encourage agencies who train peer support workers to include robust modules on harm reduction, suicide risk, trauma-informed care, homelessness issues, and issues unique to sex work.

2. Encourage agencies that provide peer support training to recruit people with a high-risk experience to become peer workers. Ensure that recruitment and eligibility criteria for peer support training do not set up barriers that make it difficult for people with a high-risk experience to apply. Encourage agencies to look at people's assets and abilities, not deficits, when reviewing applications for peer support training.

3. Encourage local agencies to use the word "peer" in job titles only when workers are performing support work consistent with that described in the "Discipline Summary of Peer Support Work," rather than for food service, front desk work, or chores, as this confuses service users about where and how to access peer support and what it involves.

4. Encourage agencies to keep abreast of changes to the Ministry of Social Development's People with Disabilities (PWD) earning exemption, and that they inform PSW trainees and graduates of their rights and responsibilities with respect to PWD earning exemptions. Information is available at: http://www.eia.gov.bc.ca/pwd.htm

5. Encourage agencies that provide formal peer support training programs to collaborate with each other and share learnings with respect to the training they provide. Encourage agencies to:
    a. Work together to develop training that meets the needs of a high-risk population.
    b. Review the MHCC's report "Making the Case for Peer Support," and discuss and promote the report's recommendations, where relevant. The PRG particularly supports recommendation number 2: "Guidelines for the funding of peer support", which include:
        - "A target and deadline for the percentage of mental health funding to go to peer support
        - A recommended level of funding for peer support initiatives, and for staff, that is equitable with other mental health services
        - A recommended funding of development infrastructures for peer support." [4]
    c. Encourage PSACC to include people with high-risk experience of mental health issues, homelessness, and/or addiction, as they develop national certification and accreditation standards, as this high-risk population is at risk of neglect. Hold PSACC accountable to ensuring the standards encompass this high-risk population.

[3] Guadagno, R.E., et al. The homeless use Facebook?! Similarities of social network use between college students and homeless young adults. *Computers in Human Behavior* (2012), http://dx.doi.org/10.1016/j.chb.2012.07.019
[4] O'Hagan et al. 10

6. Training and subsequent peer support work should be person-centred as outlined in the "Discipline Summary of Peer Support Work," prepared by the members of the At Home PSWCoP.

7. Encourage agencies to explore ways to offer online peer support services, to accommodate the growing number of marginalized people, especially young adults who are homeless, accessing the internet and social media.

VANCOUVER PEER REFERENCE GROUP

In late 2009, a number of people actively involved in the peer recovery movement and having lived experience of mental health issues, and/or addiction, and/or homelessness, as well as some staff involved at all levels of the At Home/Chez Soi research demonstration project on mental health and homelessness, were invited to become part of a working group arranged by the Vancouver Site Coordinator. The intent of the "working group" was one of developing a framework for a Peer Reference Group (PRG) for the Vancouver site. Of the individuals who attended, all felt it was an exciting and vital project to be involved in.

Early on in the process, the Site Coordinator advised members of the working group that there were funds to hire a part-time Peer Coordinator to establish and coordinate the work of the PRG. The working group had discussions regarding this position and informed the development of a job description and the interview questions. In addition, two members of the working group were part of the four-person hiring panel.

Of the original working group, those identified as People With Lived Experience (PWLE) of mental health issues, and/or addiction, and/or homelessness, and having the ability to commit the time needed for the duration of the project, formed the Peer Reference Group.

Identifying the Role

In the early stages, the Peer Coordinator and the PRG worked on clarifying what they saw as the role of the Vancouver PRG, not only in relation to the Vancouver site, but also its interplay with and accountability to the national, multi-year study into mental health and homelessness.

Two local PRG members were also members of the National Consumer Panel (NCP), whose role was to concentrate on identified issues affecting peers working on the project, and participants receiving services from the project. This connection with the NCP provided the PRG with information about other peer groups associated with the project across Canada, such as Toronto's People with Lived Experience Caucus, Winnipeg's Lived Experience Circle, and Montréal's Conseil des Pairs. These discussions informed the Vancouver PRG of the mandates of the other groups and helped the PRG to define their role.

Based on presented information and discussion within the group, the PRG developed a TOR (Appendix I). The main roles identified were:

- to inform and to advise the local Project Team (decision-making body) about issues of importance to people with lived experience, and to guide the involvement of people with lived experience across the Vancouver project;
- linkages to both local and national peers (peer groups across the project and existing peer contacts); and
- participation and input into problem solving around issues within the Vancouver site and common issues across sites.

After developing the TOR, the PRG had initial discussions about areas of importance for PWLE within At Home. One key issue was the role of peer support in a recovery-based model of care. Members acknowledged that the vulnerable population recruited to At Home had traditionally not been engaged in the mental health system and consequently had likely had minimal access to peer support. They saw the value in reviewing what peer support is available for this population throughout Vancouver. Specifically, the PRG wanted to gauge the depth and breadth of the formal training provided to peer support workers in the mental health system, and the fit between this training and the specific needs

of participants in At Home. The PRG noted that many participants had experienced substance use or dependence, mental and physical health issues, extended periods of homelessness, and lifetime trauma and abuse histories. The PRG then decided to review current formal peer support training available in Vancouver and the range of agencies providing peer support to the high-risk PWLE.

What is Peer Support?

Initial discussions among the PRG, as well as other peer groups across the project, made it clear that the term "peer support" meant different things to different people. This inconsistency resulted in the At Home Peer Support Workers Communities of Practice defining peer support work as it relates to At Home, in the document "Discipline Summary of Peer Support Work" (see Appendix II).

While the Summary was developed within the context of At Home, PRG members agreed that the vision of peer support, expressed in the Summary as a key function of an integrated, client-centred care model, aligned with viewpoints emerging from members. Members agreed that the core principles and definitions in the Summary were of relevance to the discipline of peer support within the broader community, especially for serving the population of people with experience of mental health issues and homelessness.

