



Project Outline

PEER BASED MENTAL HEALTH
SUPPORT SERVICES

Preamble

The project described in this document is designed to assist in the creation of effective models for peer based programs in a variety of settings in Canada, e.g., workplaces and schools. The catalyst was two programs that have been successfully launched in a large Canadian workplace: the Canadian Forces. One program offers peer support services to Forces' members, Veterans and their families and the other provides mental health education in the workplace. Perhaps the most remarkable aspect of both these peer based initiatives has been the transformation of military culture from one where mental illness and stress injuries were stigmatized to a more accepting culture that openly acknowledges the reality of mental health conditions.

The Forces' peer support program has served well over 5000 clients since its inception in 2002, and maintains an active client base of approximately 1200 people at any one time. These numbers are a testament to the value and benefit of peer support and reflect the findings of numerous studies that have shown the effectiveness of peer support in a variety of health situations.

Over 30,000 people have participated in the Forces' workplace mental health education program since it began in 2008, and 25,000 more are expected to complete it in 2010. A formal evaluation of this mental health education program confirmed a notable positive shift occurring in participants' attitudes in relation to mental illness after they had taken part in it.

Seeking to export and build on the experience gained within the military, the Mental Health Commission of Canada was able to secure the part-time services of Lieutenant Colonel Stephane Grenier to develop this project. He is the founder of both peer based programs currently operating within the Department of National Defence (DND).

To ensure the success of this project, stakeholder consultation is imperative, especially in relation to the peer support component described later in this document. Obtaining the views and valuable input of concerned stakeholders will be a prominent feature of this project as it moves forward.

The reality of the Canadian workplace is that mental health problems often go undetected and untreated due to stigma, shame and a lack of understanding. Workplace peer support and peer based mental health education programming are tangible solutions that can reduce isolation and increase the likelihood that people will seek treatment and comply with it. This can assist in combating the stigma surrounding mental illness, and help mitigate the costs of these illnesses to individuals, workplaces and society as a whole.

Situation

The social and economic impacts of mental illness have been well documented. Although particular statistics vary from organization to organization, mental illnesses consistently rank in

the top five disability claims. According to any number of sources, the key drivers of increasing disability costs are psychiatric disabilities or mental illnesses. The Great West Life Assurance Company reported in 2007 that mental illness is now the number one cause of long term disability claims. The most recent 2009/2010 Watson Wyatt Worldwide survey on health and productivity (involving 282 U. S. and 70 Canadian organizations representing more than 11 million employees in all major industry sectors) noted that mental health problems were the leading cause of disability in Canada. (<http://www.towerswatson.com/research/648>) The WHO also ranks mental illness as the number one disability claim in Canada and predicts that depression will become the second leading cause of disability by 2020.

The issue of the social stigma surrounding mental illness in Canada was poignantly captured through first-hand testimonies in the May 26th Senate report “Out of the Shadows At Last”. Point 1.4.4 of the report, titled *Stigma and Discrimination in Society* begins with: “Perhaps the most damaging effect attributed by witnesses to stigma and discrimination was the originating in the belittling, denigrating attitudes toward mental illness and those who suffer it that seem to pervade all levels of society”.

A good number of research studies and papers support the above statement. To provide only a few examples, the Mood Disorders Society of Canada has published “*Stigma and discrimination...*” (Nov. 2007) and “*Stigma research and anti-stigma programs...*” (Mar. 2009), and The Public Health Agency of Canada covers the issue of stigma and discrimination in its report on mental illnesses in Canada. In a paper published in the World Psychiatry Journal, October 2008, titled *Fighting the Stigma Caused by Mental Disorders:...*, author Heather Stuart writes: “Organizations such as the World Health Organization, the WPA and the World Association for Social Psychiatry, to name a few, have all recognized stigma as a major public health challenge.”

Defining the Word “Peer”

Peer is defined as *a person of equal standing*. In the context of providing peer support, the word peer is used in a broader sense to refer to *people who share in common a mutual lived experience*. However, in the field of mental health education it is necessary to define peer in a stricter sense as *someone who is either a co-worker or a person who works in a similar organizational background, or someone of the same generation or cultural background who has suffered the effects of mental illness*. The reason for this more precise definition is in relation to a concept referred to as “power differential.” Social power is the ability to influence others. There are natural power differentials in many (but not all) relationships, including those between parent and child, teacher and student, employer and employee, and health care practitioner and client. In theory and in ethical practice, the power differential is beneficial to the relationship, however when providing mental health education this power differential may prove, in many cases, to work against achieving the emotional resonance¹ required to successfully transmit the understanding that people suffering from mental illnesses are “just like you and me”.

