

SOUTHERN ADELAIDE HEALTH
SERVICE
MENTAL HEALTH DIRECTORATE



Government of South Australia
Southern Adelaide Health Service

Mental Health Peer Supported Hospital-to-Home Project

Report on the pilot period

June - August, 2006

Final

6th September 2006

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Submitted to the
Southern Adelaide Health Service Mental Health Directorate
&
Mental Health Care Improvement Initiative (MHCII)
Department of Health - Mental Health Unit

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1. Introduction

The Mental Health Peer Supported Hospital-to-Home Service is a unique project that uses the skills and experience of people with a lived experience of mental illness and currently living well with that mental illness to provide support to others with mental illness. It arose from lengthy consultation with mental health service consumers from across the SAHS region. They identified the first 2 weeks post discharge from hospital as a critical time when they often feel the most isolated and vulnerable to relapse and when they have the least energy to initiate follow-up with GPs for scripts for ongoing medication; hence when illness relapse are most likely to occur.

This 3-month pilot project is part of the Department of Health/Mental Health Unit's Mental Health Care Improvement Initiative (MHCII), recently developed and launched by the Director of Mental Services SA, to improve mental health services in SA. The project uses the resources of Metropolitan Home Link, in conjunction with existing public mental health peer-based activities in the southern region of Adelaide (Population 364,100). Funding for this service is managed by Aged Care & Housing Group / ACCA (funding to be managed by Home Support Service (HSS) from October 2006), supporting people with their care to avoid a hospital admission or to leave hospital early. This hospital to community bridging aims to reduce frequency of re-admission, particularly for people whose social supports are diminished, who are at risk of leaving hospital with a week's medication and not attending GP appointments, and those consumers who may be waiting for referrals to community mental health services to be actioned.

2. Executive Summary

Each of the project objectives will be responded to as part of summarizing the achievements of the project in its pilot phase:

1. To assess the effectiveness of using peer support workers to provide support to mental health service consumers in the first 1-2 weeks post-discharge from hospital and for hospital avoidance.

Forty-nine packages were delivered by peer support workers during the period 14th June to 31st August, 2006 (11 weeks) equating to 9 packages per fortnight and a total of 310 hours of support with the average 8-hour package costing **\$220**. All referrals were responded to promptly, with all except 1 proceeding once the person went home from hospital (person's choice). In total, 299.75 bed days were saved as a direct result of these packages equating to **\$93,156** saved after project set up, delivery and administration costs of approximately \$19,850.

2. To improve the quality of service and consumer satisfaction with the mental health services in the region.

There was overwhelming satisfaction by consumers with the way service was delivered and the context in which it was delivered. Consumers, their families and other carers, GPs and other service providers were all highly satisfied, saying the peer role specifically gave hope for recovery and greatly assisted consumers' navigation through services. The most prominent outcome of the project was the strengthening of the communication and care between hospital and community services.

3. To deliver a self-management/recovery focused service to consumers at a critical stage for learning and change in the management of their mental health.

Peers worked actively with consumers to enhance their self-management skills. Their presence gave consumers evidence and hope for recovery. Consumers reported a distinct shift

in their view of themselves and people with mental illness with many consumers actively setting goals and achieving them. Only a small proportion of consumers relapsed to hospital either during or after the support period (N= 8). Of these, more than half did so in the context of physical health conditions, many of these which had not been adequately addressed previously.

4. To reduce the re-admission rates to inpatient wards in the SAHS region.

Re-admission rates did reduce for the consumers who received support in this project when compared to their earlier experiences of hospital admission. The sample size and varied rate of referral from the different sites limited our capacity to compare this to overall rates across wards and the region generally.

5. To reduce the number of Assessment & Crisis Intervention Service (ACIS) and Emergency Department (ED) crisis contacts by people who have recently left hospitals within the region.

ACIS and ED contacts were substantially reduced when compared with these consumers' earlier periods of illness and post discharge experience. Peers effectively assisted consumers to avoid these options by providing an alternative and often more appropriate response with holistic emotional support and non-medicalised, non-intrusive support.

6. To provide an opportunity for mental health peers to gain further skills in their role.

All peers reported that this role, and the program support given to assist them, greatly assisted them to develop their skills and understanding of mental illness and systems of care. This not only gave them greater ability to advocate and navigate systems with and for consumers; it enhanced their own recovery and self-management of mental health.

7. To address access and equity issues for people with mental illness seeking the Metro Home Link service and further community supports such as NGOs.

Prior to commencement of this project, Metro Home Link received approximately 120-140 referrals each month from a range of services of which mental health referrals constituted 0 – 20 referrals each month. The peer project has clearly helped to increase this figure with approximately 20 referrals actioned each month. This does not include additional mental health referrals received by Metro Home Link for other types of support associated with accommodation, spring cleaning, and other medical support.

Additionally, Metro Home Link report that the rate of successful engagement and completion of support packages using peer support is higher than for their previous experience of delivering packages to mental health consumers and packages generally. Our response time and ability to match a support worker were also reported to be highly effective and often better than their general experience of providing packages.

Peers actively made several referrals to a diverse range of ongoing community supports as part of their role. There were several examples of highly successful collaboration, co-working and handover to NGOs such as GP Access, BCS and linkage to general community support services, as well as vital linkage to community mental health team staff.

8. To assess the effectiveness of such support in supporting carers.

Carers reported high satisfaction with the peer support workers' input. Families of first episode psychosis consumers were particularly impressed. Hostel managers and staff reported that the peer role provided a much needed and often lacking link for them.

9. To assess the level of acceptance of peer support workers by mental health service systems and GPs.

There has been overwhelming support for the peer project and workers in their interaction with mental health services and GPs. The Hospital-in-Home and Short Stay Unit have particularly found the peer invaluable in supporting their service. The majority of referrals have come from the FMC system. We believe this is due to that setting's prior cultural experience and acceptance of consumer consultants on the inpatient ward.

Referrals from Emergency Departments were less than expected, as were those from Paterson House East / Glenside and Morier / Noarlunga Hospital. The Margaret Tobin Centre move and increased presence of consumer consultants in other settings should improve this situation.

GPs reported and were reported by peers to readily accept the peer role, being very appreciative of the peer supporting the consumer to link with them post-discharge from hospital, a situation that GPs reported is often poor. More generally, feedback from GPs to this project was reported by Metro Home Link to be higher than their usual experience, that is, several GPs took the time to do it.

10. To gain feedback from the broad range of participants about how the service can be improved in order to inform further development and advice to SAHS Mental Health and other mental health services and agencies.

Feedback was received from consumers, peer support workers, carers, GPs, mental health service referrers, inpatient and community mental health service staff generally, and Metro Home Link. The project was overwhelmingly endorsed by all. Consumers and carers particularly expressed that a longer period of support would be useful, especially those families where the person was experiencing first episode psychosis.

11. To influence cultural change within mental health services towards a greater recovery and self-management focus and to further consolidate the role of peers within mental health services generally.

The project is fully supported by the SAHS Mental Health Directorate and has received overwhelming acceptance from mental health service staff in the field. All have recognized the valuable role peers have played in providing a non-clinical recovery-based approach to consumers needs.

Interest in our project has been broad and far reaching to both other metropolitan, regional, interstate and international contacts to the project coordinators. Findings from the project have been reported at the National Outcomes conference in Canberra and will be reported in a 90 minute workshop to the National Mental Health Consumer Network conference in October.

The National Mental Health Advisory Committee which reports to the Health Workforce Principal Committee that reports to the Australian Health Ministers' Advisory Council that informs the Australian Health Ministers Conference has requested a presentation on the project, having heard about our great results so far. Good news travels fast.

3. Context for Peer Services

The phenomenon of cyclic hospital re-admission of people with serious psychiatric illness is well identified internationally in the literature. Up to half of people receiving services in psychiatric hospitals are re-hospitalised within twelve months (Klinkenberg and Calsyn, 1996). A growing body of international research identifies lack of community support (Davidson et al, 1999), rather than a person's symptomatology, as a factor in re-admission. Of critical relevance, the first 3 days post discharge from hospital has been identified by international studies to be the greatest risk period for suicide for people with mental illness, particularly for those experiencing their first admission. Hence support that is appropriate and engaging at this time is crucial.