Members noted the importance of the following in particular:

- To meet and engage clients "where they are at"
- Uphold the rights of participants to have their voices heard
- Realize that relating based on shared experience is unparalleled in terms of therapeutic value
- Lived experience of mental health issues and wellness and recovery to be drawn upon in practice
- In-depth knowledge of the recovery and peer support movements
- Experiential knowledge of community mental health services and other resources
- Advocacy and counselling skills that are person-centred
- Peer-informed documentation (such as peers writing case notes)

Examining Existing Formal Peer Support Worker Training

In general the PRG, through its early discussions, identified some suspected gaps to existing recognized peer trainings offered with relation to the population in the project including:

- Harm reduction
- Suicide risk
- Trauma-informed care
- Concurrent disorders
- Homelessness and rehousing issues
- Sex work

The group then conducted a review of recognized Mental Health/Addictions Peer Support Worker trainings offered in Vancouver. Two PRG members currently overseeing mental health peer training programs for their respective agencies, Vancouver Coastal Health (VCH) and Coast Mental Health (Coast), offered to compare and contrast their curricula and

present it to the PRG to assist in identifying the breadth of formal trainings offered (see Appendix III). The VCH training is based on a template of a program developed by Ann Ryder. The Coast training was developed by a peer experienced in developing and delivering peer support and advocacy training.

VCH and Coast taught the same core principles essential for peer support workers to know, such as recovery and wellness, human rights for people with disabilities, creating dialogue, conflict resolution, community resources and co-occurring disorders. Both taught additional topics, such as effective documentation, confidentiality and understanding mental illness. VCH covered further additional topics, including medication and side effects, self-disclosure, working with older and younger adults (see Appendix IV for table listing topics covered by both VCH and Coast).

There were noted differences in expectations of graduates from the VCH and Coast trainings. Graduates from the VCH training are expected to work with clients identified by the VCH Mental Health Teams and other VCH-contracted agencies (ACE Community Link, Gastown Vocational, Venture, Older Adult Rehabilitation Program and Mental Health Housing). Graduate PSWs, in conjunction with an occupational therapist or other staff, and with the client, work on defining a goal to address through peer support.

Those graduating from the Coast program may be expected, at some Coast sites, to work with an individual on a specific goal. At other sites, the peer will act as a "generalist" who can assist clients to identify goals that will help them in their recovery process. Coast, as an agency, assumes that a majority of its clients/residents will present with co-occurring disorders and that many people accessing peer support services may have addiction issues. Training, although not formal co-occurring disorder training, presents material in a way that recognizes that many clients seeking peer support services will have co-occurring disorders.

After comparing the trainings, it was agreed that for both curricula more depth was needed in training around harm reduction, suicide risk and trauma-informed care, while issues around homelessness, rehousing, and issues unique to street sex work were largely missing and should be added.

An important issue identified was the generally low remuneration for this work and the importance of making the case for fair remuneration. There are concerns with respect to the potential exploitation of peer support "volunteers".

Other Vancouver Agencies Offering Peer Support

The PRG identified other Vancouver agencies offering peer support, such as Aboriginal Front Door Society and Lifeskills, and the Peer Coordinator was able to engage some agency representatives and had informal discussions. It appeared that there was generally little, if any, formal training, primarily due to funding constraints.

The Peer Initiatives Coordinator for Vancouver Coastal Health Addictions attended a PRG meeting to share her perspective on peer support work based on her experience. A PSW attended as well and spoke about peer support at the Grandview Woodland Harm Reduction Kiosk (the Kiosk). They noted that peers in the VCH programs can be in recovery or still actively using. At the Kiosk, peer workers hand out harm reduction supplies. They deal with the stigma of handing out these supplies; however, support from the community is overall extremely positive. Returns and retrievals are at 87 per cent. Peer programs through VCH Addictions include small groups that are run daily, outreach programs and the Kiosk. An online network was in the planning stages at the time. To our knowledge, this network is still in development.

PS from the RainCity ACT team and Coast's ICM Team, as well as PSW from the Bosman Hotel Community, attended meetings to update the PRG on their work as peers in those service arms. They observed that they were able to connect with participants in ways that other clinicians or workers on the team could not by being able to share what it is like to live with a mental illness and addiction. They can "cut through" clinical jargon and ground the conversation in the participant's humanity. This benefits the clients and the team.

Both the PS from the At Home project and their colleagues affirmed the value of having peers fully integrated into the team. The PS from the ACT team shared with the PRG the definition and primary responsibilities of the peer role from *A Manual for ACT Start-Up*.[5] The Peer Specialist must have experience as a recipient of mental health services for severe or persistent mental health issues and is willing to use and share personal, practical knowledge and insight to benefit the team and the client. Among the principal duties, the PS must provide peer counselling and support, validate clients' experiences and provide guidance and encouragement to clients to take responsibility and participate in their own recovery.[6] Of key importance for the team, the PS acts as an "interpreter to help non-mental health consumer team members better understand and empathize with each client's unique and subjective experience and perceptions." [7]

The ICM team had some initial challenges incorporating peer support, but worked through these to integrate successfully a Peer Specialist on the team. Early budget restrictions meant they could offer limited hours of peer support, making it hard for the PSWs to spend meaningful time with clients. In addition, the team acknowledged that they needed to provide the PSWs with more clarity around job roles. In response to these issues, the team took a step back, examined their processes around hiring peers and identified some ways to move forward. They acknowledged that the Housing First outreach-based model is different from what many peers have experienced and many of the trainings available do not prepare them for the demands of working as an integral part of a team providing mental health case management. The team recognized the importance of peer support and later in the project, when additional funds became available, hired a Peer Specialist for three days per week. The result was a highly successful integration of peer support that benefitted clients and the team.

Survey of Peer Support for High Risk Populations in Vancouver

The PRG designed and implemented an information seeking survey related to participants' experiences with peer support. The survey was conducted in focus groups with a number of the participants from the ACT, ICM, and Bosman service arms, including members of the Speakers Bureau. In total, 45 participants completed the survey.

The survey did not ask for demographic information. However, At Home research provides a socio-demographic profile of all 497 Vancouver participants at baseline. On average, study participants were 41 years old, were first homeless at age 30, and had been homeless for about five years of their lives. Nearly three-quarters of the sample were male. All participants had some type of mental illness, most commonly a psychotic illness (52 per cent) or depression (40 per cent). Although the study did not seek out people with drug problems, a majority of participants had substance dependence (58 per cent) and/or dependence on alcohol (24 per cent).

Summary of Survey Results

Peer support was defined verbally, as follows, for participants taking the survey at the beginning of each focus group:

> *"What is peer support? Peer support occurs when people provide knowledge, experience, and emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained Peer Support Workers or Specialists, and can take a number of forms such as peer mentoring, listening, or counselling. Peer support is a structured relationship in which people meet in order to provide or exchange emotional support with others facing similar challenges."*

[5] Allness, Deborah J. and William H. Knowedler. A Manual for ACT Start-Up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illness. NAMI, 2003. 187
[6] Ibid. 187
[7] Ibid. 187

The implementation of the survey revealed that, even when provided with a definition, many participants were confused about what peer support was and who was offering it. Although some of the participants who completed the survey received professional, formalized peer support services from PSW such as those trained by VCH and Coast, or those employed by At Home, many more identified peer support as coming from places like a baseball team and food or meal programs. The survey collected information about what participants found helpful and not helpful in the services received, and their suggestions for improvements.