¹ Emotional Ecology in Education by C. Turner and J. Shepherd, Health Education Research Theory and Practice, Oxford Journals.

Project Purpose and Preface

This project has two purposes, one is to promote the use of peer support in the workplace as an effective complement to traditional clinical care, and the other is to foster a change in societal attitudes towards mental health illness through the provision of peer based mental health education in the workplace and in schools.

The key factors that influence and shape this project are detailed in Annexes A and B to this project outline.

A fundamental requirement to promote the use of peer based services in workplaces is to have tested and proven management frameworks that employers and managers can rely on to achieve professional, consistent delivery of such services within their organizations. With the “bottom line” driving business decisions and government organizations having to answer to taxpayers, it can be expected that evidence-based frameworks will need to be developed before organizations are willing to invest in peer based initiatives such as peer support and mental health education.

Project Components

Mental Health Peer Support

The purpose of this component of the project is to develop a model peer support program for use in Canadian workplaces that may also be later used in other settings as the need arises. The program model would be developed in a manner designed to help elevate the practice of peer support to a formally recognized and nationally accepted method of mental health care, complementary to clinical care methods.

To achieve this purpose, this component of the project is to:

- Develop competency requirements for peer support workers in the workplace, standards of practice and competency-based curricula for training peer support workers, and;
- Develop and implement an effective, credible and grounded performance measurement and management framework, designed to expand the evidence base corroborating peer support practices.

Mental Health Peer based Education

The purpose of this component of the project is to transform the way Canadians perceive and understand mental health issues by having peers with lived experience deliver a non clinical curriculum specifically designed to fit within the organizational/societal culture of targeted audiences.

The curriculum will be adapted from a program utilized within the Canadian military; a program which has successfully demonstrated that the inclusion of peers in mental health education is key to establishing credibility and connection with audience participants. Research has shown that real life case examples provided by credible sources elicit emotional responses that can have a strong, positive effect on attitudinal change².

Pre and post questionnaires that were administered to participants to evaluate the Canadian Forces' education program appear to support the research findings, with evidence of a notable positive shift occurring in participants' attitudes in relation to the issue of stigma associated with mental illness.

This component of the project consists of:

- Developing a validated methodology to provide peer based mental health education, establishing competency requirements for peer educators, and developing curricula for the delivery of peer based mental health education in workplaces and in schools; and
- Developing and implementing an effective, credible and evidence-based evaluation and validation framework that is viable, and that will further substantiate peer support practices.

Status of project activities

Mental Health Peer Support

Consultation with peer support groups and stakeholders across Canada is taking place this year to take into consideration the broad range of expertise, knowledge and experience of those currently providing peer support services and to profit from lessons learned to implement workplace peer support programs in the most successful way.

² Gardner, H., *Changing Minds: The Art and Science of Changing Our Own Mind and Other People's Minds* Boston, MA: Harvard Business School Press, 2004

A chief concern is to not lose sight of the grass-roots, community based practices that have thus far characterized the success of this type of mental health intervention and to develop a balanced approach to encourage the full acceptance of peer support practices within Canada's mental health care system.

A performance measurement and management framework, formulated upon results-based outcomes is currently being developed in support of this project component.

Mental Health Peer based Education

Workplace – education modules, based on the one developed and used by the Department of National Defence, will be developed and pilot tested as soon as all of the groundwork has been established, as outlined in this project component, above.

Youth in school – Preliminary curriculum content will be developed this year for a pilot project that will initially be trialed with mid-level high school students.

Outcome based performance measures, for the education component, are being developed in full consultation with the MHCC's opening minds initiative to ensure congruence.

Deliverables

Over the course of the next two years the project will deliver the following. A detailed project plan timeline is being developed.