Our local experience has been that people with mental illness relapse and are re-admitted to hospital in part because post transfer and return to the community, their subsequent social and clinical supports, such as social networks and GP contacts, do not occur, or happen later than planned or advised. This places them at risk of inadequate monitoring of, and access to, medications and other supportive treatments, hence illness episodes recur leading to re-admission to hospital. Likewise, people with mental illness who present to Emergency Departments often do so because of a lack of support or of timely support in the community, not necessarily because they require admission, but because no other appropriate support is available to them in the community. This includes the period of waiting for referrals to community teams to be actioned. Likewise, Metro Home Link has clearly identified several problems with providing support to people with mental illness who have been referred to them for post-hospital support. This includes the low number of referrals, engagement issues with mainstream support workers who have limited understanding of mental illness, and lack of skills and confidence of support workers in many of the agencies that provide Metro Home Link with brokered services.

A recent audit of one of the inpatient wards within our service estimated that approximately 30% of consumers were readmitted within 3 months of discharge, largely due to lack of community supports, lack of or poor discharge planning and linkage GPs post discharge, and problems with compliance and adherence with treatment post discharge. A further survey of 298 community clients in our regional locations revealed that 51% lived alone, many of these with little to no family contact and with few community supports or contacts other than the mental health service (Lawn, 2006). This suggests that linkage and follow-up support are currently not meeting the needs of consumers.

Peer workers are integral to a recovery orientated mental health service, acting as positive role models for both recipients of mental health services and staff. They have the expertise of having experienced a mental illness and recovering, and have a heightened capacity for empathy and developing relationships with other consumers because of that experience (Fox and Hilton 1994). Evidence from research studies suggest that consumer providers are as effective as non-consumer delivered services, and when partnered with non-consumer providers actually produce better outcomes (Paulson et al, 1999; Solomon & Draine, 1995; Felton, Stasny, Shern et al 1995; Edmondson, Bedell & Gordon 1984; Klein, Cnaan & Whitecraft 1998).

Peer support in mental health grew out of the civil/human rights movement. In mental health the shared experience has had more to do with negative experiences of and responses to treatment and services than the shared experience of mental illness (Mead and MacNeil 2004, p.4). Helen Glover, a leader in international recovery-based practice, states that she recovered "in spite of and despite access to services" (Glover, 2005, p.1).

The language of mental health services has traditionally kept consumers "stuck" in power structures that have imposed a narrow meaning on their words and conversations, whereas peer language has a richness of conversation that goes beyond the limited language relating to the

medical model of illness (Mead & MacNeil, 2004). Peer workers work within the recovery model, which focuses on hope and experiencing a life of quality. Under the medical model consumers are burdened with a medical interpretation of their experience and the viewpoint of what is wrong with the consumer rather than what is wrong with the situation (Mead & MacNeil, 2004 p.7). Glover refers to this as relating to the person through the 'It' rather than the 'Me' (Glover, 2005), a situation that encourages consumers to be passive recipients rather than partners in their care, expecting the permanency of disability, and with little hope of change. Having peers in the mental health system therefore adds a source of accountability and can help maintain the shift of focus towards a recovery approach to services.

Ashcraft et al. (2006) identify mutuality as the major defining factor of peer support, in which peers partner with consumers as co-learners to assist them to discover their own strengths and skills inspiring them to become active participants in their own lives. The peer role also gives the peer worker the opportunity to facilitate the recovery of others, and to give back to others the support they received. In all studies of peer support, this is reported to be particularly rewarding and facilitates peer workers' own recovery. Peer work increases their sense of interpersonal competence associated with having an impact on another's life and gaining new, personally relevant knowledge through the helping process (Salzer and Shear, 2002).

Finally, one of our directors, when quizzed by an inpatient nurse who was skeptical of allowing peers to provide support to other consumers, stated that the project arose "Because it's a damned good idea".

4. Objectives:

1. To assess the effectiveness of using peer support workers to provide support to mental health service consumers in the first 1-2 weeks post-discharge from hospital and for hospital avoidance.
2. To improve the quality of service and consumer satisfaction with the mental health services in the region.
3. To deliver a self-management/recovery focused service to consumers at a critical stage for learning and change in the management of their mental health.
4. To reduce the re-admission rates to inpatient wards in the SAHS region.
5. To reduce the number of Assessment & Crisis Intervention Service (ACIS) and Emergency Department (ED) crisis contacts by people who have recently left hospitals within the region.
6. To provide an opportunity for mental health peers to gain further skills in their role and to further consolidate the role of peers within mental health services generally.
7. To address access and equity issues for people with mental illness seeking the Metro Home Link service and further community supports such as NGOs.

Further Objectives:

8. To assess the effectiveness of such support in supporting carers
9. To assess the level of acceptance of peer support workers by mental health service systems and GPs.
10. To gain feedback from the broad range of participants about how the service can be improved in order to inform further development and advice to SAHS Mental Health and other mental health services and agencies.
11. To influence cultural change within mental health services towards a greater recovery and self-management focus and to further consolidate the role of peers within mental health services generally.

5. Methodology

The Service in Practice:

Through a statewide call centre, referrals are made by staff from inpatient wards, emergency departments, short-stay units and Hospital-in-Home services, following consumer consent, as part of discharge planning. The project coordinator receives faxed referrals, which are then matched to one of 10 paid peer support workers who all have:

- Prior experience of providing support to others,
- Undertaken training in support work (TAFE or higher),
- Experienced hospital admissions, an understanding of the system, and living well with their own condition, and
- A clear understanding of client confidentiality, OHS, medical and police clearance and licence checks as per standard employee procedures.

Packages of support of 8-12 hours in total are organised for a 1- 2 week period. Fully trained and supported mental health peers meet with consenting consumers prior to discharge and offer mutually agreed on practical social support in the first 2 weeks after leaving hospital. Alternatively, hospital avoidance packages of 1 week duration can be offered where consumers are at risk of needing admission. This support consists of phone calls, home visits and accompanying the person to GP and other mutually agreed on appointments and activities. The peer support worker is closely monitored and supported by the project coordinator and peer coordinator, who provide ongoing debrief, supervision support and additional training options as required. Likewise, peers offer mentored support to each other as an ongoing part of the project and 'Buddy' support to peer volunteers interested in becoming support workers. Four buddies have been involved in the project, gaining valuable experience and providing them with learning opportunities to become support workers in future. Peers are paid from Metro Home Link funds and are deemed casual employees of SAHS Mental Health with all entitlements and processes that other casual employees of the service receive.

Criteria for Referral/Access to this Service:

- a consumer of mental health services living in the SAHS region,
- consent for service,
- significant social isolation with limited community supports,
- satisfactory completion of risk assessment identifying safety for peer home visiting,
- support facilitates early discharge and/or avoids hospital re-admission, and
- the person does not have a current community case manager (negotiable).

Support packages consist of 8-12 hours of support over a 2-week period, commencing prior to discharge with linkage occurring within 24 hours of referral. Hospital avoidance packages comprise similar levels of support over a 7 day period. The support includes:

- Pre-discharge link to engage and negotiate discharge plan with the person and inpatient staff
- Transportation home from hospital
- Support phone calls
- Support home visits
- Accompanying people to the GP/chemist
- Shopping to 'fill the cupboards' again, bill paying
- Other mutually agreed on appointments and activities
- Linkage with community supports and liaison with key services and supports

Evaluation Methodology

The evaluation of this project covers referrals received during the pilot period from June 14th to August 31st 2006. Qualitative feedback was sought from all participant groups including:

- Consumers referred to the project
- Carers of these consumers
- Peer support workers
- Mental Health Service staff
- GPs
- Project Coordinator
- Peer Coordinator
- Metro Home Link staff

The following consumer qualitative and quantitative evaluation methods are summarised as follows:

- The experience of receiving support generally and support specifically from a peer worker and how this has impacted on their mental health post discharge.
- Statistics on readmission rates/ED presentations/ACIS contacts for consumers receiving peer support post discharge compared
- Statistics on readmission rates/ED presentations/ACIS contacts for consumers receiving peer support post discharge compared to their own experience following earlier admissions (ie. Using themselves as their own controls).