Many participants who took the survey had used peer support in the past. Several respondents said that peer support was more helpful coming from someone with similar experiences to themselves, particularly in terms of helping them connect to resources within the community, to adjust to "coming inside," and helping them to deal with substance use and mental health issues. People would like to see more funding for peer support services, more training of peer support workers and they think peer support workers should be well paid. They felt that peer support is more helpful when it is consistent and received on a regular basis. Some people felt care should be one-on-one; others found peer support groups helpful.

A significant number (just over half) indicated they received peer support through food or meal programs. PRG members were not sure how food and meal programs related to peer support. One theory is that participants receive informal support by being around their friends and peers at meals. The PRG also believe this response could be based on confusion about job titles.

At the Bosman Hotel Community, many participants work in a form of sheltered employment doing chores in the building, including cooking group meals for residents. These participants are referred to by the Bosman management as "peer workers" which can lead to confusion with peer support. This issue goes beyond At Home, as many local agencies and shelters are prone to labeling front desk workers and other positions as "peer workers" because a PWLE occupies the role, leading to confusion related to relative roles and responsibilities. The trend is also problematic for PWLE, who have the stigmatizing "peer" label on their resume instead of a neutral "cook" or "front desk worker" title (see the NCP report *Stigma, Discrimination, and PWLE Knowledge*, available online at http://bit.ly/122cFIW). Unless a PWLE is doing peer support, peer research, or advocacy work in which it is fundamentally necessary to the work to disclose up front that they are a peer, the word "peer" has no relevance to a job title. As for as the survey results, it becomes unclear whether participants actually received peer support at an identified agency, or simply ate a meal.

The survey responses are consistent with findings and key recommendations in *Making the Case for Peer Support*,[8] a report commissioned by the MHCC, capturing the peer support experiences of over 600 people with lived experience of mental health issues, and reviewing Canadian and international literature around the role of peer support in mental health. The report's recommendations included developing guidelines for funding peer support, creating guidelines to support the development of peer support, including curricula for peer support workers, leading to a formal qualification, options for affordable training opportunities and education guidelines for peer support and its values for the non-peer workforce.[9]

The PRG also acknowledged the newly formed Peer Support Accreditation and Certification (Canada) (PSACC), a non-profit organization coming from the MHCC's Peer Project, led by Stéphane Grenier. PSACC will create national certification and accreditation services in accordance with nationally endorsed standards of practice for mental health peer supporters. The PRG recommends that PSACC ensure that the vulnerable, high-risk population of people such as those recruited to At Home, be considered in the process of developing the certification and accreditation, as this population is often neglected within the mental health system.

[8] O'Hagan, Mary [et al.]. Making the Case for Peer Support: Report to the Mental Health Commission of Canada, Mental Health Peer Support Project Committee. Mental Health Commission of Canada, 2010. www.mentalhealthcommission.ca
[9] Ibid. 10-11

The survey of peer support asked an additional question about whether participants would use online peer support. One-third of respondents answered yes, one-third no, and one-third maybe. This suggests that participants are, at least, curious about accessing online peer support services. Recent research, such as Guadagno, et al., in "The Homeless Use Facebook?! Similarities of social network use between college students and homeless young adults,"[10] suggests that marginalized populations, including young adults who are homeless, access the internet and social media more often than at first thought.

In Guadagno's study, 75 per cent of youth experiencing homelessness studied reported that they use social media. This is consistent with the lived experience of some PRG members. The Internet provides a free point of contact, a way to stay in touch with friends and family without a mailing address or phone number, as well as being the primary contemporary means of finding jobs and housing. It can be used successfully to provide support and services. Agencies may want to consider exploring ways to offer peer support online. Although people without access to computers might not utilize it, those who do use the Internet, and who indicated they would like to or might use online services, should not be overlooked, as support can be offered where they already are: on social media.

[10] Guadagno, R.E., et al. The homeless use Facebook?! Similarities of social network use between college students and homeless young adults. Computers in Human Behavior (2012), http://dx.doi.org/10.1016/j.chb.2012.07.019

RECOMMENDATIONS

In concluding its role in 2013, the PRG makes the following recommendations with respect to peer support training for people experiencing mental health issues, homelessness and/or transitioning from homelessness, and/or addiction:

1. The specific needs of people with lived experience of mental illness, addiction, and/or homelessness can be addressed by developing training specific to the population as an adjunct to existing trainings offered. Encourage agencies who train peer support workers to include robust modules on harm reduction, suicide risk, trauma-informed care, homelessness issues, and issues unique to sex work.

2. Encourage agencies that provide peer support training to recruit people with a high-risk experience to become peer workers. Ensure that recruitment and eligibility criteria for peer support training do not set up barriers that make it difficult for people with a high-risk experience to apply. Encourage agencies to look at people's assets and abilities, not deficits, when reviewing applications for peer support training.

3. Encourage local agencies to use the word "peer" in job titles only when workers are performing support work consistent with that described in the "Discipline Summary of Peer Support Work," rather than for food service, front desk work, or chores, as this confuses service users about where and how to access peer support and what it involves.

4. Encourage agencies to keep abreast of changes to the Ministry of Social Development's People with Disabilities (PWD) earning exemption, and that they inform PSW trainees and graduates of their rights and responsibilities with respect to PWD earning exemptions. Information is available at: http://www.eia.gov.bc.ca/pwd.htm

5. Encourage agencies that provide formal peer support training programs to collaborate with each other and share learnings with respect to the training they provide. Encourage agencies to:
    a. Work together to develop training that meets the needs of a high-risk population.
    b. Review the MHCC's report "Making the Case for Peer Support," and discuss and promote the report's recommendations, where relevant. The PRG particularly supports recommendation number 2: "Guidelines for the funding of peer support", which include:
        - "A target and deadline for the percentage of mental health funding to go to peer support
        - A recommended level of funding for peer support initiatives, and for staff, that is equitable with other mental health services
        - A recommended funding of development infrastructures for peer support." [11]
    c. Encourage PSACC to include people with high-risk experience of mental health issues, homelessness, and/or addiction, as they develop national certification and accreditation standards, as this high-risk population is at risk of neglect. Hold PSACC accountable to ensuring the standards encompass this high-risk population.

