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Using Personal Experience To Support Others With Similar Difficulties

A Review Of The Literature On Peer Support In Mental Health Services

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30th September 2010



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Background

The support that people with experience of mental health problems provide for one another has been well described in self-help literature (e.g. Chamberlin, 1988) and in accounts of living in the old asylums (c.f. Porter, 1987). This mutual or peer support appears to offer particular or additional value because “.. they have found their way out of the hole that you find yourself in” (Arnold, 2009) so the experience has credibility, peers embody personal inspiration and hope, and they can share practical strategies and coping mechanisms.

Traditionally peer support has occurred naturally in settings shared by people with mental health problems, but intentional or formalised peer support probably began with the establishment of Alcoholics Anonymous. This organisation operates on the principle that people who have experienced and overcome alcohol misuse will be more effective in assisting others who are trying to do the same. Shared experience also provides the foundation for self help/mutual support groups in mental health, and for rights based campaigning/action groups set up to challenge existing services (Mead & Macneil, 2004).

A search of the grey literature reveals literally thousands of descriptions of peer led and peer run services in UK, USA, Canada, Australia, New Zealand, Greece, Peru, Argentina. In fact, in the USA, it has been reported that services run for and by people and their families with serious mental health problems now number more than double traditional, professionally run, mental health organizations (Goldstrom et al, 2006). Most provide support for people living in a local community with a defined problem (substance misuse, anxiety and panic, people recently discharged from hospital, people in crisis) or with a defined purpose (support into education or employment). Some provide telephone or on-line support, others offer mutual support groups, others give opportunities to meet and do things together. In contrast, the employment of peer support workers within mental health services has been slower to develop, possibly impeded by stigma and stereotypes about mental illness. It is only recently, perhaps aided by the promotion of a Recovery focused approach across mental health services, that the value of intentional peer support is becoming recognized.

Davidson et al (1999) in the first review of the evidence surrounding peer support in mental health services, describe three broad types of peer support; informal (naturally occurring) peer support, peers participating in consumer or peer-run programs, and the employment of consumers/service users as providers of services and supports within traditional services. Bradstreet (2006) organizes his later review around these same three categories, which have distinct features and are addressed in different bodies of work. A number of reviews have reviewed the literature concerned with self-help/mutual support (Raiff, 1984; Pistrang et al, 2008) and peer run services (e.g. Davidson et al, 1999; 1988; Humphreys, 1997). Other reviews have concerned themselves with all types of service user employment in evaluation, training and service delivery in mental health (e.g. Simpson and House, 2002). This current review is primarily concerned with peer support workers employed within traditional mental health services.

Aims and Objectives

This review aims to draw on published literature to describe the role of intentional or formal peer support workers and their impact on the experience of people who they work with; the system they work in; and the effect of the role upon their own well being. It also examines considerations and concerns that are raised in the literature around definitions, roles, relationships and some of the challenges presented in the employment of peer support workers.

Various terms are used to describe people with lived experience who are employed to support others who face similar challenges: 'peer support workers', 'consumer-survivors', 'consumer-providers', 'peer educators', 'prosumers' and 'peer specialists'. For the purpose of clarity, this paper will refer to peer activities as, "peer support work (PSW)", and peers who work within these initiatives as "peer support workers" (PSWs).

Method

Approach

This review was driven by the pragmatic intention to employ Peer Support Workers in local mental health services. We were therefore interested in clearly defining and distinguishing peer support and in determining ways in which it could be implemented most effectively. This raised methodological questions: what type of evidence should be included (i.e. what search and selection strategy was most appropriate)? How were we defining the intervention (i.e. what inclusion and exclusion criteria would apply)? Given the breadth of the aims a broad and pluralistic approach was adopted to include multiple sources of evidence and types of data.

Published literature in the field consists largely of qualitative studies often with small sample sizes and descriptive cross sectional or longitudinal (follow up) designs. Whilst this may be due to the early stage of development of the intervention, it may equally be a response to the limitations and restrictions presented by the process of random assignment in controlled trials. For peer services, built on the principle of inclusion and the development of a supportive, empowering culture, randomized manipulation may change the peer service being researched (Resnick & Rosenheck, 2008). In addition, since peer support is relatively innovative and un-researched, the understanding provided by narrative, personal and qualitative accounts is as valuable as more outcome-focussed comparative and quantitative studies. The development of PSW in mental health services raises many questions and challenges for all concerned and it is not only *whether* it makes a difference that is of interest, but also, in *what* circumstances, with *whom* and *how* that are, as yet uncharted.

Inclusion and Exclusion Criteria

Papers were included only if:

- peers were offering support for people with mental health problems
- peers were working in statutory or professionally led services.
- papers were written/published between 1995 and 2010.

They were excluded if:

- peers were working in a consumer led service
- peers were not offering support to others experiencing mental distress
- peers were employed to provide training, interviewing or research
- papers were published before 1995.

Search Strategy

The search strategy took three different approaches:

1. The procedure began with a title search of databases Cinhal, medline and psych INFO using key words including: 'mental health', 'consumer', 'survivor', 'recovery', 'peer support'. Subsequently, the abstracts were screened for reference to 'peer support' and 'mental health' and all relevant papers retrieved.
2. This method was strengthened by identifying relevant review papers and retrieving all additional relevant papers cited in reference lists.
3. Relevant websites were consulted.