For Peer Support Worker, the following qualitative data collection methods are being used:

- Qualitative report by peer support workers throughout the period
- Peer worker reflections via journaling during the project period
- Individual indepth interviews
- Peer worker focus group at the end of the project
- Issues identified from peer debriefs and peer group meetings

The following questions guided interviews and focus groups with peer support workers:

- Their thoughts on the support they have provided and whether they thought it was beneficial to consumers
- What they have thought about providing support from a peer support worker perspective
- Whether they have experienced any particular challenges or problems in undertaking this support role
- Any changes that they consider would be important for us to implement to improve this service
- How this role has impacted on their own health and wellbeing

Mental Health Service were asked the following feedback questions:

- Thoughts on the support provided and whether they thought it was beneficial to consumers
- Their views on the use of peers in this support role
- Any changes that they consider would be important for us to implement to improve this service
- How the peer support service has impacted on their role, service and work with consumers

GPs were asked for their brief writing feedback to similar questions as staff participants.

6. Results

Demographics of referrals

Forty-nine support packages were delivered by peer support workers during the period 14th June to 31st August, 2006 (11 weeks) equating to 9 packages per fortnight. Of these, 41 were discharge support packages and 8 were hospital avoidance packages. Several of the discharge support packages involved active hospital avoidance. All referrals were responded to promptly, with all except 1 proceeding once the person went home from hospital (person's choice). Ongoing support was arranged with a full range of agencies, including 8 referrals made to GP Access and 3 to BCS.

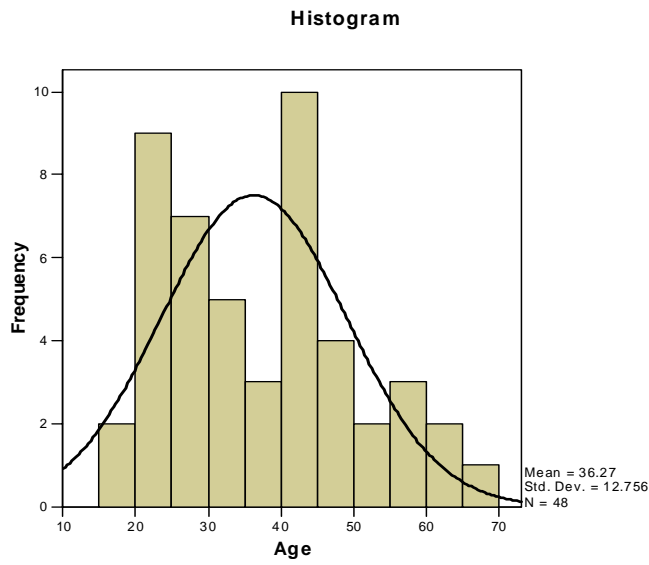
Approximately three quarters of referrals were for females. This may be due to gender differences in views of accepting support and referrer bias towards females patients.

Gender		Frequency	Percent
Valid	male	13	26.5
	female	36	73.5
Total		49	100.0

The average age of consumers receiving support was 36, ranging in age from 18 to 66 years. Of note, more than a quarter of consumers were in the 18-25 yr age bracket.

N	Valid	48
	Missing	1
Mean		36.27
Median		36.50
Mode		41
Range		48
Minimum		18
Maximum		66

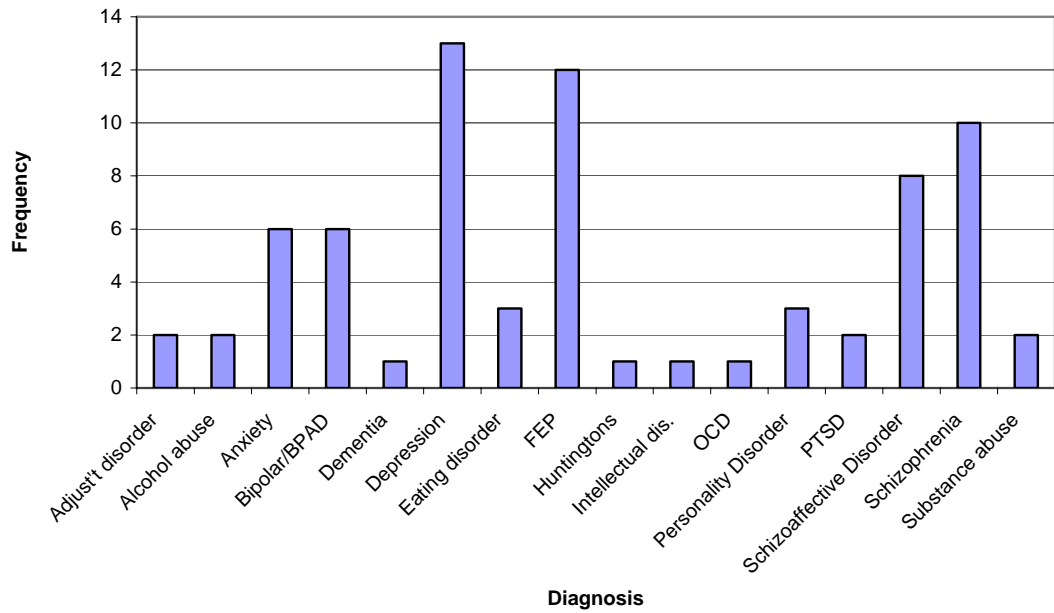
		Frequency	Percent
Valid	18-25yrs	13	26.5
	26-30yrs	8	16.3
	31-35yrs	2	4.1
	36-40yrs	6	12.2
	41-45yrs	8	16.3
	46-50yrs	3	6.1
	51-55yrs	4	8.2
	56-60yrs	2	4.1
	61+yrs	2	4.1
	Total	48	98.0
Missing	System	1	2.0
Total		49	100.0



A full range of sites made referrals, although the majority of these came from the FMC site which contributed 54.8% of referrals overall. Paterson House East contributed 18.4% and the Noarlunga Health Services contributed 12.2%. These differences may be due to the 2 latter settings not being as familiar with consumer roles and therefore more reluctant or knowledgeable about peer capacity.

Referrer Location		Frequency	Percent
Valid	4G FMC	11	22.4
	FMC HinH	4	8.2
	FMC (medical)	2	4.0
	FMC EECU	1	2.0
	Short stay FMC	9	18.4
	FMC ED	2	4.1
	Self	5	10.2
	PHE Glenside	9	18.4
	Noarlunga ED	1	2.0
	Adaire Community	1	2.0
	Morier	4	8.2
	Noarlunga	4	8.2
	Total	49	100.0

Consumers experienced a full array of mental illnesses, with 36 people having a psychotic illness (BPAD, FEP, Schizoaffective, Schizophrenia) and several consumers experiencing more than one illness either as a primary or secondary diagnosis.

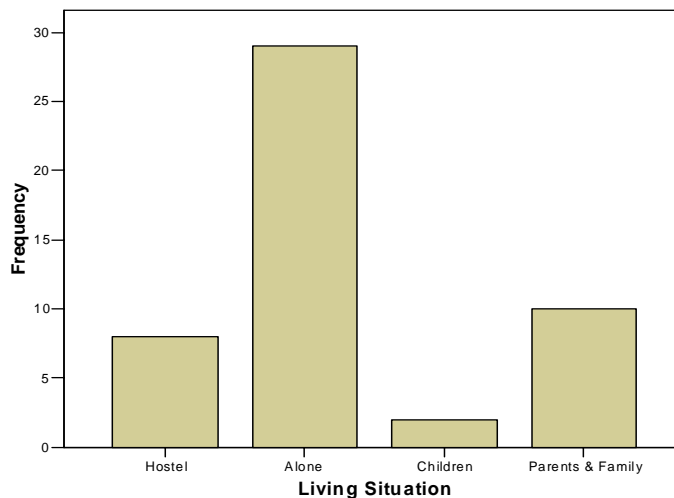


The majority of consumers lived alone with few other supports. Two consumers also had the burden of caring for children on their own. All consumers living in hostels were new to that setting upon discharge from hospital and receiving peer support.