Peer support

- Competency requirements for peer support workers
- Standards of practice for providing peer support
- Training curricula for peer support workers
- A performance measurement and management framework for peer support
- A select core group of trained peer support workers
- Pilot testing of peer support programs in workplaces

Mental health education

- A validated education methodology for education provided by peers
- Curricula for peer based education in workplaces and schools
- Competency requirements for peer educators
- An evaluation and validation framework for effective peer based education
- A select core group of trained peer educators
- Pilot testing of education programs in workplaces and schools

Context

Mental Health Peer Support

The essential difference between mental health peer support and traditional clinical mental health services is that peer support is a de-medicalized (non-clinical) approach to care. According to author Shery Mead:

“Peer support can offer a culture of health and ability as opposed to a culture of ‘illness’ and disability. The primary goal is to responsibly challenge assumptions about mental illnesses and at the same time to validate the individual for who they really are and where they have come from. Peer support attempts to think creatively and non-judgmentally about the way individuals experience and make meaning of their lives in contrast to having all behaviours and feelings diagnosed and labeled.”

Nonetheless, it is fully recognized and acknowledged that peer support is only one method of assisting those suffering from mental health conditions. It is one that is complementary to traditional clinical approaches, and not in competition with them.

Peer support can best be characterized by the fact that people who have like experiences can better relate and consequently offer more authentic empathy and validation. It is also not uncommon for people with similar lived experiences to offer each other pragmatic advice and suggestions that professionals may not be able to offer them. This kind of support reduces isolation, increases treatment compliance and reinforces treatment seeking behaviors, which, in turn, helps to combat the stigma surrounding mental health illness. Maintaining a non-clinical vantage point helps peers rebuild their sense of community and trust as these relationships are built around a deep mutual understanding, in contrast to the relationship between clinician and patient.

For the most part, peer based support activities take place across Canada in clusters and are conducted through a variety of means ranging from one to one support, support groups, social activities, supported employment, recovery education, social enterprises and even advocacy services. Leveraging the lived experience of people who themselves have been affected by mental health problems is the key ingredient to success that underlies all of these means of providing support. However, it is generally recognized that having lived through a mental health condition does not in and of itself qualify someone to provide peer support in a constructive and helpful manner. While many

peer support services and programs offer training there is currently no validated standard of practice for peer support work across Canada, nor have the competencies required for peer support work been well defined. This has likely been a key factor that has impeded its evolution and integration into the mainstream mental health care system, whether it is at the community level or within the workforce as a recovery and return to work enabler.

During initial consultations that have taken place, concern was expressed among some that moving away from the grass-roots values upon which peer support groups were founded, and/or losing the community essence of peer support could be a step in the wrong direction.

As we move forward in developing the function of peer support it is important to understand how occupations develop. In 2006, the President of the National Organization for Competency Assurance in the US, Cynthia Durley wrote:

“Historically, as a new occupation comes into being and evolves, its body of knowledge develops and becomes accepted by the individuals performing that job, by employers, and by customers. The emergence of a defined body of knowledge and a specific vocabulary are important steps in the development and definition of an occupation”.

She further expanded by stating:

“skill sets must be defined, and knowledge and skill sets must be assessed and validated. Credentialing programs perform those functions, helping an occupation mature and become stable. This longstanding process, culminating with the development and acceptance of professional credentials, is especially imperative in occupations in which public protection is of primary importance”.

Annex B

Peer based mental health support services

Context

Mental Health Peer based Education

The inclusion of “peers”, as defined in the main body of the project outline, in the delivery of mental health education is key to establishing credibility and connection with target audiences. Peers are mindful of the culture of the organization or the social group with whom they interact; therefore, within the realm of mental health education they can bring essential cultural knowledge and understanding to both curriculum development and delivery. They are knowledgeable about their work or social environment, having direct experience with the occupational/social stressors that may impact mental health, and are able to use an audience appropriate language. This latter point is especially important. For example, while mental health professionals are prone to use medical language to convey information, this language is not easily understood by laymen/women, thus difficult to relate to by those outside the profession, whether they be employees of large companies or high school students. Peers are able to “de-medicalize” terms in a manner that speaks directly to the audience. This results in “informed consumers.” By conveying mental health knowledge in a language that is understood, people are better able to make informed decisions about their care and seek out the clinical services they require. This leads to a gradual development of early treatment seeking behaviors and increases treatment compliance, all resulting in better treatment outcomes.

There exist a number of initiatives in Canada, the aim of which is to educate members of the workforce about mental illnesses. These initiatives may very well raise awareness about mental health but the degree to which some of these initiatives have resulted in measured, demonstrable attitudinal and behavioural changes towards mental illness and those people suffering from it remains to be determined. A formal evaluation of the educational program named “Joint Speakers Bureau”, which is offered within the Department of National Defence (DND), has shown a notable positive shift occurring in program participants’ attitudes in relation to mental illness. It is believed that the key factor in this success is in fact the inclusion of peers in both curriculum design and delivery of the program.