Data Analysis

The challenge of including all sources of information in one area lies in the sheer volume of papers generated. A systematic approach was therefore undertaken to carefully read the selected papers and order them. Initially, they were all entered into a matrix describing study design, intervention and findings. Following this, a list of main themes was developed with reference to papers referring to those themes and main points included. Finally, the text was constructed to draw together main themes, synthesising findings and giving a critical analysis of implications, gaps in understanding and issues raised for service provision.

Findings

Definition of Peer Support

There is no universally accepted definition of peer support but the term generally refers to mutual support provided by people with similar life experiences as they move through difficult situations. At its most basic, the peer support 'approach' assumes that people who have similar experiences can better relate and can consequently offer more authentic empathy and validation (Mead & Macneil, 2004). Furthermore, peer support is generally described as promoting a wellness model which focuses on strengths and recovery: the positive aspects of people and their ability to function effectively and supportively, rather than an illness model which places more emphasis on symptoms and problems of individuals (Carter 2000). Mead (2003) offers a short and all encompassing definition of peer support as, '*a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful*' (Mead, 2003, p1).

In both mutual support groups and consumer-run programs, the relationships that peers have with each other are valued for their reciprocity; they give an opportunity for sharing experiences, both giving and receiving support, and for building up a mutual and synergistic understanding that benefits both parties (Mead et al, 2001). In contrast, where peers are employed to provide support (intentional peer support) reciprocity is a feature but the peer employed in the support role is generally considered to be further along their road to recovery (Davidson et al, 2006). They use their own experience of overcoming mental distress to support others who are currently in crisis or struggling. This shift in emphasis from reciprocal relationship to a less symmetrical relationship of 'giver' and 'receiver' of care appears to underpin the differing role of peer support in naturally occurring and mutual support groups and peer support workers employed in mental health systems (Davidson et al, 1999). Yet it seems that whatever the setting, reciprocity is integral to the process of 'peer to peer support' as distinct from 'expert worker support'. This is not to say that

peer support is not an 'expert role', a point recognised in the training materials used by META, Arizona: "Peer support is about being an expert at not being an expert and that takes a lot of expertise".

The reciprocity that is singular to PSW goes some way to avoid the power imbalance that typifies staff – patient relationships in statutory mental health care (Mead et al, 2001). The mental health system currently provides a 'one way ' service, which maintains static roles of helper and helpee (Mead & Macneil, 2004) or 'expert' and 'passive recipient' (Repper & Perkins, 2003). Peer support, on the other hand, asserts a mutual process in that both peer support worker and service user see themselves in multiple roles throughout any given conversation. As a result dialogues are created that resemble those in more community type relationships, and as such, move the service user forward towards full community integration and away from feeling like a mental patient in the community (Mead & Macneil, 2004).

Furthermore, peer support is a way for people to come together with shared experiences and the intention of changing unhelpful patterns and moving beyond their perceived limitations by building relationships that are respectful, accepting and mutually responsible (Macneil & Mead, 2003). As such, peer support can be defined as: "social emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change" (Solomon, 2004, p. 393).

Role of Peer Support

There have been few attempts to operationally define the role of PSWs, but Davidson et al (2006) summarise the literature in this area and offer a list of possible functions based on shared experiences which include: offering understanding, acceptance, empathy (thought to lead to increased hope, self efficacy and willingness to take personal responsibility for working towards recovery); role modeling and provision of practical information, support to access community facilities, ideas about coping strategies and problem solving skills; exposure to "alternative worldviews, ideologies and contexts which offer cognitive and environmental antidotes to the isolation, despair and demoralization many people experience as a result of their contact with mental health services" (p.448).

Mowbray defines a broader role for PSWs: "peer support relationships can challenge unacknowledged stigma, discrimination, bias and emphasize full community inclusion over a singular focus on symptom management whilst instilling hope for recovery by role modeling that recovery is possible, helping service users navigate systems and teaching successful coping strategies" (Mowbray et al, 1997. P.398)

Given the paucity of studies describing the process of peer support, it is helpful to describe a few of the services that have been developed.

1. The Missouri Department of Mental Health is committed to employing PSWs as their primary strategy in moving the mental health system to a wellness (Recovery-focused) model that empowers individuals to establish their personal mental health goals and manage their own mental health through education and supports. To achieve this Missouri gives equal weight to expertise of lived experience as to other credentials and knowledge bases.
2. The US state of Georgia developed one of the first certified PSW training, they define the primary responsibility of the certified peer specialist as to provide direct services "designed

to assist consumers in regaining control over their own lives and control over their recovery processes” (Sabin & Daniels, 2003).

3. Recovery Innovations (RIAZ) started in Arizona as a crisis response service META. Ten years ago their CEO made a decision to transform the services to become Recovery focused so they began to employ peers on the staff, and made a policy decision towards stopping all incidents of seclusion and forced restraint. With around 65% of staff employed as PSWs and a further 20% of professionally qualified staff having personal experience of mental health problems, the service has adopted an education based Recovery philosophy and provides peer-led education programmes in areas related to well-being, getting into work/education, practical skills and ‘getting involved’ – working in services (Ashcraft and Antony, 2005). RIAZ have since expanded and developed their services to provide community support, housing support and a peer run ‘living room’.

The Peer run ‘living room’ was set up as an alternative to traditional crisis environment and provided a space for service users to access whilst in crisis that was primarily run by peer support workers. The success of the ‘living room’ was attributed to the peer support worker’s ability to empathize with the service user and their focus on the person as opposed to the problem (Ashcraft and Antony, 2008). Peers have provided the vehicle for shifting the whole service towards a Recovery focused culture. Other system changes include ceasing to use restraint, seclusion and forced medication.