Living Situation

		Frequency	Percent
Valid	Hostel	8	16.3
	Alone	29	59.2
	Children	2	4.1
	Parents & Family	10	20.4
	Total	49	100.0

Living Situation



Quantitative Results

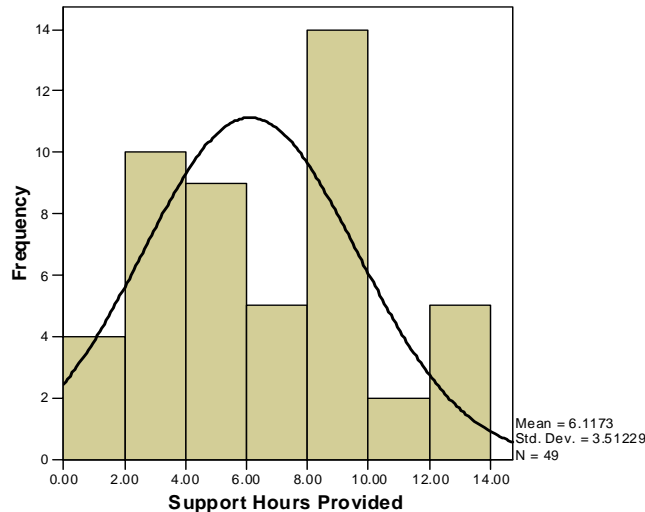
Bed Days Saved, Readmissions, ED & ACIS Use

Bed days saved for each referral was determined by asking the referrer and the consumer to estimate this. In total, **299.75 bed days** were saved as a direct result of these packages. This figure does not reflect the additional days saved for one consumer who had recently been placed on a 6-month guardianship order and had been awaiting transfer to extended care inpatient services just prior to referral to our service. Our conservative estimate of bed days saved for this consumer was 14 days, where in fact it was several weeks (see first scenario below).

Support Hours Saved

N	Valid	49
	Missing	0
Mean		6.1173
Median		6.0000
Mode		8.00
Std. Deviation		3.51229
Range		14.00
Minimum		.00
Maximum		14.00
Sum		299.75

Histogram



Calculating the cost of bed days at \$377 per day and the days saved as 299.75, the project saved **\$113,006** before costs. Overall, monetary savings to the system equated to more than **\$93,156** after project set up, delivery and administration costs of approximately \$19,850 were deducted (see budget below). A total of 310 hours of support was provided over the 11 week period. Length of support packages varied with the most frequent length being for 8 hours of support (n=12) representing 25.5%. Cumulatively, 83% of consumers required 8 hours or less support whereas 17% of consumers required more than 8 hours of support. The average cost of an 8 hour package delivered by a peer support worker was approx. **\$220** (8 hours + reimbursement for 80km travel).

Support Hours Provided	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	1	2.0	2.1	2.1
.50	1	2.0	2.1	4.3
1.00	2	4.1	4.3	8.5
2.00	6	12.2	12.8	21.3
2.50	1	2.0	2.1	23.4
3.50	3	6.1	6.4	29.8
4.00	2	4.1	4.3	34.0
4.50	1	2.0	2.1	36.2
5.00	4	8.2	8.5	44.7
5.50	1	2.0	2.1	46.8
6.00	3	6.1	6.4	53.2
6.50	2	4.1	4.3	57.4
8.00	12	24.5	25.5	83.0
8.25	1	2.0	2.1	85.1
9.50	1	2.0	2.1	87.2
10.00	1	2.0	2.1	89.4
11.00	1	2.0	2.1	91.5
12.00	1	2.0	2.1	93.6
12.50	1	2.0	2.1	95.7
13.00	1	2.0	2.1	97.9
14.00	1	2.0	2.1	100.0
Total	#47	95.9	100.0	
Total Hours	293			

(missing values of 12 and 5 hours, not reflected in above table.)

CBIS information was used to determine each person's path through the system and to confirm rates of ACIS contact and readmission. Close communication with referrers, peer worker knowledge of ED contact as part of their contact with consumers, and consumer consultant and coordinator contact with inpatient settings elicited rates of ED contact, given this is not recorded on CBIS.

Only a small proportion of consumers relapsed to hospital either during or directly after the support period since commencement of the project (N= 8). Of these:

- Four did so in the context of physical health conditions which had not been adequately addressed during the previous admission or which arose after discharge.
- One of the readmissions was for the consumer who had elected not to take up peer support once home.
- Two of the readmissions were brief and for consumers who had highly complicated conditions and circumstances that should have precluded them from meeting criteria for referral to the peer project in the first instance, a situation that only became apparent after their first discharge. The peer support worker in these instances did superbly and went on to successfully provide further discharge and hospital avoidance to these 2 consumers, which has been maintained.
- The final readmission was for a consumer who required readmission in order to commence ECT, as determined by her doctor, after which avoidance packages using peer support were initiated for all further ECT treatments.

Of note, when tracking the admission history over the past 2 years of CBIS recording, one of these consumers' usual patterns of service use in the past has been:

- 6 admissions in 2006, 2 of these being several weeks long, with 4-5 admissions in rapid succession (revolving door).
- 6 admissions in 2005, 2 of these being several weeks long
- Brief admission in late July, 2006 with peer support in place for hospital avoidance following earlier discharge package, with no admissions or ED/ACIS contact since that time (see scenario 1).

Two other consumers also demonstrated improvement in this pattern to a lesser degree, one of these having 3 admissions earlier this year of 1 month duration each, with a recent brief admission once peer support was in place and no further admission since late July 2006, and the other remaining stable for the past 6 weeks following an extremely chaotic period of illness and attempts to stabilize their mental health.

In general, the short time frame of the project pilot period and therefore the inability to draw on future data on relapse at this point means that further quantitative data on readmission rates is premature. The nature of mental illness as episodic also means that many mental health consumers are likely only to have one admission during the life of their contact with services and therefore it is not valid to compare admission experience quantitatively. Their qualitative report of how this experience of discharge compared to prior experiences of discharge is more meaningful. Also, the small sample size and varied rate of referral from the different sites in comparison to the overall volume of discharges from the sites limited our capacity to compare the impact of this as part of overall rates across wards and the region generally.

ACIS and ED contacts were substantially reduced when compared with these consumers' earlier periods of illness and post discharge experience. Only the 8 consumers who had readmissions also had further ED contact and this was in the context of that admission for each of these consumers, except for 2. These 2 consumers, as mentioned earlier, were high risk consumers who in reality were beyond the criteria for the project's initial mandate. They attended the ED for assessment with their peer support worker and a successful plan of hospital avoidance was negotiated with the consumer, peer and ED staff. They have not had any further ED/ACIS contact or admissions. Peers effectively assisted consumers to avoid these options by providing an alternative and often more appropriate response with holistic emotional support and non-medicalised, non-intrusive support. Three consumers in particular had been heavy users of ACIS and ED prior to the project input. They have not contacted ACIS since receiving support from the project; nor have they required admission. One of these consumers has attended ED much less frequently since receiving peer input to link him to community supports (once in the last 14 days), as reported by ED staff who state that he would often 'pop in' 3-4 times a week or visit the ward for companionship (see scenario 2).

All other consumers made no further ED or ACIS contact following receipt of peer support. A Case note audit of the frequency of their past admissions and ACIS/ED contacts prior to CBIS commencing is pending.

Qualitative Results

Preliminary qualitative feedback has been highly positive from all participant groups, as reflected by the following examples of comments that reflect the dominant ideas from all participants. Further qualitative results appear in the appendix as a series of scenarios of individual consumer journeys to demonstrate the depth of the peer contribution.

Consumers:

All recipients of this service were contacted by the coordinators via phone at the completion of the support package period. All except one, the person who didn't follow through with support once discharged, gave feedback. Their comments reflect several important themes including:

- The importance of someone who understands, reassures, and is credible because of their lived experience of mental illness.
- The vast improvement in the discharge experience this time compared with earlier admissions.
- The improved continuum of care created by the peer support process, often filling holes in the system.
- Peers as positive role models of recovery for consumers and staff.
- The strength of linkage with community supports by 'walking with the person', this being particularly important for people with mental illness.

"I've found your support far less invasive...not firing questions at me when I already felt overwhelmed."

"I haven't had a drink for a whole month and that's never happened before. The peer has given me ways to cope with my anxiety that I wasn't aware of before."

"Meeting a recovered person with a mental illness made me feel normal and not different."

"Helping to provide transport in the first 2 weeks was really useful, especially until I got my confidence back."

"The last time when I went home from hospital, I had no-one. I got confused and overwhelmed and paranoid and ended up back in hospital within a few days. This time was completely different."

"I could talk about things that I felt I didn't feel comfortable talking about with a health professional. The peer worker helped me to like myself better and understand myself more, to believe in my own potential more and to achieve my goals....She helped me to get back into society which I was scared of doing on my own. She gave me someone to talk to about my issues and a reality check."

"It helped me to get home early. The peer worker understood my situation and was always on time and easy to talk to and reassuring. The service was great."

"It relieved my anxiety about going home to an empty house...I was in control and directed all decision making in relation to my care plan."