6. Training and subsequent peer support work should be person-centred as outlined in the "Discipline Summary of Peer Support Work," prepared by the members of the At Home PSWCoP.

Encourage agencies to explore ways to offer online peer support services, to accommodate the growing number of marginalized people, especially young adults who are homeless, accessing the internet and social media.

[11] O'Hagan et al. 10

VANCOUVER PEER REFERENCE GROUP TERMS OF REFERENCE

The Mental Health Commission of Canada (MHCC) is implementing a research demonstration project to study approaches to ending homelessness among people with mental illness in Canada. This involves comparing the current service array (e.g., "care as usual", local practice) with an intervention based on a "Housing First" philosophy. Housing First is an approach for addressing homelessness that combines rental subsidies/allowances with intensive services and supports and is based on consumer choice. The project is called the At Home/Chez Soi Project.

This project is taking place in five Canadian cities over the next four years. The information gathered from this project will provide evidence about what services and systems best help people living with a mental illness who are also homeless. One of the key principles of the project is to engage fully people with lived experience in all aspects of the project.

In Vancouver, the oversight for the project resides with the Vancouver Project Team. The Peer Reference Group (the PRG) will inform and advise the Vancouver Project Team about issues of importance to people with lived experience. The Vancouver Peer Coordinator is the co-chair of the PRG and shall be a member of the Vancouver Project Team. The PRG will be co-chaired by one other member of the PRG. The PRG will include people with lived experience from the Vancouver Advisory Committee, ex-members of the Working Group to Engage People with Lived Experience and people with lived experience recruited by the Peer Coordinator from the community.

The Role of the PRG

The main role of the PRG is to inform and advise the local Project Team about issues of importance to people with lived experience and to guide the involvement of people with lived experience across the Vancouver project. The PRG will:

- provide a forum for people with lived experience to have input in the At Home project;
- train, educate and develop people with lived experience to be effective participants in the PRG and other project working groups;
- connect local people with lived experience involved in the project with their peers involved nationally and/or in other sites;
- identify opportunities to partner with other peer-based groups and organizations;
- identify opportunities for peer roles throughout the Project (peer support, communications, other); and
- provide input to the Vancouver Communications Subcommittee and to the Project Team.

Guiding Values and Principles

Members are guided by a commitment to:

- strengthen policy and program evidence in Canada related to mental health and homelessness, and ultimately to improve the quality of life for people who are experiencing mental illness and homelessness;
- cooperate and collaborate with the various committees and working groups related to the At Home project;
- recognize differing power dynamics among members and work to create a space where cultural safety and equity is promoted, and power is shared;

- directly and indirectly demonstrate respect for the full range of members' opinions, values and expertise;
- contribute to open discussion by expressing their views, respectfully listening to and considering the views of others and expressing differences of opinion so that they can be explored further; and
- engage in consensus-based decision making (written and oral). Consensus is considered achieved when each person is able to state explicitly that he/she has been heard and is prepared to support the decision, even if it is not the member's preference.

Principles supported by the members include:

- Peer liaison role in issue identification and resolution
- Nothing about us without us
- Equal pay for equal work

PRG Membership

The PRG will have approximately 10 to 15 members. Members will include people with lived experience from the Vancouver Advisory Committee, ex-members of the Working Group to Engage People with Lived Experience and people with lived experience recruited by the Peer Coordinator from the community.

How will the PRG Work?

The PRG will meet approximately monthly. The Vancouver Peer Coordinator will set the agenda for PRG meetings in consultation with the co-chair of the PRG.

Relationship to other Entities

The Vancouver Peer Coordinator shall be a member of the Vancouver Project Team. A member of the PRG shall join the Communications Subcommittee. Membership of other Vancouver committees and working groups is to be determined. The PRG will have ongoing interaction with the National Project Team, the National Consumer Panel, the National Working Group and the Safety and Adverse Events Committee.

Additional Background

The Canadian multi-site "Research Demonstration Project in Mental Health and Homelessness" is funded by Health Canada through the Mental Health Commission of Canada (MHCC).

The four-year project involves housing and support services that will be provided through collaboration among a number of groups such as government, service providers, academics, and homeless people. The project is based on the Housing First philosophy, which is one approach to ending homelessness. Each city will compare Housing First approaches with the current service array (e.g., "care as usual," local practice). The overall goal is to generate evidence that will inform national and provincial policy and help us understand what works best for different populations in various settings.

Vancouver Peer Reference Group Terms of Reference

The overall project lead is the MHCC Director of Policy and Research.

Project Teams in each city are accountable to the Commission and are responsible for overseeing the project, including the coordination of research and service plans and business functions.

Local Project Teams include (at a minimum):

- The local MHCC Site Coordinator
- Principal Investigator(s) and
- Representative(s) from the lead service provider agencies.

Local Advisory Committees in each site provide advice, input and feedback to the Local Project Team for planning and making sure local concerns are taken into consideration.

The Local Advisory Committees include:

- Local MHCC Site Coordinator
- People with lived experience
- Family members of those who are experiencing mental illness and homelessness
- Senior official(s) from provincial government ministries (Health and Housing)
- Senior official from local health authority or equivalent
- Senior official from municipal government
- Representatives from local service providers
- Other relevant stakeholders

A National Research Team provides expertise regarding research methods.

The National Research Team includes:

- The National Research Lead (Chair)
- Researchers from across Canada with quantitative and qualitative expertise

The National Consumer Panel provides expertise and input from people with lived experience/consumers.

The National Consumer Panel will include:

- The Consumer Research Consultant
- Consumer members from the Local Advisory Committees
- People with lived experience/Consumers

Communities of Practice support networking, problem solving and information sharing among project participants. For example, Communities of Practice have been developed for:

- Service providers (ACT/ICM)
- Psychiatrists
- Research Coordinators
- Housing providers

PEER SUPPORT WORKERS COMMUNITIES OF PRACTICE: DISCIPLINE SUMMARY OF PEER SUPPORT WORK

1. **PSWCoP Mission Statement**
   To foster, develop and implement Peer Support Work on the At Home/Chez Soi project to better support participants in the five project sites, while contributing a unique perspective to the discipline of Peer Support Work more broadly. The Peer Support Workers Community of Practice (PSWCoP) uses an approach that recognizes the value of developing peer support practice, while also strategizing better ways to improve interdisciplinary practice as part of Assertive Community Treatment (ACT) teams and Intensive Case Management (ICM) teams.