4. Sherry Mead and colleagues provide training in peer support work and have written influential papers on the definition and process of peer support. Underlying their ideas is the belief that times of crisis can be transformational in that if cared for in mutually supportive relationships new ways of thinking about the experience can be explored. Specifically, that crisis doesn’t become objectified in relation to illness, rather it becomes a time in which people can learn and share their experience in a bid to grow beyond and learn from it. As Mead (2003) points out; the experience is ‘shared’ as opposed to ‘handled’. MacNeil and Mead (2003) have developed a list of fidelity standards (with associated indicators) of peer support from an ethnographic study of a Peer Centre in a large traditional mental health system.

They include:

- Peer support promotes critical learning and re-naming of experiences
 - The culture of peer support provides a sense of community
 - There is great flexibility in the kinds of support offered
 - Peer support activities are instructive (through sharing skills, knowledge, experience ...)
 - There is mutual responsibility across relationships
 - Peer Support involves sophisticated levels of safety and safety is mutually negotiated
5. Closer to home, the Scottish Government recently commissioned peer support workers after a successful peer support pilot scheme. The research report (McClellan et al, 2009) found that Peer Support Workers were able to build empathetic and open relationships, which could overcome the power dynamic that might happen in a staff-patient relationship. The sense of mutuality created through thoughtful sharing of experience was found to be influential in modeling recovery and offering hope to service users in a unique way, that no other person in the medical team could do. Finally it was stated that although some of the activities a peer support worker did overlapped with other roles, such as support workers,

the mutuality in the relationships encouraged working together in a different way that would complement other team relationships.

- 6 There are very few reports of peer support workers employed in statutory services in England. An exception is a small pilot study undertaken in South West London. Perkins et al (2005) report their experience of employing two part time peer support workers on an acute inpatient ward. Qualitative interviews with inpatients before and after this initiative indicated marked increases in the opportunities they had been given to talk about their own experiences, and in their belief in the possibility of recovery for themselves.
- 7 Another small pilot project is reported by Coleman and Campbell (2009) who evaluated a voluntary sector run service providing peer support for people using Early Intervention Services in Nottingham. Two part time workers, selected for their own experience of using EIP services, provided a community based social group, facilitated access to mainstream activities and services, and offered support to attend social and music events, clubs, music workshops and other activities as requested by the people referred to the service.

It is important to note that the role of the Peer support worker is not confined to acute and recovery services. It has also been used in specialist mental health services including; homelessness and co-occurring psychiatric and substance disorders (Fisk et al, 2000) Adolescent mental health services (Killackey, 2009), Addiction services (White, 2004) and Forensic services (Davidson & Rowe, 2008).

What Makes Peer Support Unique?

The clear distinction between Peer Support Workers and other roles is the requirement of post holders to explicitly draw on and share their own experiences of emotional distress and/or of using mental health services in order to inspire, model, support and inform others in similar situations. Although many people already working in mental health services have experience of using services (Ghoury et al, 2010; Perkins et al, 2005), and this will inevitably have an impact on their work, they may or may not disclose their experiences, and they occupy more or less conventional roles.

Many services have developed service user development posts, but rarely have these entailed the intentional use of their own experiences to support others going through similar situations. This is an important point to note when reading research in this area, as several studies have employed 'peers' in conventional posts/roles (e.g. Solomon and Draine, 1996), and these need to be distinguished from those studies that employed peers in dedicated posts specifically for their ability to empathize and engage with others with similar experiences (e.g. Sells et al, 2006).

Effectiveness of Peer Support

Most of the research literature on peer support focuses on outcome in terms of the benefits experienced by those receiving peer support. However, only seven Randomised Control Trials (RCTs) met the inclusion criteria for this review (Solomon & Draine, 1995; O'Donnell, Parker & Proberts, 1999; Clarke et al, 2000; Dummont & Jones, 2002; Davidson, et al, 2004; Sells et al, 2006; Rogers et al, 2007) and these offer inconsistent findings and use varied outcome measures.

A discussion of these findings is based on the wider evidence base including follow up studies; the aggregated results paint a more complete picture of the impact of peer support workers on: empowerment (Corrigan, 2006; Nelson et al, 2007; Resnick, & Rosenheck, 2008; Dumont & Jones, 2002; Rogers et al, 2007), admission rates (Solomon & Draine, 1995; O'Donnell, Parker &

Proberts, 1999; Clarke et al, 2000; Chinman et al, 2001; Forchuk et al, 2005; Min et al, 2007; Lawn et al, 2008 Dumont & Jones, 2002), self esteem (Verhaeghe et al, 2008; Davidson et al, 2004), stigmatization (Verhaeghe et al, 2008), quality of life (Nelson et al, 2007; Resnick, & Rosenheck, 2008; O'Donnell, Parker & Proberts, 1999; Solomon & Draine, 1995), symptom distress (Nelson et al, 2007; Resnick, & Rosenheck, 2008; Davidson et al, 2004; Solomon & Draine, 1995), satisfaction with care (O'Donnell, Parker & Proberts, 1999; Solomon & Draine, 1995), confidence (Resnick, & Rosenheck, 2008), community integration (Trainor et al, 1997; Nelson et al, 2007), social support (Nelson et al, 2007; Solomon & Draine, 1995) and social functioning (Resnick, & Rosenheck, 2008; Yanos et al 2001; Davidson et al, 2004; O'Donnell, Parker & Proberts, 1999).