"If in the future I required hospitalization, I would use this service if offered and I would highly recommend it to others."

"They kept me calm, understood what I was talking about and made me feel safe and secure. They could see the funny side of things and shared a laugh...the best thing in the world and a necessary service."

"I was able to be discharge several months early. The peer worker settled me at home. I felt comfortable talking through issues with them. They encouraged me and showed me my true potential. A brilliant service."

"The peer worker assisted me with new accommodation so I was discharged several weeks early. It felt easier knowing that they had a mental illness."

“It’s the best service in the world. Knowing I can have a hospital avoidance package if I need support is reassuring; knowing there is someone out there in a non-clinical service.”

“The peer helped me to organize myself and my thoughts and gave me lots of ideas for keeping well.”

“I would like to become a peer worker in the future.”

Carers:

Peers providing support to consumers negotiated consent for the coordinators to make phone contact with carers to elicit feedback. Six of the seven available family carers responded. All hostel managers responded.

“Meeting a young person similar in age to our son with the same illness has given us hope for our son in what has been a devastating time for us. The information and support he gave to us all has been invaluable...It would be great to more time.”

“He helped our son get out and about again.”

“If it hadn’t been for the peer support workers and their coordinators, we would not have known anything about this man’s needs when he arrived at the hostel. We had no details about his medication or any plan from the inpatient staff. The peers really understood what was needed.”

“Knowing that someone was there to support my daughter once she went home gave me peace of mind during a very stressful time in our lives.”

“I live interstate and cannot always give the hands-on support needed for my daughter. The peer worker reassured us all.”

“This support has been extremely helpful to me personally, given that I have another family member also unwell in hospital at present. Someone, my son’s age and with a mental illness, has given him hope for getting better.”

“If it hadn’t been for the peer support program, we wouldn’t have known much at all about this person when he arrived at the hostel. He came to us with no information and only 2 days medication and no English. He was just dumped here. When he was starting to get agitated with another resident, we called and the peer responded the same day and he’s now settled again. A brilliant service, especially given the community team hasn’t picked him up yet either.”

“We didn’t know who to contact because the hospital didn’t refer him to a community team. He arrived here with no information about his depot. Luckily the peer was able to relay our needs to the inpatient doctor and fix what was a pretty sloppy handover process to us.”

Referrers and other staff:

The coordinator contacted all referring staff via email requesting their feedback and also spoke with staff generally during the period of the project. All responded.

“The response time was excellent. It definitely facilitates early discharge...Knowing the support is there is very helpful. It was accessible, easy, quick and no hassle in doing the referral.”

“I had initial concerns about stressing the peer with consumers who are demanding and sometimes manipulative. Our consumers (PHE) are different to 4G ones.”

“I believe the warmth and understanding that peers have portrayed to consumers is invaluable in building rapport. It eases the patients’ anxiety at discharge which is demonstrated by the trusting atmosphere established between the patient and the peer support worker.”

“To enable a patient at discharge to have the support of a person who has personal experience of the stresses this can create, and support the patient during this time is invaluable. It eases the load of community mental health workers, who often cannot respond to the request for support for some time due to their excessive case loads. It eases the anxiety of staff who are concerned about the patient’s ability to cope after an acute episode and often only partial recovery. It is well known amongst mental health service staff that the first week or two after discharge is the critical period for patients, and before the peer support program this support was often difficult to obtain, and without this support can be the trigger to relapse and readmission to acute care in hospital.”

“The peer support program makes an important and highly appropriate contribution to enabling patient to adjust to life after discharge.”

“The program coordinators were highly accessible. Being able to refer on weekends was very important. They often filled communication gaps between us and the community.”

“As a community mental health key worker I found this program exceptional in its ability to help the flow of information and consumer care between us and the inpatient ward.”

“I guess sometimes hearing nothing means everything is going well because you always hear the complaints. There has been total acceptance of this service in my estimation, but not all consumers would be considered appropriate for referral. People with no insight and not accepting of services generally have not been considered by us as referrals to this program.”

“This lady was completely stuck prior to meeting the peer. I thought she’d be here for several weeks and now here she is on her way home...she had no insight and didn’t want to engage with us or her treatment. Talking with peer workers has altered my view of the whole process of how we see the patient. It’s astounding the difference it makes.”

“Our clients are staying longer in hospital and it would be helpful if the peers had more allocated time so that they could be introduced to the client sooner and follow them up for longer upon discharge.”

“I feel some clients feel more at ease to confide with the peer support worker, as they view them as peers. Some also feel less threatened or challenged, sharing similar life experiences with them. In some instances, our Hospital-in-Home client contact has been reduced, which has been beneficial to both parties. I feel both services compliment each other and work well together and that our roles don’t overlap.”

“I’ve found my interaction with the peers has been nothing less than beneficial, professional and a positive inclusion to our service.”

“I found the peers were more holistic and recovery-based, not just a brief medical focus.”

GPs:

A request for feedback was made to each GP as part of faxing them the consumer’s discharge summary at the completion of the support period. Eight GPs took the time to fax back written feedback.

“The peer worker has provided a valuable link. Often we are kept out of the communication loop, especially when they first go home, with dire consequences for patient care. This is a quality service.”

“I thought the peer support was very beneficial for this very difficult and dependent patient. The peer could help the person be accountable for their decisions in a way that had a credibility that a doctor could not give.”

“An essential service.”

“It was very beneficial and helped her cope with those initial days at home.”

“It allowed me to concentrate more on the patient’s medical needs and saved me time.”

“It was very helpful, especially as I am only a part-time GP and not available every day.”

“This was one of the few times that I felt there was good communication with mental health services in letting me know what was happening for my patient.”

“The peer helped me to understand more about my patient’s needs and how the symptoms of their schizophrenia affect them personally. This was new knowledge to me.”

Metro Home Link:

A focus group was conducted with the Metro Home Link South Team during which the following points were made:

- Compared to other referrals to the Metro Home Link service, the peers have been generally more prompt with pick-up of referrals and more successful with providing the required support to this population.
- The initial contact with patients while they are still in the ward has been an additional benefit that is often absent and not possible with other packages provided by MHL.
- The communication with the peer project coordinator has been of great value, clearly linking well with existing MHL processes and procedures, as if they were part of the one team.
- The ability of the peer project to gain GP feedback for evaluation has been more than MHL’s usual experience, as has been the response from recipients of MHL packages generally.

Peers:

Comments from all peers were drawn from individual interviews, comments made during group debriefing meetings and from comments made as part of ongoing communication with the coordinators. Several general areas are covered:

The personal impact

“I’ve found a new confidence in myself. It’s wonderful. I feel valued as a person for the first time in years.”

“It’s been a big learning curve...I learnt that I have to learn to know my boundaries better.”

“It was quite a learning process for me of the subtleties and challenges of MHS delivery; the things you can’t read in books...There’s not a person that I haven’t learned from or enjoyed working with.”

“It was good to be able to give something back, rather than just passively receive services.”

“It helped solidify my own recovery and strategies and focus on the strengths I’ve got that I can now share with others. I’m more emotionally connected with myself now...With each person, I’ve learnt more about myself and I manage my overall health better. I’m much more confident.”

“I had some goals to prove to myself, but also to give back...It has given me more insight in the MHS and a new appreciation of the workers, especially in the community; it’s a hard role...I realized I can’t save everyone.”

“I have received a newfound respect from my family and feel much closer to them. They’re asking me for advice which wouldn’t have happened before.”

“I feel better in myself and am drawing from my own recovery and experience, though record keeping is a new challenge...I’ve enjoyed the advocacy the most and helping consumers get access to services.”

The value of the peer role

“We had a shared understanding that was non-clinical and more relevant to where she was at with needing real practical help. The peer doesn’t have the boundaries of the professional staff.”

“There’s an increased feeling of safety for the person because we have less power to take away their rights; we’re less controlling and intrusive.”

“It was reassuring to her that I was someone working with a mental illness and being open with it. It gave her a sense of hope that she could return to work without being victimized.”

“I would make sure I gave her options and choice and with that responsibility.”

“To see someone go from very very ill to her deciding to let go and take control and it was at her pace. She took what she needed.”

“It’s a very short time, given the needs of the person and because of holes in the system...We could have achieved more if we had more time, for example, 4-6 weeks.”

“When I was with this person in the ED and it was clear that the medical person had no idea what they were doing, my capacity to help the person be understood and advocate for them and clarify what they were feeling was obvious.”