2. **Core Values/Principles**
   I. To meet and engage clients "where they are at."
   II. Uphold the rights of participants to have their voices heard.
   III. Treat participants with respect, and expect respect in return.
   IV. Help people move forward, regardless of their diagnostic criteria and status.
   V. Realize that relating based on shared experience is unparalleled in terms of therapeutic value.
   VI. Recognize that Peer Support Workers (PSW) have a different level of empathy than those without lived experience, which includes challenging people to be "better" and accountable.
   VII. The ability to share one's own story, and show a level of vulnerability as a central component of practice.
   VIII. Fostering independence, and resisting dependencies in working with participants.
   IX. Taking chances in being honest and using direct communication with participants.

3. **The Discipline of Peer Support Work on At Home/Chez Soi**
   In developing recommended criteria for Peer Support Work, the PSWCoP has taken into account existing guidelines on PSW in the At Home/Chez Soi project included in the fidelity scale. Overall, the At Home/Chez Soi project's fidelity scale is meant to ensure that the tenets of the Housing First philosophy are being implemented in the services provided in the sites. Peer Support Workers are one component of this. The Fidelity Scale definition of PSW was developed based on the Pathways to Housing model and sets national criteria for PSW across the five project sites. The criteria in the scale states that a PSW:
   I. (1) self-identifies as an individual with a serious mental illness who is currently or was formerly a recipient of mental health services; (2) is in the process of his/her own recovery; and (3) has successfully completed training in wellness and recovery interventions.
   II. In considering this framework, the PSWCoP has expanded these criteria to better reflect the work and knowledge of the group. The following are the PSWCoP suggestions for a definition of PSW that reflects the national and site-specific aspects of peer support work on At Home/ Chez Soi:
      a. Work towards a national definition of peer support that draws on experiences of mental health issues and homelessness, while also recognizing relevant site/city-specific lived experience. This mode of practice caters to participants' needs by including a definition of PSW that includes a diversity of experiences:

i. National Criteria:

- self-identifies as an individual who has experienced marginalization/oppression as a result of having mental issues and/or homelessness, and/or addictions.

ii. Local Criteria:

- Mental health/homelessness experience.
- Is contingent on the experience and identity of participants in a given community/site. PSWs draw on their experiences with migration, Aboriginal cultural identity, racialization, language barriers, rural homelessness, and Justice system experience to respond to the needs of local People With Lived Experience (PWLE) communities.

4. **Background/Approaches to Practice on At Home/Chez Soi**

I. While applying similar principles and values, PSWs take up site-specific titles in their work, including Peer Specialist, Peer Support Specialist, Peer Advocate, Human Service Counsellor, and Case Manager.

II. PSWs are part of both ACT and ICM teams on At Home/Chez Soi, which means PSW principles are applied in different ways based on the structure and culture of individual teams.

III. As part of At Home/Chez Soi, PSWs practice Housing First-informed Peer Support Work that:

a. is based on a lived experience perspective, which negotiates the realities of working from a Housing First model (e.g., supporting housing choice; navigating scarce housing market; determining democratic methods for rehousing participants).

b. has a holistic view of service that weighs out individual participant and broader participant community needs.

5. **Specific Skills**:

I. Transforming lived experience into Peer Support Practice

a. Draw on in-depth analysis of personal and peer community knowledge in practice.

b. Engage in participant interactions, which negotiate complex boundaries of self-disclosure and appropriate working relationships.

c. Experiential knowledge of services creates highly specialized knowledge of potential resources for a wide array of participants.

II. One-to-one Counselling/Support/Advocacy

a. Practice a bottom-up approach to working relationships that starts from "where the participant is at":

i. Sees the potential for addressing a participant's needs, even in minor interactions, regardless of whether there is a specific goal or plan involved.

ii. Depart from the clinical methods of using traditional assessment tools, or discipline-specific modalities, to achieve optimal peer working relationships.

b. Care is provided within the case management model, but with high emphasis placed on self-direction by the participant and on peer working relationships, the approach to care translates into an alternative to traditional case management models.

c. While not following particular counselling framework, utilize multiple models of peer relevant counselling methods, including motivational interviewing and reality therapy to inform peer practice.

d. Helps facilitate reframing of participants' experiences:

i. From internalized doubt, blame, etc., towards experience as valued knowledge.

ii. That are negative, to see them through a lens of individual and systemic discrimination.

iii. Works from a strength-based peer approach, which is informed from a position of lived experience.

iv. The ability to work with the idea that failure is an important experience.

v. Works with participants and encourages participants' ideas and projects, even if they are not "attainable" from the perspective of the worker.

vi. Relates on an experiential level that not only nurtures and supports, but also challenges participants.

vii. Negotiates ways to provide service that facilitates empowerment in housing decisions, and resists creating dependencies.

viii. Advocates for the rights of participants inside and outside the mental health system.

III. Peer and Peer-Informed Group Settings

a. Groups are based on community connections and decreasing isolation.

b. Create meeting spaces that are more relaxed and inclusive, which includes groups away from the office.

c. Groups also "meet people where they are at", and are built from the bottom up.

d. See Groups as a valuable space for peer relationships to develop.

e. View activities and outings as having a parallel value in terms of relationship building and recovery principles, compared to traditional groups.

IV. Facilitating community relationships

a. Possess community development skills, which transfer to drop-in management where applicable.

b. Help foster peer relationships among participants that include support and friendships.

c. Empower participants to seek out alternatives in the community that fit their medical, support, and cultural needs.

d. Unlike in-patient, and to some extent outpatient clinical settings, PSWs on ICM and ACT teams on At Home/Chez Soi have fully integrated relationships in the community, and can draw on individual and community connections in their sites. PSWs have well-established boundaries, yet "insider" knowledge of their sites.

V. Negotiating Peer Principles in Clinical Settings

a. Develop working relationships around medication that fosters participant autonomy over treatment.

b. Use models such as Gaining Autonomy through Medication (GAM) to help participants think through their relationship to medication in individual and group settings.

c. While sometimes involved in medication dispensing, promote choice and learning about medication among participants.

d. Legislated Treatment in the Community (LTC)

i. Recognize the tensions between peer work and LTC in terms of participant's autonomy.

ii. Grounded in recovery principles and help find eventual alternatives to LTC for individuals under legislation.

VI. Interdisciplinary communication and teamwork

a. Peer informed documentation:

i. PSWs are versed in recovery language, and take a narrative approach to documentation that captures interactions with the intent of relaying experience, rather than medicalized descriptions.

ii. Engage in limited assessment, using the least harmful and non-stigmatizing language, and are carried out in collaboration with the participant.

b. Educate team and broader community on peer support and peer support principles.

c. Can be a resource on language used by participants that may be unfamiliar to the rest of the team.