Benefits for Consumers

Admission Rates and Community Tenure

The RCTs focusing on admission rates report mixed results; Solomon & Draine (1995) in a 2-year outcome study reported no differences between care provided by peers and care as usual on hospital admission rates or length of stay. Furthermore, O'Donnell, Parker & Proberts (1999) reported no significant difference on admission rates when comparing 3 case management conditions; standard case management, client focused case management and client focused case management with the addition of peer support. It seems prudent to mention that a result of no difference demonstrates that people in recovery are able to offer support that maintains admission rates (relapse rates) at a comparable level to professionally trained staff. Interestingly however, Clarke et al (2000) found that, when assigned to either all peer support worker or all non-consumer community teams that those under the care of peer support workers tended to have longer community tenure before their first psychiatric hospitalization.

The majority of the wider evidence on admission rates report positive results, suggesting that people engaging in peer support tend to show reduced admission rates and longer community tenure. Chinman et al (2001) compared a peer support outpatient program with traditional care and found a 50% reduction in re-hospitalizations compared to the general outpatient population and only 15% of the outpatients with peer support were re-hospitalized in its first year of operation. Furthermore, Forchuk et al (2005) in an evaluation of a model of discharge involving peer support report that peer support used as part of the discharge process significantly reduces readmission rates and increases discharge rates.

In a longitudinal comparison group study, Min et al (2007) found that consumers involved in a peer support program demonstrated longer community tenure and had significantly less re-hospitalizations over a 3-year period. Finally, in an evaluation of an Australian mental health peer support service providing hospital avoidance and early discharge support to consumers of adult mental health services Lawn et al (2008) found in the first 3 months of operation more than 300 bed days were saved when peers were employed as supporters for people at this stage of their recovery.

Empowerment

Empowerment is an important element of peer support as it refers to people's ability to overcome the stigma, poverty, and social isolation that reinforce cognitive deficits, emotional insecurities, and social difficulties. A raised empowerment score has been reported in several studies of peer support (Resnick & Rosenheck, 2008; Dummont & Jones, 2002; Corrigan, 2006). Davidson et al (1999) attribute these improvements in empowerment to the new ways of the thinking and behaving that occur when engaging in reciprocal peer support relationships.

In a qualitative study of consumer views, Ochoka et al (2006) reported that participation in peer support as both a provider and recipient resulted in an increased sense of independence and empowerment. Specifically, consistent engagement in peer support increased stability in work, education and training which all allow for a sense of empowerment. Furthermore, participants reported gaining control of their symptoms/problems by researching their illness independently, and, consequently becoming more involved in their treatment, thereby moving away from the traditional role of 'mental patient'. Although the study comprised a small sample, the introduction of a comparison group receiving care as usual allowed for the reduction of extraneous variables that could account for the change.

Related to this, several studies have found that peer support improves self-esteem and confidence (Davidson et al, 1999; Salzer, 2002). This has been attributed to the mutual development of solutions, the shared exploration of 'big' feelings (Mead 2004) and the normalization of emotional responses, which are often discouraged and seen as crises in traditional health care.

Social Support and Social Functioning

Social Isolation is often one of the most significant challenges faced by individuals with mental health problems. Other than superficial social contacts with sales assistants or cashiers, many people have little social contact that does not involve mental health staff (Davidson et al, 2004). Outcome studies repeatedly report improvements in both level and quality of social support, social functioning, social networks and social integration.

Mead et al (2001) assert that engagement in a peer support relationship allows participants to create relationships and practice a new identity (rather than that of mental patient) in a safe and supportive environment. This is supported by Yanos et al (2001) in a cross sectional study where individuals involved in consumer run services had improved social functioning compared to individuals involved in traditional mental health services. One explanation for such a change is that when engaging in peer support, consumers are exposed to differing perspectives and successful role models who may share problem solving and coping skills and thereby improve social functioning (Kurtz, 1990).

In a longitudinal study, Nelson et al (2007) reported that at 3 year follow up consumers continuously involved in peer support programs scored significantly higher than comparison groups on a measure of 'community integration' which was assessed using the Meaningful Activity scale (Maton, 1990). This finding is consistent with a previous qualitative study in which members of Peer support initiatives in Ontario reported enhanced community integration (Trainor et al, 1997).

Ochoka et al (2006) reported at 9 and 18 months follow up. Consumers receiving peer support reported more friends and more social support not only within the initiatives they were involved with, but from other settings and relationships compared with participants not receiving peer support. Similarly, Forchuk et al (2005) found that participants who received peer support demonstrated improved social support, enhanced social skills and better social functioning.

Empathy and Acceptance

An important aspect of peer support is the sense of acceptance and real empathy that the peer gains through a sharing relationship (Davidson et al 1999). In a qualitative study exploring the peer support relationship within mental health, Coatsworth-Puspokey et al (2006) found that consumers believed the experiential knowledge provided by peer support workers created a 'comradery' and a 'bond' which made them feel that their challenges were better understood.

Similarly, Paulson et al (1999) demonstrated through qualitative data there were significant differences in the focus of consumer and non-consumer providers of assertive community treatment. Specifically, the consumer providers emphasized 'being' with the client whereas the non-consumer providers emphasized the importance of 'doing' tasks. Moreover, both sets of providers asserted that it was the consumer providers' better understanding of what the patient was going through which was their greatest strength.

Finally, in a randomized controlled trial comparing the outcomes of people receiving peer support with traditional care, Sells et al (2006) demonstrated that individuals receiving services from peer support workers reported having greater feelings of being accepted, understood and liked compared with individuals receiving traditional care by mental health providers after 6 months.