Response from MHS staff

“I think some of them find it threatening. It’s like you have people without academic qualifications coming in and doing work that they’d like to perhaps be able to do but the system is not set up that was. It’s almost like a jealousy.”

“For some staff, their only way to deal with the frustration, anger and jealousy in their role is not to co-operate. I think they resent our freedom and our capacity and our access to management and that we can have a say and they don’t like that.”

“The issue of reliance on the social worker to make referrals is huge. When they are off sick, referrals have tended to come to a grinding halt. Doctors and nurses need to be encourage to believe that it is also a role for them.”

“We can’t just sit back and think it’s going to happen on its own. We need to actively promote the role, often.”

“It was an odd feeling standing outside the glass nurses station and remembering being a patient there. The staff treated me well in my new role.”

“The social work staff were wonderful in communicating and arranging appointments, as well as the Hospital-in-Home staff and MACS. I felt part of the team. It was a real collaborative effort. I definitely perceived that more senior staff on the ward are not as keen though, given me past experience as a patient there.”

“The mindset of one staff member was definitely paternalistic; a non-recovery view...it’s a challenge generally for some inpatient staff who have little or no experience of community

“...the doctor was clearly feeling that we shouldn’t have been there supporting this young man, even though this meeting had been clearly planned and our presence requested by the consumer beforehand. The doctor turned around and suggested that my peer colleague wasn’t looking too good. It was demoralizing for us and the consumer was said he was very upset by the doctor’s behaviour.”

Interaction with other peers

“Excellent. It removes that feeling that you’re out there on your own. There’s a camaraderie.”

“It’s a good way to learn by hearing about what others are doing to support consumers and to problem-solve together.”

“We’re a close-knit group who support and mentor each other.”

Feedback about the coordination role

“The project wouldn’t have got off the ground without the structure and support, especially in the learning phase. It’s a very new concept. The MH coordinator acted as a buffer, mediating between the peers and mental health service providing advocacy, debrief and support. This service could evolve into a consumer-run service but initially needed to be by a worker who know the system, could pave the way and make it easier for us.”

“She was always calm and accessible and had the serenity of holding it all together. The unflappability is appreciated to keep everything in control and perspective.”

“The MHS is a chaotic system by its nature and you need a service that is calm and running smoothly. We had this, thanks to the coordinator.”

“I have felt well-supported, able to contact them at any time. We’ve had time to sit back and talk and problem-solve. I consider them my mentor.”

“They are very engaging and easy to talk to. I feel I can discuss anything.”

7. Budget

The project delivery costs closely matched the predicted budget of \$19,795 allowed for in the original application to the MHCII. The goods and services costs are an estimate given these have not been finalised for August at the time of report.

SALARIES (If applicable)		\$	\$
	Salary Cost	On costs	Sub-totals cost
Project Manager PSO3 Level 1 (0.4 fte for 4 months)	9450	1890	11340
Peer Coordinator OPS2 Level 2	1046	208	1254
Performance of peer support duties (OPS2, level 1)			5256
Sub-total salaries			17850
GOODS AND SERVICES		\$	\$
<ul style="list-style-type: none"> • Attendance at training and debriefing, meetings • Phone, travel & other reimbursement 			1000
			1000
Sub-total goods and services			2000
PROGRAM SUBTOTAL			
GST			
PROGRAM TOTAL			\$19,850

8. Conclusions

Peer workers within this project have been well received by the overwhelming majority of staff. However, the project coordinators have needed to work diligently and persistently with services promoting the project and encouraging staff in some settings to make referrals. A number of structural aspects of acute service delivery and design have contributed to this. With many of these, it is a case of 'Old habits die hard'. The temporal focus of inpatient staff on the immediate and what is known to them, reliance on social workers to make referrals, and their general lack of focus on the longer-term community needs of consumers, has meant that they do not necessarily have peer support input as an option in their field of view. If we add to this the existence of fragmented communication and roles within teams, a silo view of service delivery & discharge, lack of planned or coordinated care, fragmented discharge processes generally, and pressures on day-to-day inpatient settings (the 'Arthur or Martha' problem!), the addition of another new aspect of service has required much persistence to build a structure within what is essentially a very fragmented service model. We believe that this situation will improve as this and other SAHS Mental Health initiatives develop towards greater coordination of care across the services.

The emergence of the peer role has challenged and tested the core value systems of service staff generally. This has created confusion more so than outright opposition in some staff, making them reflect on their practice at a level that is deeper than their usual level of comfort. Management and the vast majority of staff have been fully supportive of the project. In essence, the presence of peers has encouraged staff to not only say that they work in a recovery-based, client-centred way, but to put it into practice. The project coordinator is aware of only 2 staff who have been less than supportive. Further efforts by mental health services to move towards recovery-based practice generally, should support the further integration of the peer role. We see these processes of adjustment as a positive part of what Helen Glover (2005) calls the 'tension' necessary to progress with cultural change. In this sense, the peers in this project have been autonomous and independent and clear in their role, rather than becoming enculturated into the service. They have successfully worked with mental health services, but not as a dependent agent of services as the international movement warns against, but which often occurs with a paternalistic approach to the use of peer input.

Where this project has been particularly useful, and differs from the delivery of other Metro Home Link packages, is that the peer support worker has been able to link with the consumer prior to discharge, enhancing engagement and discharge planning for all concerned. In addition to this the existing consumer consultant presence in 4G and their direct access to consumers has promoted a 'PULL' process into the community.

Peer support workers have been important role models of recovery and hope for consumers, carers and mental health service staff. The Mental Health Peer Supported Hospital-to-Home Service has been borne out of consumer driven needs and wishes, mirroring a truly community development focus. Practical implementation has been a case of 'Create the field and they will come', rather than driven by service providers alone. Initial results have been extremely positive qualitatively and monetarily. The impact on improving service culture is 'Priceless'.

9. Recommendations

- Continuation of the Peer Supported Hospital-to-Home Service to providing discharge and hospital avoidance packages for consumers with mental illness, pending the support of the new funding body Home Support Services (HSS) to keep this service intact according to current arrangements and current peer numbers (n=8). This would involve:
 - Providing greater certainty and security of employment for the peer coordinator and peer support workers by setting a minimum contract period of no less than 6 months, preferably 12 months. We are at risk of losing these skilled peers to other positions, this having already occurred with 3 peers gaining 12-month positions with CNAHS as peer specialists in inpatient wards in that region.
 - Further development of the peer coordination role for this service and for SAHS mental health generally. We recommend the position be 0.6fte spread across 5 days given the nature of the service, with weekend phone contact/liaison with support workers and referrers likely and expected as part of the role with a classification of OPS3 level 1.
 - The position could build to 0.8 – 1.0fte to allow this person to have input to more general peer initiatives in a coordinating capacity similar to the existing CNAHS Peer Coordinator who is 0.8fte, or be a shared position, given peer consumers' own mental health needs. We have done this sharing of role in the early stages of our project with success.
 - The presence of a mental health service clinician (0.4fte) acting as project coordinator to support this initiative has played a significant role in ensuring the current development and delivery of the project. We look to a future where this service may be peer-run with minimal oversight and supervision support within the package of other services provided by SAHS Mental Health. A process of

stepwise handover could be developed over the next 6 months. We would therefore recommend further continuation of their role as project coordinator to facilitate that handover to the peer coordinator then ongoing supervision support to the peer coordinator of 0.1 - 0.2fte. This would allow the project coordinator to dedicate more time to the development and set up of other related initiatives, for example, carer roles and further consumer roles, both paid and unpaid.