Peers who have first hand knowledge of living with a mental health illness are able to anchor mental health theory in real life experiences, creating emotional resonance with audiences. Empathy is a mode of understanding that specifically involves emotional resonance. *“The capacity to know emotionally what another is experiencing from within the frame of reference of that other person, the capacity to sample the feelings of*

another or to put one's self in another's shoes."(D.M. Berger)¹ DND's program achieves this emotional resonance through the deliberate disclosure of the mental health condition late in the delivery of the curriculum, after credibility has been well established. In this way, participants are forced to confront their own preconceived attitudes or beliefs about mental illness and are faced with their own stigma.

Achieving emotional attunement greatly serves the cognitive goal of truly being able to understand what it is "to be in someone else's shoes". This has important implications when designing educational strategies aimed at reducing the stigma in society associated with mental illnesses.

The body of research on how attitudes are formed early in life has challenging implications in relation to the issue of stigma and providing mental health education to youth in school, in view of the fact that 18% of those suffering from mental health problems in Canada are aged 15-24, making up the largest affected age group in Canada, yet they are the least likely group to seek help. "Stereotypes, which are based on the categorization process, are learned. Children first acquire a category of a social group and subsequently attribute characteristics to the group (i.e., form a stereotype)." Daniel Bar-Tal, Tel-Aviv University. From Shery Levy & Melanie Killen, Oxford University Press, 2010: "Recent work has highlighted the distinction between two components of stereotype and prejudice. The first component, referred to as implicit attitudes, includes automatic and unconscious beliefs (stereotypes) and affect (prejudice)...Devine (1989) has suggested that adults' implicit attitudes are generally acquired during early childhood" And, from the University of Illinois, Chicago, IL, USA, extracted from *How Children Stigmatize People With Mental Illness* (Corrigan & Watson). "Many advocates have called for more anti-stigma programs targeting the attitudes of children towards people with mental illness as a way to forestall subsequent prejudice and discrimination as they age and develop. In order to better understand how children stigmatize people with mental illness, we reviewed the substantial literature on social cognitive development and ethnic prejudice. Children as young as three show some endorsement of stereotypes about people."

¹ Thompson & McCreary, *Attitudes and Attitude Change: Implications for the OSISS Speakers Bureau Program* (Toronto, ON: Defence Research and Development Canada).

Annex C

Peer based mental health support services

Project Team Members

Lieutenant Colonel Stephane Grenier MSC, CD

Project team leader:

Currently in his 27th year of military service, Stephane is on part time assignment with the MHCC from the Department of National Defence for the purpose of this project. A self declared mental health consumer, he coined the term Operational Stress Injury (OSI) in 2000, founded the Operational Stress Injury Social Support Program in 2001 and the Mental Health & OSI Joint Speakers Bureau in 2007. These national, non-clinical mental health programs leverage the skills and competencies of those who have dealt first hand with mental health disorders, enhancing the mental health care system within the Canadian Forces. The proven success of these peer based initiatives is the foundation upon which he hopes to build as this project evolves.

Professor Rachel Thibeault Ph.D.

Project development, evaluation and research:

Full Professor in the Occupational Therapy Program at the University of Ottawa. Her approach combines occupational therapy, community psychology, community-based rehabilitation, psychosocial care, and issues of meaning, resilience and social justice in health care. She works from a participative perspective that fosters community decision-making at all levels and promotes approaches that build on the principles of sustainable livelihoods, service integration and social inclusion.

Dr Ian Arnold MD, MSc, FRCPC, FCBOM

Project Advisor:

Ian has had many years of experience as an Occupational Health Physician working with both government and industry across Canada. He has developed and implemented EAP systems in industry and has been closely involved with the development and use of internationally recognized management systems in Health, Safety, and Environment. In recognition of this experience and his personal family interest in the field of mental health, Ian was appointed as Chair of the Workforce Advisory Committee of the MHCC in 2008.

Mary Ann Baynton, MSW, RSW

Project Advisor:

A workplace relations specialist, Mary Ann is a consultant for government, businesses, institutions and unions that wish to improve or address organizational and individual workplace mental health issues. She is an advisor to the project within her position as a member of the Workforce Advisory Committee of the Mental Health Commission of Canada.

Julie Ducharme

Project Advisor:

Ms. Ducharme is a teacher and department head in a secondary school. She is providing advice regarding curriculum development and the distribution of an education module on mental health within the high school network.