Reducing Stigma

Ochoka et al (2006) found that participants involved in peer support were less likely to identify stigma as an obstacle for getting work and were more likely to have employment. This makes sense as peers embody the possibility of acceptance and success so they can challenge the barriers created by self-stigmatisation: anticipation of discrimination. Indeed, Mowbray et al (1998) reports that peer support workers recognised that through engaging in peer support they were altering attitudes to mental illness and as such breaking down the stigma and fostering hope in the peers they were working with.

Hope

One of the essential benefits gained from peer support is the sense of hope (a belief in a better future) created through meeting people who are recovering, people who have found ways through their difficulties and challenges (Davidson et al, 2006). The inspiration provided by successful role models is hard to over-state. So many people who have been supported by peers describe their surprise when meeting others who describe similar experiences (c.f. Ratzlaff et al 2006).

Benefits for Peer Support Workers

Aiding continuing recovery

Giving peer support, like receiving it, results in increased sense of self-esteem. Salzer & Shear (2002) in a qualitative study of 14 interviews with peer support workers showed that over half of respondents indicated that they benefited from the feeling of being appreciated and felt their confidence and self-esteem increased and further facilitated their recovery. Similarly, Ratzlaff et al (2006) found that the self-esteem of peer support workers improved.

The 'helper-therapy' principle (Riessman, 1965) may account for the self-esteem increase observed in peer support workers as helping others can be especially rewarding and can result in an increased sense of inter personal competence. Interestingly, Bracke et al's (2008) results showed that providing peer support is more beneficial than receiving it in terms of self esteem, empowerment etc. This could be due to the importance of employment and the identity shift from consumer to provider, and therefore becoming a 'valued and contributing citizen' (Hutchinson et al, 2006).

Mowbray et al (1998) interviewed 11 PSWs in depth about 12 months after their employment ended. These workers identified money as the primary benefit of the role, followed by the structure of the job, the supervision provided and the safety of a job in which they could disclose their prior difficulties. Respondents felt that the role had allowed them to gain skills, personal growth and self-esteem through doing something worthwhile. Salzer & Shear (2002) also reported that peer

support workers learnt from their relationships in terms of skill development and self-discovery, which helped them, deal with their own problems and as such facilitated their continuing recovery.

Benefits for the system

Communication

In a survey of 110 administrators, providers, and patients in 3 Veteran administration clinics asking about their perceptions of feasibility and acceptance of peer support services, Chinman et al (2006) found that respondents were enthusiastic about peer support workers serving as a 'bridge between the mental health system and the patient to improve service delivery'; they also believed that peer support workers could help both the professionals and patients to get a better understanding of each other's needs. An example was given of a doctor using medical terms, which could be translated for the patient by the peer support worker, who could also help to convey the patient's point of view to the doctor.

Reduced Workload for Staff

Introducing peer support workers into the mental health system may remove some pressure from other overstretched staff (Mowbray et al 1998). Peer support workers can also augment the services of mental health staff by assisting consumers through the service and aiding consumers with support activities such as childcare, transportation and most importantly life skill development (Mowbray et al 1996).

Explaining the Benefits of Peer Support

Salzer (2002) identifies a number of theories that might explain the beneficial processes underlying peer support:

- Social comparison theory (Festinger, 1954) asserts that people seek out others with similar illnesses (i.e. peers) in order to help them maintain a sense of the normality of their experiences.
- Social learning theory (Bandura, 1977) suggests that behaviour change resulting from interactions with peers may be more likely because peers are perceived to be more credible role models and enhance self-efficacy.
- Social support is a particularly important part of peer support. Salzer describes five types of support that might be provided by PSWs: emotional, instrumental, informational, companionship and validation.
- Self-help groups are thought to offer an antidote to the passivity that may result from participation in services with a hierarchical structure, and diminish the isolation and despair that many experience. Overall, experiential knowledge promotes choice and self-determination that enhance empowerment.
- The helper-therapy principle (Reissman, 1965) suggests that peer support provides opportunities for consumers to benefit from helping others through developing more reciprocal relationships, seeing the impact of mutual support and receiving approval (Skovholt, 1974)

Implementing and Adopting Peer Support

A number of key papers have presented lessons learnt through the implementation of peer support. Gates et al (2007) interviewed the leaders of 27 organisations that had employed peer support workers in New York. They found 5 key issues impeding integration of peer support workers into services in which they were employed: a lack of understanding of recovery (among

existing staff), role confusion (among peers and existing staff), lack of confidentiality about peers' history, insufficient job structure and inadequate social support.

In order to promote integration of peer support workers Gates et al (2007) offer a number of suggestions; Human Resource policies and practices should implement recruitment policies that allow experience in lieu of formal credentials. Positions should be permanent and independent of changing levels of funding and be compensated and evaluated on the same performance standards as other staff. Previous treatment records of internally recruited peers may be kept in confidential files. Peer support workers should have the opportunities to be promoted; this will make it clear that peers are as valuable to the agency as their other staff. Peers should also be offered training to learn language of the workplace and the Peer posts should be viewed as essential rather than an add-on.

A recent summit of PSW providers from 23 states in North America (Daniels et al - Pillars of Peer Support - 2010) met to determine the level and nature of State support required for system transformation through peer support as envisaged in recent US policy documents (e.g. New Freedom Commission on Mental Health, 2003). Each of these States employ between 9 and 500 PSWs and each provide a state certified training lasting between 40 and 80 hours. The challenges experienced and recommendations suggested in this report closely reflect those previously cited.