- Incorporation of the peer support role as part of the model of care for the Margaret Tobin Centre, including discharge processes and integration with community, from commencement of operations in that unit.
 - Development of strategies to increase the rate of referrals from Morier.
 - More active promotion of the service and referral process to all inpatient clinical staff generally to overcome inherent problems with ward teams' reliance on the social worker to make referrals. We would propose to do this using more site visits, direct and indirect communication with teams, offer forums as part of staff development to teams and specific disciplines.
- General expansion of the paid peer role to include roles that provide support to existing mental health service consumers who are clients of community mental health teams in our region. This could include:
 - Their role in delivering hospital avoidance/discharge packages through the process used for this pilot of by dedicating SAHS Mental Health funds to its development.
 - A pilot in the MACS team may be feasible, offering input to self-management, goal setting, and modeling recovery for consumers and staff.
 - Likewise, use of peers for phone support to consumers inappropriately using ACIS and ED in the absence of social and emotional support may be feasible.
 - Possibilities of working with the Divisions of General Practice and the Shared Care Initiative to promote the use of peers to support consumers in primary health care contexts as part of prevention, early intervention, recovery and relapse prevention.
 - The current pool of 8 peers could meet the further demands and growth proposed for the Hospital-to-Home service given their capacity to work up to 16 hours per week. Further peers would need to be recruited as part of general expansion in the use of peers in other roles. We also expect that some of the peers in our project may win positions as consumer consultants in the Margaret Tobin Centre which would impact negatively on our capacity if we then lose those workers to those positions. We would therefore recommend further recruitment of at least 3 peers. We currently have a small pool of volunteer unpaid peers who are 'buddies' to the peer support workers in the project who could be considered.
 - Further development of the consumer consultant role in inpatient settings as well as their interface with peer support worker roles, and including all psychiatric wards, including Morier and Margaret Tobin Centre, and emergency departments at Noarlunga and FMC. (The general difference between consumer consultant roles and peer support roles being that the former supports self-advocacy by the consumer whereas the latter provides practical to the consumer primarily.)
 - Investigation of the options for developing longer packages (2-4 weeks) with HSS, given the needs of some consumers for longer support.
 - Building closer collaboration with NGO agencies and their packages to ensure even better transition and integration of support in the community and use of mental health peers in this capacity. We have had preliminary contact with United Care Wesley projects in our region (GP Access, Metro Access) and they are keen.

- Improved handover processes and discharge planning whilst the person is an inpatient. We understand that the SAHS Directorate is attempting to improve this with several initiatives in process. We ask that any materials developed include and acknowledge the peer support option along with other potential options.
- Specific education for mental health service staff about the role of peers to enhance their understanding of the role in the context of recovery and service delivery generally.

10. Appendices

- a. Information to services**
- b. Information to consumers**
- c. Referral Flow Chart**
- d. Scenarios**

SAHS Mental Health

Peer Supported Hospital to Home Project

Reason for the Project

Through extensive consumer consultation, the 2 weeks post discharge has been identified as a particularly vulnerable time for many consumers of our services. They often relapse and are re-admitted to hospital in part because post transfer and return to the community, their subsequent social and clinical supports, such as social networks and GP contacts, do not occur, or happen later than planned or advised.

Likewise, people with mental illness who present to ED often do so because of a lack of support or of timely support in the community. This includes the period of waiting for referrals to community teams to be actioned.

Metro Home Link has clearly identified several problems with providing support to people with mental illness who have been referred to them for post-hospital support as part of our communications over the past 2 years. These include the low number of referrals, engagement issues and lack of skills and confidence of support workers in many of the agencies that provide them with brokered services.

This is a pilot project that uses the resources of Metropolitan Home Link and a fully trained and supported group of peers (people with a lived experience of mental illness) to provide this support.

The Project in Practice

Once a referral is made by your team via the usual Metro Home Link Referral process, a peer support worker would ideally meet with the consumer prior to discharge. A mutually agreed on plan of support would be devised with the consumer, the peer and inpatient staff as part of discharge planning.

Support activities may include:

- Phone within the first 2 days
- Home visit for support at a mutually agreed time/day
- Accompany/transport the consumer to the GP or other appointments as needed, for example, next day follow-up with ED outpatient service.
- Accompany/transport the consumer to shops for groceries and/or bill paying
- Provide respite to carers/family
- Assistance with meal preparation
- Transportation home from hospital if needed

As per Metro Home Link criteria, the support package will range from 8-12 hours in total for the 2 week support period, 7 days a week, with capacity for some evening support.

Support will not include overnight stays, medication management, personal care beyond prompting, child care, lifting or other manual handling support, toileting, etc.

Criteria for Access to this Service

- A consumer of mental health services living in the SAHS region (living independently or in SRFs)
- Consent for service
- Significant social isolation with limited community supports. This primarily means consumers living alone but may include consumers with carers who have problems providing support, isolated consumers living in SRFs, or consumers who have young children.
- Satisfactory completion of risk assessment identifying safety for peer home visiting
- Support facilitates early discharge and/or avoids hospital re-admission
- The person does **not** have a current Key Worker (under special circumstance this criterion can be negotiated. Eg. if the key worker is on leave)

Referrals will be accepted from services within the SAHS region:

- Inpatient wards of Morier / Noarlunga, Patterson House East / Glenside, 4G / FMC
- Short Stay Units
- Mental Health Hospital in Home (in conjunction with H-in-H or in the 2 weeks following their input for additional support)
- Emergency Departments of Noarlunga and FMC for consumers who present to ED because they are lonely or lack other supports rather than because they are in crisis

How to Make a Referral

Please use the standard Metro Home Link Mental Health referral form and identify your referral as a "Peer Support Referral" by clearly marking at the top of the referral that it is for a Peer Support Worker.

Then send through your written referral to the Metro Home Link Contact Centre:

Fax: 8206 0141.

They will then send the referral to the project coordinator.

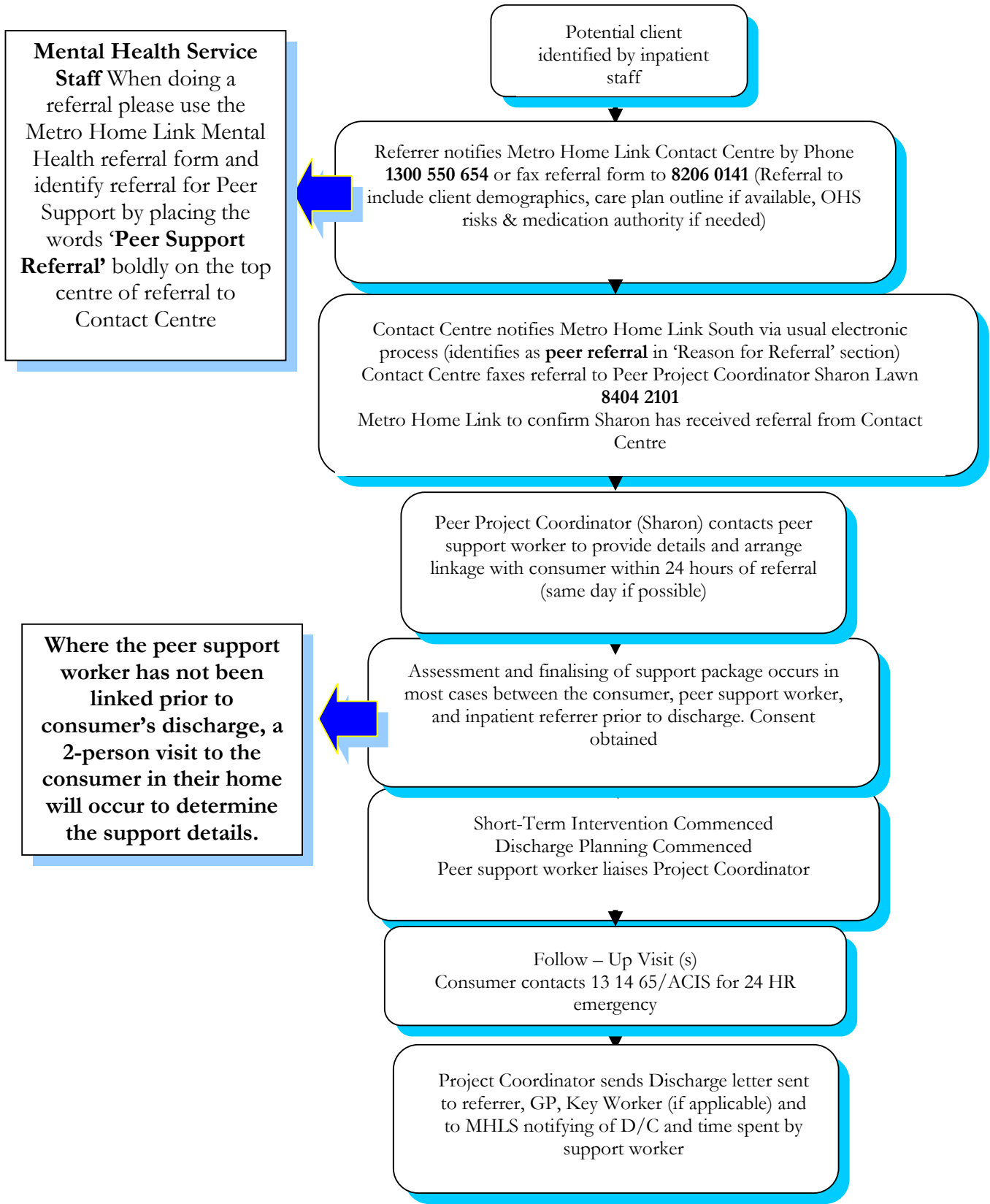
Please contact Sharon Lawn, Project Coordinator for any enquiries re types of support required or eligibility.