6. **The Relationship Between Education and Experience in Peer Support Worker Positions**

Anchored by experience, Peer Support Workers come from a variety of educational experiences that inform their practice. However, unlike other disciplines which determine a fixed pay scale based on level of education (i.e., social work is categorized as Social Work 1 and Social Work 2), Peer Support Worker positions should take education into account only so much as it contributes to the style and type of an individual's practice. Overall, the role of education in this understanding of PSW informs the type of groups, individual practice, and wider team education.

I. Recognize the importance of specific training related to Peer Support positions, however training certificates should not necessarily be prerequisite in acquiring PSW position:

a. Personal, community, and educational experience should be considered on par with Peer Support Worker certificates.

b. Equally value the experience of those who "grandfather" peer support certificates.

c. Put focus on acquiring Peer Support Worker certificates on the job, so PSWs can improve practice and remain current in terms of Peer Support knowledge.

Review and Comparison of Recognized Formal Mental Health Peer Training Done by Vancouver Coastal Health and Coast Mental Health

RECOVERY SUPPORT WORKBOOK TOPICS (Ann Rider)	VCH TOPICS COVERED IN WORKBOOK Italics show additions	COAST TOPICS THAT MATCH THE WORKBOOK
	Generally 84 hours training, 30 hours practicum	100 hrs training Practicum = 50 hours + 6-month placement for mentoring (PB/PS) & (PA) above in each
Role of Peer Support	Role of Peer Support	Characteristics of Helpers
Recovery, Wellness, Wholeness	Recovery, Wellness, Wholeness	Recovery,
Unlearning Patient-hood, Learning Personhood	Unlearning Patient-hood, Learning Personhood	Covered in Recovery section (Medical Model vs. PSR Model)
Culture & Worldview	Culture & Worldview	Covered in Recovery section
Worldview: Who am I & Who are You?	Worldview: Who am I & Who are You?	Covered in Recovery section
Wellness Tools	Wellness Tools & WRAP	Wellness/Stress
Creating Community	Creating Community	Covered in Recovery section and Advocacy Training/Monthly Meetings
Human Rights and People with Disabilities	Human Rights and People with Disabilities	Acts that Govern, Systems (Advocacy Training)
Advocacy	Advocacy	Advocacy (90 hours training, 50 hours practicum and 6-month placement)
Communication Fundamentals	Communication Fundamentals	Communication/Non-Verbal Communication, Paraphrasing, Summarizing, Perception Checking
Creating Genuine Dialogue	Creating Genuine Dialogue	
Conflict & Understanding	Conflict & Understanding	Conflict Resolution
Resources in the Community	Resources in the Community	Community Resources
Understanding the Process of Change	Understanding the Process of Change	Expanding Awareness, Change
Drugs and Alcohol	Drugs and Alcohol, *Co-occurring Disorders*	Addictions, Co-occurring Disorders
Crisis and Recovery	Crisis and Recovery, *Suicide Intervention*	Crisis is covered in Practicum Orientation
Grief and Loss	Grief and Loss	Grief and Loss
Healing from Trauma	Healing from Trauma	
Ethics and Boundaries	Ethics and Boundaries	Trust/Boundaries; Ethics covered in Boundaries and again in Practicum Orientation
Working, Wellness & Self-Care	Working, Wellness & Self-Care	Covered in section on Goal Setting and at Monthly Meetings

APPENDIX III

	ADDITIONAL VCH TOPICS	ADDITIONAL COAST TOPICS
	Confidentiality & Continuity of Care	Confidentiality
	Understanding Mental Illnesses	Mental Illness
	Goal Setting & Empowerment	Decision Making/Problem Solving
	Effective Documentation	Documentation
	Overview of VCMHS	
	Medications and Its Side Effects	
	Self-Disclosure	
	Psychosocial Rehabilitation	
	Recreation & Leisure	
	Working w/Older Adults and Younger Adults	
	Working at Team and Hospital Settings	
	Supporting Volunteers	
	Smoking Cessation	
	Working Collaboratively	
	Universal Precautions	
	Resource Presentations	
	Non-Violent Crisis Intervention	
	Guidelines & Practicum Preparation	
	Exam	
		Journal Keeping
		Maslow's Hierarchy of Needs
		Self-Esteem
		Anger Management
		Feedback
		Preparing to Meet Health Care Professionals
		WHMIS
		Food Safe
		Standard First Aid

SURVEY OF PEER SUPPORT FOR HIGH RISK POPULATIONS IN VANCOUVER

The At Home/Chez Soi Peer Reference Group is conducting a review of community peer supports available to "high risk" populations in Vancouver. To make this review most relevant, we are asking participants in the At Home project in Vancouver to help inform this process.

This is optional and is a confidential process for participants. This is a unique opportunity to help improve peer support services in your community for future development and consideration.

The Peer Reference Group will make recommendations and will forward its findings in a report (based on your feedback and from information provided by peer support service providers) to the At Home project locally and nationally. It will also forward this report with recommendations to the MHCC and to local community stakeholders including VCH, Coast Mental Health and the City of Vancouver.

Your participation is humongously appreciated and is highly valued. You will receive a cash honourarium (☺) and will be entered into a draw for a cool prize (☺☺☺).

What is a peer?

A peer has "been there, done that" and can relate to others who are now in a similar situation.

Wikipedia definition

What is peer support?

Peer support occurs when people provide knowledge, experience, and emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained Peer Support Workers or Specialists, and can take a number of forms such as peer mentoring, listening, or counselling.

Peer support is a structured relationship in which people meet in order to provide or exchange emotional support with others facing similar challenges.

Some examples of peer support include: a family member, friend or even a support worker with similar lived experience — who discloses that they have similar lived experience — and offers support. VANDU, 12-step programs, some workers at Insite, PACE, WISH, LifeSkills and all members of PONY are all examples of agencies that offer peer support services.

Survey

1. Have you ever used peer support services in the PAST?
   - ○ Yes
   - ○ Don't know

2. If yes, what were they? Please check those that apply:
   - ○ Family member or friend (with similar lived experience)
   - ○ Support Worker (who discloses that they have similar lived experience)
   - ○ 12 or 16-step programs:
     ○ AA ○ NA ○ 16 Step ○ Other_____
   - ○ WISH
   - ○ John Howard
   - ○ Insite
   - ○ Peer programs at Coast Mental Health
   - ○ VCH peer support worker (in some hospitals or connected by a Mental Health team)
   - ○ Meal or food programs (offering support from those w/ similar lived experience)
   - ○ Mental Health Care Worker (who discloses that they have similar lived experience)
   - ○ Any person in authority (who discloses that they have similar lived experience) (examples: teacher, cop, doctor, nurse)
   - ○ PACE
   - ○ West Coast Mental Health Network
   - ○ PONY
   - ○ VANDU
   - ○ Peer Specialist
   - ○ Peer Support Worker
   - ○ Clean Start (at Coast)

Other peer support/s used but not listed above (Please remember this is "peer specific".)