Barriers to peer support reported by participants in this summit included: incomplete acceptance of the role and value of peer support workers by commissioners and managers; lack of understanding of the role of peer support workers (by others and by PSWs themselves); stress for peer support workers created through their dual role as 'patient' and worker; implications for receipt of benefits; fear of job loss. Recommendations for State level support include sustainable funding and multi level support through the provision of a comprehensive certified range of training options (including training for trainers and training for non-peer staff), a clear job description, competencies (tested), professional status, a career pathway and a specific code of ethics.

Similar recommendations are made by others:

- a) Training programmes need to be introduced to staff in local statutory mental health service with a focus on the evidence base behind recovery and peer support, the benefits of employing peer support workers, adjustments that would be required to traditional ways of working and the supervision and support requirements of peer support workers (McLean et al, 2009).
- b) A standardized role description is essential but this needs to be sufficiently flexible to enable peer support workers to use their own experiences of recovery (McLean et al, 2009). Paid positions may require the candidates have some level of formal education in order to ensure they can complete any paperwork etc. However, this will however restrict the pool of potential candidates for the roles and also as Salzer (2002) points out, more rigid personnel requirements increase the likelihood that the nature of peer support services will be altered which could diminish their unique benefits.
- c) Optimum caseloads, remuneration and hours of work should be specified in advance and recruitment needs to determine that only those who will be able to complete them, with or without reasonable accommodations are employed (Chinman et al, 2006).
- d) It is essential to recruit people who have first hand experience of mental health problems

(Chinman et al, 2006). It is therefore likely that some applicants will be on benefits so advice about their welfare rights should be available to enable them to make informed decisions about the number of hours to work. (Gates et al 2007) suggest that peer support positions should come with retirement benefits that most workers come to rely upon or a wage high enough to compensate for the loss of benefits.

- e) Consideration needs to be given to peer support workers' dual relationships with teams that have previously or are currently providing them with mental health services. One of the problems that has been experienced by peer support workers is lack of confidentiality about their past history (Gates et al, 2007). Practices have ranged from requiring the peer support worker to sever all relationships with patients in the system to allowing relationships but requiring that they not be romantic or financial to minimize the possibility of exploitation (Chinman et al, 2006) – interestingly these might usually be called 'professional relationships' yet peer support workers are keen to move away from a 'professional role' so language becomes problematic. Clear and consistent policies need to be both developed, with input from multiple stakeholders, and reliably implemented.
- f) A standardized training programme is required to train peer support workers in the fundamental skills required for their position (McLean et al, 2009)
- g) Local advisory bodies and organizational plans are developed to oversee and shape the introduction of peer support workers in the local area (McLean et al, 2009)
- h) Supervision is available to the peer support workers, both clinical from team leaders and with other peer support workers (McLean et al, 2009)
- i) At least two peer support workers should be employed in each team/service to reduce the risk of isolation and coercion to other mental health agendas (McLean et al, 2009)

Challenges

Friend or Worker?

Peer support workers may be viewed more like friends than non-peer case managers or clinical staff, especially since peer support workers are not only allowed but are in fact expected to disclose personal information and to share intimate stories from their own lives. Mowbray et al (1998) found there were some difficulties when peer support relationships took on more friendship roles. Particular to the US context, this brought into question what was considered reimbursable or billable use of time.

Closer to home in the Nottingham project (Coleman and Campbell, 2009) questions arose about how close a PSW should get to the peers with whom they worked; socializing might involve drinking, dancing, going home together – and then it could be difficult to resume a more therapeutic relationship within a work context. However, Mead et al (2001) suggest that egalitarian relations provide an opportunity for both peers and peer support workers to grow and create meaningful and reciprocal relationships; boundaries should be flexible and individually governed as to avoid perpetuating the power structure of traditional, formal professional relationships. Furthermore, in a series of interviews with peer support workers, Macneil & Mead (2003) found that levels of intimacy and as such boundaries varied from individual to individual and that the peer support workers evolved professionally as they learned to reflect upon and articulate their limits.

Davidson et al (2006) raise other questions: are peer support workers able to maintain friendships they may have had with other people in recovery prior to being recruited to provide services to these same people? Can peer staff accept support offered to them by the people they serve? If not, then does this not move them closer to behaving and functioning in the traditional clinically driven manner - which would therefore negate the uniqueness of the peer support relationship?

It is clearly essential for Peer Support Workers to have a clear code of conduct, which sets out principles and the practice that flows from these. Certain practices, which might occur between friends, are not permissible in peer support working relationship, for example: sexual relationships, promising to keep secrets; sharing illegal substances, financial transactions; what is less clear is the level of disclosure and sharing that is either helpful or comfortable to both parties. Obviously there are some grey areas in peer support work and it is essential that training focuses on the rules governing decision making in any situation, rather than the myriad of specific dilemmas that might face a PSW on any one day.

Power

Mead et al (2001) point out that formalizing peer support by offering payment, training and titles will inevitably lead to power differences - even if these are minimized. They go on to assert that, if these power differences go unrecognized or not worked through, it could lead to peers being less than honest and saying or not saying things through fear of retribution.

Also of critical importance is the fact that many peer support workers may have to work with professionals that have treated them in the past (Fisk et al, 2000). This could challenge the possibility of respectful equal relations within the team as staff may fail to treat them as professional equals (Mowbray et al, 1998) or continue to view them as 'patients' (Davidson et al., 1999). A number of surveys have found that mental health professionals do view consumer delivered services as helpful (e.g. Hardiman (2007) found that 84% of professionals surveyed believed that service users could provide effective services), but less helpful than professionally delivered services (Salzer et al, 2002).