Phone: 8404 2321 / 0434 601 714

Fax: 8404 2101

METRO HOME LINK FLOW CHART

MENTAL HEALTH PEER SUPPORT REFERRAL



Scenarios of Support Journeys

(1) A chronically unwell long-term high user of services

A woman in her mid twenties with a long-standing psychotic illness and a history of multiple admissions, many lasting several months as well as frequent contact with ED, was referred for discharge support. She was a frequent marijuana user and often non-compliant with medication, resulting in her being placed on a 6-month detention order and a 12-month CTO, with referral to extended care inpatient services initiated. On commencement of peer support she had been an inpatient for many months and was deemed by staff to be 'stuck' and in the 'too hard basket' with staff holding no hope for her discharge in the near future. A peer support worker began engaging with her on the ward and taking her out into the community, enabling her to increase her confidence and social skills and participation with her peers. With support from her peer support worker, this lady was able to connect with a range of community services for the longer term. Very quickly, she was more able to engage better with inpatient staff also, her mood improved and she began to set goals and take more responsibility for her recovery. After less than one month since receiving peer support as in inpatient (funded by MHS), she was discharged with continuing peer support and hospital-in-Home while awaiting MACS team follow-up 2 weeks later. Her change from a 'stuck' long-term inpatient to an active, engaging, hope-filled lady amazed her doctors and was believed to be largely due to peer input.

The peer support worker provided the crucial engagement link between this lady and her new MACS team worker, having also provided crucial support until the support from them commenced. They continued to assist her to engage in community activities and set achievable goals for herself. As a result, she has ceased smoking marijuana and has stayed compliant with her medication. Her community team are so pleased with her progress that she may be able to cease having depot medication and change to oral medication soon. She was also able to plan and take a holiday that had been a long-term goal for her. She is now considering returning to study next year and is planning her next holiday.

(2) A frequent ED user:

A man in his fifties was referred to the Metro Home Link peer support Hospital to Home project by a community case manager to provide support to help prevent his continual presentation to the ED and to provide support until he could be linked into the GP Access program for ongoing support. He is currently not managed by a community team and has a private psychiatrist. This gentleman has lost his sense of self identity due to loss of his career and future employability. He feels as though he has been unable to achieve his life's goal. The peer worker and the consumer were able to relate well to each other as the peer worker had been through a similar experience and was able to role model adjusting to a disability, rebuilding an identity and returning to work in a different and more rewarding capacity. Unfortunately linking this man to a non-mental health support worker may not benefit him as he requires reassurance and understanding of his current mental illness. He frequently visits the ED department and the local acute inpatient ward seeking assistance. Longer term support potentially could change this pattern of behaviour and adjustment to his current situation. The peer worker was able to assist him with a food hamper after his pension was stolen leaving him without the means to purchase food for the fortnight. A friendship and trusting relationship developed quickly between the peer worker and the man who had previously been cited as potentially aggressive. There was no evidence of this behaviour during the time of the Metro Home Link support package.

(3) Another high user of services:

A female patient in her late twenties who was on a long-term detention order and was exhibiting depression and anxiety and becoming increasingly unsettled on the ward due to being confined to the ward was referred to the Metro Home Link Peer Support Hospital to Home project by her treating doctor who was becoming increasingly concerned by her patient's worsening of symptoms. The view of the referral was to allow supervised time off the ward with a non-clinical worker as she was isolated from her family and friends and had no visitors. The change in her demeanour was readily evident as she became more cooperative, and returned animated and commutative with staff after outings with the peer worker. Her depression lifted and she was more settled on the ward and looked forward to visits from her peer worker and her regular time away from the ward. This provision of support enabled the continuation of treatment and enlisted the person's cooperation, which enabled her to return home to her family without a further period of detention being imposed.

(4) A unique paradoxical case:

A mental health worker was referred to the Metro Home Link Peer Support Hospital to Home project by the Hospital at Home team. This proved to be a very difficult and complex case requiring long term support. When referred to the project the person was psychotic, disorientated, paranoid and chaotic in their thinking and behaviour and refused any clinical services due to their employment history, only allowing visits and phone calls from the peer worker, constantly seeking reassurance that she was not going crazy or losing her mind. Poor compliance with a medication regimen, failure to attend appointments with the private psychiatrist, and two major upsetting events, have resulted in a decline in their personal, financial and household management. The peer worker has suggested linking them into GP Access, BCS, a psychologist, local council's Home Assist program and suggested an alternative psychiatrist and community mental health case management, all but the suggestions were declined. As their situation worsened the treating psychiatrist put the client in the too hard basket and requested further peer support and referral to ACIS for assessment which is still to be followed up. This person has been, and remains high risk and will require medical intervention and long term support to improve their situation. It is important for their mental health that there be a steady and continuous level of support as they are facing potential legal action.

(5) Hostel experience:

A man from rural SA with a very chronic psychotic illness was discharge to a hostel outside our SAHS catchment area. The peer met him in the ward and took him on leave from the ward for a coffee, at which time staff had said he would be detained in hospital for a further week at least due to his level of paranoia. The following day, he was discharged, as staff deemed that he was much more settled following the peer input. The peer transported him to the hostel and provided full liaison with hostel staff, the local GP and chemist about his medication needs. Attempts to clarify the plan for his medication and community follow-up were met with chaotic and confused responses from the ward as no-one seemed to know what the plan was! If the peer had not sorted the situation and followed through as well as settling the man into the new area, this man would not have received his depot and likely would have left the hostel and turned up back in inpatient care through 'non-compliance'.

(6) Non-English Speaking experience

A man abandoned by his family was discharged to a local hostel. Chaotic discharge planning on the ward due to there being no consistent social worker for several days meant that information and communication was fragmented. The peer became the main contact person between the person, the interpreter, the hostel, the inpatient doctor and the GP, almost acting as a case

manager because there was no-one else coordinating anything. The consumer was mistakenly discharged on 2 days medication with a weekend approaching. They were able to contact the hospital doctor, pick up further supply then take the consumer to their GP for further scripts and fill them at the chemist, all within the required timeframe of 3 days after admission. The referral to the community mental health team had also been missed, so the peer project did this also. Hostel staff kept in close contact with the peer project as the main contact agency throughout the period and several basic needs were able to be sorted. The peer and the interpreter worked as a well oiled team. The man is now very settled but this situation could have easily been a disaster.

(7) A first episode psychosis consumer and their family

The peer support worker managed to give the young man and his family much needed support as part of discharge. The witnessing of recovery of a powerful demonstration to them and gave them hope. The consumer was able to develop coping strategies based on psycho-education input from the peer who talked about their own experience and journey. Not 4 weeks since discharge from hospital, the consumer is enrolled in study and is reconnecting with friends. The family and consumer wish that they could have this support for several more weeks. The GP wants to employ the peer support worker to work with his other patients in his practice, providing early intervention support, to help engage patients with the GP, information on services and as a model for recovery.

(8) An Indigenous consumer

A young Aboriginal lady was discharged with peer support but no other community supports after a short inpatient stay in during which she was highly suicidal. She was extremely anxious and did not feel ready for discharge. She was concerned about her living and financial situation and felt overwhelmed, expressing a desire to receive counselling. Her peer support worker was able to reassure her and assist her to obtain financial support and engage her with social services including Centrelink and Housing SA. On one occasion, shortly after discharge, when visiting her family with her peer worker, the lady became increasingly anxious and upset expressing suicidal thoughts. The peer worker took her to ED upon her request, where she settled with reassurance from the peer and was able to be discharged with peer support. The peer continued to support the lady over the coming days, linking her with a range of Aboriginal and other community services so that, on completion of the peer support package, she felt more confident in own ability to cope. A further family crisis precipitated an admission following which she received further post-discharge peer support. She has remained stable for the past month and would like to be a peer support worker one day.

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