- _____
- _____
- _____
- _____

Addiction, substance use and peer support: A variety of peer programs are available including info, outreach and harm reduction peer supports. Have you used this type of peer support?

- ○ Yes
- ○ No
- ○ Not sure

If yes, and you know name of the program or service, please list:

- _____
- _____
- _____
- _____
- _____

3. Are there peer supports that you've used in the PAST that were helpful?

- ○ Yes
- ○ No
- ○ Not sure

Can you say why it was helpful?

_____

_____

_____

_____

_____

_____

Can you say why it wasn't helpful:

_____

_____

_____

_____

_____

_____

_____

4. What peer supports are you using NOW that are helping with your transition?

   Can you say why it is helpful:

   Can you say why it isn't helpful:

5. Transitioning from homelessness:

   Can you think of any ways that would be helpful to improve peer support services for people transitioning from being homeless to being housed?

6. Addiction and substance use:

   Can peer supports be improved for this?

   - ○ Yes
   - ○ No
   - ○ Maybe

   Can you think of any ways that would be helpful to improve these peer support services?

Halfway finished...

7. Fleeing violence and/or exiting the sex trade:

   Can peer supports be improved for this?

   - ○ Yes
   - ○ No
   - ○ Not Sure

   Can you think of any ways that would be helpful to improve these peer support services?

8. Trauma and abuse-related issues:

   Can peer supports be improved for this?

   - ○ Yes
   - ○ No
   - ○ Maybe

   Can you think of any ways that would be helpful to improve these peer supports?

   _____

   _____

   _____

   _____

   _____

   _____

9. Peer Support Services for people w/ mental health issues (including depression, anxiety, bipolar disorder, anorexia, self-injurious behaviours, etc.):

   Can peer supports be improved for this?

   - ○ Yes
   - ○ No
   - ○ Maybe

   Can you think of any ways that would be helpful to improve these peer supports?

   _____

   _____

   _____

   _____

   _____

   _____

   _____

10. Employment and education: Can peer supports (and peer mentorship) be improved for this?

    - ○ Yes
    - ○ No
    - ○ Not sure

Can you think of any ways that would be helpful to improve these peer supports and peer mentorship programs?

Only two questions left...

11. Aboriginal peer supports:

Can peer supports be improved for this?

- ○ Yes
- ○ No
- ○ Not Sure

Can you think of any ways that would be helpful to improve these peer supports?

12 Community inclusion:

Is loneliness or isolation an issue for you?

- ○ Yes
- ○ No
- ○ Sometimes

Can you think of ways that peer support could help assist you being more integrated and feeling "a part of" your community?

BONUS question:

Would you use online peer support?

- ○ Yes
- ○ No
- ○ Maybe

Is there anything else you want to say about peer support?

Thank You!!!

Your feedback is really appreciated and will be incorporated into the Peer Reference Group's final recommendations and report on Peer Supports Available for High Risk Populations in Vancouver.

Please pass in your completed Survey, along with your filled out ballot, if you'd like to be entered into the Prize Draw.

Please be sure to print your name and provide us with your best contact info. The Draw will take place in a few months. Good Luck!

On behalf of the members of the Vancouver Peer Reference Group, be well and take care.

SUMMARY OF SURVEY RESULTS

The numbers

Forty-five At Home participants took the "Survey of peer support for high risk populations in Vancouver." Of the 45 who took the survey:

- 10 participants were in the At Home participant Speakers Bureau (Speakers Bureau members are from all three Vancouver intervention teams. Of Speakers Bureau members taking the survey, nine were from HN cohort, one from MN cohort);
- 22 participants lived at the Bosman at the time of the survey (HN cohort);
- Seven participants were with the Rain-City ACT team (HN cohort), and
- Six participants were with Coast's ICM team (MN cohort).

Approximately two-thirds of those surveyed said they had used peer support in the past. Around one-third said they had received services from a Peer Support Worker. Fourteen people said they had accessed peer programs at Coast and nine said they'd used VCH Peer Support Workers (possibly through hospitals or connected by a mental health team).[12]

Some people accessed peer support through substance use programs such as AA or NA and some identified Insite as a place they'd received peer support. Close to one-third accessed support through Vancouver Area Network of Drug Users (VANDU). Similar numbers received support from family members or friends with similar experience, and from support workers disclosing similar lived experience. A slightly smaller number (eight responses) indicated support received from Mental Health Workers disclosing similar lived experience. A higher number (just over half) received peer support through food or meal programs.

When asked about other peer support services accessed, people listed a broad range including support through non-profit organizations such as Lifeskills, the Kettle Drop-In, Belkin House, PHS and MPA. Organizations listed more than once are Carnegie Outreach, Covenant House and Lifeskills, as well as the At Home RainCity ACT team's group "Becoming an Insider" (most of the participants surveyed from the ACT team were attending this group at the time of taking the survey). Other places mentioned are the Dr. Peter Centre for HIV/AIDS, Three Bridges Community Health Centre, Washington Needle Exchange, Prison Outreach Program, Gathering Place, Hustle and Men on the Move. One person listed the faith-based program Celebrate Recovery. The At Home baseball team and At Home Speakers Bureau were also mentioned.

The survey asked respondents to list peer programs they had accessed specific to addiction and substance use. Responses included several programs already listed including Carnegie Outreach, WISH, Insite, VANDU and AA. Programs or organizations not previously listed included Oppenheimer Park Red Coats, Cash Corner, WISH, Alpha Program, Alcohol Victorious (faith-based program) and support from RainCity ACT team (during home visits).

Summary of Survey Results – Themes

The survey asked respondents whether they could say why peer supports used in the past were helpful and why they were not helpful. Some respondents found it helpful to talk to someone who had similar experiences to their own, to someone who's "been there." Peer support helped people feel less alone and one person said it helped them feel more able to deal with mood disorders, especially when the support was provided on a regular basis.

[12] Note that there could be some duplication in the number who checked "Peer Support Worker" and those who checked Coast or VCH programs.