Interestingly Dixon et al (1997) examined attitudes towards peer support workers comparing staff members who worked with 'consumer advocates' with attitudes of staff members who did not. They found significant differences in 5 of the 30 items and on each of these staff working with consumer advocates scored more positively. This suggests that Peer Support Workers are their own best advocates – changing attitudes through experience of working together.

Related to the problems of power differential is the problem of recognition of the potential benefit of peer support. Burns-Lynch and Salzer (2001) describe the difficulty in establishing an innovative peer support project in Philadelphia. Although set up to fill a recognised gap in provision, receiving positive feedback from recipients and clinical agencies, and resulting in significant cost savings, this programme closed after one year because of the lack of referrals.

Reasons given for the poor take up of the service include: the lack of incentive to refer to peer-led services where many alternatives are available; no consistent Recovery and social inclusion philosophy of care; no recognition of the potential for peer support to provide an alternative to hospitalization; insufficient start up time to allow the service to become embedded into the system, insufficient needs analysis prior to the project commencing. The authors conclude by suggesting that " the main lesson learned from this programme is that as much attention should be paid to facilitating the adoption of such treatment innovations as spent in their design" (p. 520)

Stress for Peer Support Workers

Chinman et al (2006) found that providers were concerned that peer support workers might be exposed to stress, which could result in a reoccurrence of symptoms, which may result in re-hospitalization. This would be detrimental to the peer support worker and the people with whom the peer support worker was working - due to the effect it may have on the sense of hope instilled by the perceived recovery of the peer support worker. Paulson et al (1999), comparing differences in practices of consumer and non-consumer providers found that the biggest weakness of the non consumer teams was found to be the lack of workforce stability due to relapse. Paulson et al (1999) go on to suggest that an adjustment of staffing patterns is required to account for peer support worker's greater vulnerability.

Yuen & Fossey (2003) found that peer support workers emphasize that they need to monitor their own workloads and demands that are placed on them, and that they also need to feel able to take time out when required. McLean et al, (2009) also reported several of the 11 peer support workers in the Scottish pilot study had experienced readmissions to hospital since starting in the role. These admissions were not in the same service that the peer support worker was working in and that was believed to be a key factor in preserving relationships with colleagues and peers. Furthermore, the peer support workers used the experience to enhance the ways in which they could apply their experience to their role.

Peer Support Workers reflecting on the benefits and limitations of their employment (Mowbray et al, 1998) stated that some of the people who they were assigned to work with created stress because they directly affected the PSWs ability to do their job. For example, peers who were 'uncooperative', 'unmotivated', did not turn up for appointments, who were very troubled or in major debt, created feelings of frustration, disappointment, failure, fear, guilt. PSWs who had little training were shocked at the levels of disturbance in some clients. Some wanted to separate themselves from the people they worked with; some did not feel able to admit their feelings to the staff team; some found it hard to work out what they were supposed to do. This clearly demonstrates the need for support and training.

Accountability

The peer support workers in Chinman et al (2006) study also voiced worries about accountability, especially relating to risk. Mead & Macneil (2004) talk of a shared responsibility, between peer support worker and peer, that moves away from risk assessments toward mutually responsible relationships. This is increasingly referred to as relational risk management, or negotiated safety planning wherein control, as far as possible, remains with the person who appears to be at risk. They are asked what can be done to help them to feel safe; what they would like, where they want to be. The peer support worker might suggest alternatives that they themselves have found useful, or that others have utilized, but ultimately the decision lies with the individual about what will make them feel most comfortable.

Maintaining Peer Support Workers' Distinct Role

It appears to be the case that peer support offers distinctive features that are not currently provided by professional workers: support based on experience rather than professional expertise, more reciprocal relationships, more egalitarian conversations. Questions remain about whether it is possible for professionals who have personal experience of mental health problems to offer this kind of support. Solomon (2004) states that, "Consumer provided services need to remain true to themselves and not to take on characteristics of traditional mental health services" (p.8). However, there is the risk of peer support workers becoming socialized into the 'usual ways of working' or

following professional role models in a bid for respect. This is particularly likely when professionals do not value the peer support workers' role (see challenges above).

Mead & Macneil (2004) assert that the language of mental health plays a crucial role in separating the peer support roles from traditional mental health care. If peer support workers feel the need to talk about peers in medical terms to 'fit in' with the team, they neglect the unique personal experience of the peer that they are in a position to capture. Ultimately this undermines the potential of peer support. One way of maintaining a distinctiveness and continually maintaining awareness of the peer relationship is through peer led training and peer supervision, provided by a service user led organization, and group supervision to share insights, coping strategies and experiences.

Training

Since peer support roles have become formalized it has become apparent that there also needs to be some standardization in terms of their values, skills and knowledge base so that they are able to fulfill a distinct role with competence. For this reason, various organizations have developed peer support worker training. Although there is no common curriculum, a few key topics are central:

- Recovery (and Personal recovery planning)
- Peer Support (what it is and how it is distinct)
- Code of Conduct, ethical issues, peer relationships and boundaries
- Active listening skills
- Recovery language
- Problem solving
- Understanding difference (including different experiences – voices, paranoia, anxiety) and diverse cultural, ethnic and religious backgrounds.

Of most importance appears to be leadership of the training by peers who themselves have lived experience of distress (c.f. courses run by Working Towards Recovery; University of Nottingham; RIAZ). This retains the distinctive difference in approach (lived v. learnt) and agenda (Recovery of a life v. Recovery from symptoms).

Training is usually designed to prepare workers for a specific service or organisational context (e.g. 'Been There, Done That', Hodges and Hardiman - 2006 - Los Angeles) offers peer support to people returning to work and the 8 week training covers common issues such as empowerment, boundaries, crisis intervention as well as work related issues; RIAZ prepares peer support workers for work in a largely peer run service; the Nottingham Course prepares PSWs to work with and/or within statutory services. Courses run for between 3 days and 10 days and are accredited at different levels. In the UK the Nottingham Course is 10 days long and accredited at National Vocational Qualification Level 4.

Ongoing Supervision, Training and Support

There is little in the literature about the day-to-day experience or process of offering peer support within traditional services, nor of the ongoing support of workers. McLean et al (2009) provide the most detailed account and they emphasise the need for training for service providers where PSWs are to be employed to provide clarity about the role of the PSW, the importance of the whole team working towards well-being and Recovery. In a multi-site evaluation of the development of PSW posts in Canada, Moll et al (2009) conclude that the integration of peer support workers requires

ongoing support for the worker, flexible development of the work environment, and training and support for the team in which they are base in a long term evolutionary process.

Mowbray et al (1996) state that “ the necessity of consistent mentoring and supervision for consumer employees cannot be over-emphasised” (p.47). This is due to the role ambiguity (for them and for the team they are working in), the novelty of the role, and the complexity of the organizations in which they are working. Mowbray and colleagues distinguish between managerial supervision (designed to assist with the particular requirements of the job, relevant policies and procedures, time management, productivity and relations within the team) and mentoring from a senior peer/consumer worker to provide support, problem-solving assistance, trouble shooting and help to negotiate the ambiguities and complexities of the role.

In addition, PSWs’ performance will be enhanced by in-house training designed to augment the role (such as additional peer led training in Recovery Planning, Life Story Work, Life Coaching, Community Mapping) as well as having access to the range of skills based training and mandatory health and safety training provided for all staff in many healthcare organizations.

Conclusion

Although mutual support, friendships and support networks have traditionally developed naturally, these evolutionary dynamics change when peers are employed in formally defined roles in professionally led organizations. When one partner is paid, works predetermined hours, follows an institution’s employment policies and procedures and works to a job description, then the relationship between peers is not based on an equal footing. This review has examined the literature and research that describes this sort of intentional peer support work and measures the impact on the peer support workers themselves and the people they support and the services in which they are employed.

Clearly there has been exponential growth in the employment of peer support workers in the US, Australia and New Zealand over the past decade and more recently this expansion has spread to the UK. The focus of all recent mental health policy upon Recovery focused practice appears to be a key driver for these initiatives. The employment of peer support workers is seen to be a vehicle for the transformation of mental health services and research appears to be bearing out these policy aspirations. Trials show that at the very least, PSWs do not make any difference to mental health outcomes of people using services.

When a broader range of studies is taken into account, the benefits of PSW become more apparent. What PSWs do more successfully than professionally qualified staff is promote hope and belief in the possibility of Recovery, empowerment and increased self esteem, self efficacy and self management of difficulties, social inclusion, engagement and increased social networks. It is just these outcomes that people with lived experience have associated with their own Recovery; indeed these have been proposed as the central tenets of Recovery: Hope, Control/Agency and Opportunity (Repper and Perkins, 2003; Shepherd et al, 2008). In addition, employment as a peer support worker brings benefits for the peer support workers themselves in every reported evaluation. The experience of valued work in a supported context, permission to disclose mental health problems, which are positively valued, all add to self-esteem, confidence and personal Recovery. Experience of peer support working also increases chances of further employment, personal development and achievement of life goals.

Whilst there is some evidence that PSWs can challenge discrimination, promote positive language, emphasise strengths and possibilities, it is also clear that they cannot do this alone. The whole system needs to support the change through changes in language, practices, procedures and policies consistent with a Recovery-focused approach. Recovery Innovations in Arizona is testament to the wholesale change in culture brought about by a focus on Recovery; a Workforce comprising over 50% PSWs is a large part of this change but there were simultaneous changes in policies (e.g. no restraint) in staff training and roles (see recoveryinnovations.org) and in service structures (e.g. Recovery Education Centre to provide accredited training rather than therapy; introduction of a peer run crisis centre - The Living Room) and in procedures (training in Wellness and Recovery Action Planning (WRAP) for everyone using the service).

On the whole, the literature reflects a movement in its early stages of development, particularly in the UK. Whilst full of promise and potential, this initiative needs careful nurturing and shared learning so that early pilot sites pass on their learning and others can develop it further. This way Peer Support Workers are not put under unnecessary stress; mental health services evolve gradually with attention to the needs of existing staff, and people receiving support achieve optimal outcomes.

Questions abound: Can PSWs retain their efficacy when formally employed in traditional services or do relationships become distorted when non-reciprocal? How are the distinctive features of PSWs accommodated in traditional mental health teams? How will the job descriptions of Health Care Assistants and Peer Support Workers differ? Should PSWs be involved in the administration of medication, observation and restraint procedures? How would this be reflected in a PSW Code of Conduct? Is available training adequate and appropriate? Should there be a standard job description and banding to allow PSWs to transfer between services and progress up a career ladder? Can professionally trained staff fulfill a peer support role if they have lived experience of distress?

Although there are some answers to these questions within the literature, much more needs to be learned from experience. The ongoing sharing of experience, research, service and training evaluation and service descriptions is needed to inform further developments.

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