People found it helpful to get peer support around substance use and addiction issues. They found peer support gave them practical advice about their current situation. Peer support helped connect them to employment, housing, life skills, meals and fresh food, computers and music. One person enjoyed the opportunity to vent.

Overall, respondents felt that peer support provided connection, common ground, a feeling of belonging and being connected to resources to fulfill basic needs.

On the other hand, a number of people expressed an inability to relate to the peer support provider. They said they wanted someone who could relate to their experiences. Some people said the support wasn't there when needed and that the provider wasn't working hard enough to help with concrete needs such as employment goals. (Note: it's possible this comment refers to service on current team rather than peer support in particular.) Conversely, some felt too pushed by providers setting goals they hadn't set for themselves.

Some participants felt the peer support provider acted with a sense of superiority. They felt a lack of common ground between themselves and the provider and that they weren't treated as equals. Overall, the negative experience seems to be that respondents didn't experience trust and safety and that peer support was unreliable.

The survey then asked participants what peer supports they are using now that are helping with their transition. Participants listed organizations and programs previously mentioned. When asked if they could say how these supports are helping, several respondents' answers seemed to be referring to the At Home intervention rather than peer support in particular. A common theme according to responses is that the support is helpful because it is providing housing, shelter, financial support. Another is the idea of common ground and connecting with people who are "similar." One person felt safe and said the intervention had kept them from suicide.

When asked if they could say why current peer supports are not helpful, again several respondents seemed to be referring to the At Home intervention rather than to peer support. A common theme is that help is not available when needed, leaving respondents feeling abandoned in their current situation, not knowing how to move forward. One person felt positive about current support.

People reflected about how peer support services for people transitioning from being homeless to being housed could be improved. Some felt peers could help others adjust to "coming inside." One person suggested a group of tenants provide support to a newcomer to a building; another that it would help to go for a coffee with a friend. There were comments about the need for more Peer Support Workers, including more training for Peer Support Workers or the implementation of training. Some felt it important for there to be continuity of support, i.e., consistency and follow-up to reinforce the benefits.

Some respondents suggested peer support to help access concrete resources such as financial resources, housing and activities that promote community inclusion.

The importance of housing is a recurring theme, including anxiety about being able to keep current housing, the importance of a safe and comfortable place to adjust to transitions and the importance of being provided housing first, then supports. Some people are interested in support with exploring vocational options and employment opportunities.

The majority of survey respondents felt peer supports for addiction and substance use could be improved. They felt it would be helpful to have a peer support worker who has lived through the same experiences as they have. One person expressed it as "someone like me." Some thought of peer support as recovery groups while others suggested one-to-one support would be helpful. People talked about the importance of care, compassion, awareness and understanding for support around addiction.

One person thought it would be useful to have groups run according to type of drug use. Another suggested a model similar to Insite for crystal meth users to use safely, inside. Fast access to affordable programs was suggested. One

person asked for access to programs other than 12-step. Another said it would be helpful to have support that is more frequent and support in the home for people with disabilities such as mood disorders.

Another idea is that it would be helpful for the peer support worker to lead by example, or be further along in their recovery.

When asked how peer supports for people fleeing violence and/or exiting the sex trade could be improved, respondents said that more outreach and more people to talk to would help. One person suggested talking to people when they're young. Some said there should be better victim services. One suggested victims need more support from police and that a victim accompanied by an advocate will be taken more seriously by police.

One person said that decriminalizing the sex trade would help. Another thought there should be stricter laws but didn't specify what type of laws. One answer suggested the need for services, including a safe place for men who are being victimized by women.

One respondent noted that escaping the violent behaviours of the DTES neighbourhood can be life altering but people are often forced back there to access needed services such as free food.

Most people felt peer supports for victims of trauma and abuse could be improved. Again, people felt talking with a peer with similar experience would help; especially, it might help victims who are struggling to find a voice. One said it would help to identify peer support workers willing to disclose their own related experiences. Some felt support groups would be beneficial. Many felt supports fall short and that victims should receive more support. A couple of people related the idea of trauma and abuse to their childhood or youth. One person answered simply "power."

A majority of those surveyed felt peer support services for people with mental health issues could be improved. They felt it was important for people to be able to talk about their issues and to get regular help. One person said "talk therapy with less medicine." Some felt it would improve peer support if workers identified themselves as having experience of mental health issues. One person noted that, while mental health disorders require a clinician with mental health training, talking to a peer with similar experience is always helpful.

One interesting response suggested that peer support providers and mental health workers connect to debrief about clients so that peers can offer advice to the mental health workers. As with responses to other questions, there's a suggestion for more funding.

Reflecting about how to improve peer supports around employment and education, participants reiterated that receiving help from someone with lived experience is helpful. Some people thought there needed to be more employment and education programs and others that they needed help with identifying and accessing those programs. Some wanted more support overall with vocational goals and help with finding work. There was one comment about reminding friends of the importance of working.

Respondents felt there needed to be more funding and supports for Aboriginal communities, starting with meeting basic human rights and health needs. One person articulated a need for more one-on-one peer support, that peer support workers should be well remunerated, and that there should be opportunities for them to work.

The survey asked participants to think of ways that peer support could help them feel more integrated and part of their communities. Generally, there were comments around the need for more services to combat loneliness and isolation: in-reach/outreach support, training more peer support workers, one-on-one peer support and counselling, group activities and access to different group activities to make connections and experience new people and ideas. Some spoke to feeling isolated, not having many friends and finding it difficult to ask for help. Others said they enjoyed time alone. Again, one respondent spoke to the need for regular follow-ups.

Some participants shared final thoughts about peer support. One respondent said that peer support is vital, though almost unheard of, and suggested there needs to be a "central number," perhaps meaning a peer support helpline. People felt peer support plays a role in helping people figure out where they're at and thinking about next steps. Overall, respondents felt peer support was helpful. One person said they had been homeless and that now they were a Peer Support Worker. Another said it would be helpful if Peer Support Workers were informed about a broad range of services within the community.

Recurring themes and questions

Many participants who took the survey had used peer support in the past through a variety of non-profit organizations, programs, the Vancouver Coastal Health Authority, and/or via family, friends and professionals.

Several respondents said that support from someone with similar experiences to themselves could be helpful in many facets of their lives, including helping them connect to resources within the community, to adjust to "coming inside," and helping them to deal with substance use and mental health issues. People would like to see more funding for peer support services, more training of peer support workers and they think peer support workers should be well paid. They felt that peer support is more helpful when it is consistent and received on a regular basis. Some people felt care should be one-on-one, while others found peer support groups helpful.