Peer Support:

A Theoretical Perspective

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Abstract

This article offers one theoretical perspective of peer support and attempts to define

the elements that, when reinforced through education and training, provide a new cultural

context for healing and recovery. Persons labeled with mental illness have become victims

of social and cultural ostracism and consequently have developed a sense of

self that re-enforces the "patient" identity. Enabling members to understand the nature and

impact of these cultural forces leads individuals and consumer communities toward a

capacity for personal, relational and social change. It is our hope that consumers from all

different types of programs (e.g. drop-in, social clubs, advocacy, support, outreach,

respite), traditional providers, and policy makers will find this article helpful in stimulating

dialogue about the role of peer programs in the development of a recovery based system.

Peer Support:

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The consumer movement, in the mental health arena, seeks social justice through understanding mental illnesses in terms of human rights, the social suppression of difference, and the medicalization of difference by psychiatric diagnosis. The consumer movement seeks personal liberation and wellness in the context of *recovery* based environments (Curtis, 2000). Through developing an understanding of oppression as a common theme among all of us with psychiatric labels, we discover the ways in which people have been marginalized by their culture, as opposed to seeing us simply as "insane".

Cultural Context

The cultural mainstream defines and decides ranges of "normal", seeking to have those of us with psychiatric labels blend into those ranges. People labeled with mental illness often fall outside the typical definition of "normal" and do not smoothly blend with the dominant culture. We, as users of mental health services, often referred to as "consumers", are forced to understand our problems as solely a biological matter. This denies the social and environmental factors that may have precipitated or contribute to the distress. Having been marginalized by this model we tend to adopt roles as "mental patients." Some of us have accepted this role, while others have not.

In general people with perceived difference internalize the dominant cultural perception. This is true of the "mental patient" role in society and is largely why we have a

mental health industry. Yet, even in "insanity", there are "islands of clarity" (Podvill, 1990). If we can pursue a broader discussion, if we can step outside of the box of the medical model, what the mental patients, themselves, have revealed is that environments of health create healthy members and environments of illness create professional mental patients.

Early on in the consumer movement, Zinman and Harp, in <u>Reaching Across</u> (1987), made clear how pervasive the impact of the medical model was on mental health policy, practice and research: our "problems" have been defined as diseases to be "treated" by professionals. This process tends to deny that other contributing stressors (e.g. abuse, poverty, loss, violence and trauma) are factors. Perpetrators are thereby overlooked; children are over-medicated; and society ignores the culturally sanctioned epidemic of violence. For example, White (1990) writes, "these ways of speaking and interacting with people puts them on the other side of knowledge, on the outside. These ways of speaking and acting make it possible for mental health professionals to construct people as the objects of psychiatric knowledge, to contribute to a sense of identity which has "otherness' as it's central feature" (p. 14).

Traditional research methodologies and hypotheses are founded on beliefs that we won't get over being mentally ill; we are only capable of "functional" healing as we attain certain socially prescribed goals – housing, job security, social integration, and so forth. There is no dialogue about wellness or about how we might exist, even thrive, within a culture that values and evaluates based on *our own* personal goals. If researchers would let go of methodology and epistemology that defines mental illness as a permanent disability we could, through a dialectical evaluation of how people have recovered, explore the

relationship of peer support and self-help to recovery. In this we could establish a new foundation for how we understand mental illness within the context of recovery. What ex-patients know is that we can and do get well.   We outgrow the role of mental patient. This discovery came from the arena of peer support and advocacy, however, hence the need to understand and document the theoretical underpinnings of how this works in these environments.

At the same time peer support programs are developing, they must participate in the design of research and evaluation processes that are drawn from the rich evolving nature of what we are learning. Some of these research methods might include action research (Rogers & Palmer-Erbs, 1996), narrative research (Polkinghorne, 1988), ethnography Denzin, 1997), life story models (Hertz, 1997), empowerment research (Fetterman, Kaftarian, Wandersman, 1996), measures of "healing cultures" (Mead & Curtis, 2000), and quantitative studies that show patterns of recovery which challenge traditional prognoses (Ralph et al 2000; Harding, Zubin & Strauss, 1992). Internally, for the peer organizations, these methods could establish the benchmarks for quality and effectiveness that will support continued funding.

Defining Peer Support

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain.

When people find affiliation with others they feel are "like" them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to "be" with each other without the constraints of traditional (expert/patient) relationships. Further, as trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves in conflict. This allows members of the peer community to try out new behaviors with one another and move beyond previously held self-concepts built on disability and diagnosis. The Stone Center refers to this as "mutual empowerment" (Stiver & Miller, 1998).

Peer support can offer a "culture" of health and ability as opposed to a culture of illness and disability. (Curtis, 1999; The primary goal is to responsibly challenge the assumptions about mental illness and at the same time to validate the individual for whom they really are and where the have come from. Peer support should attempt to think creatively and non-judgmentally about the way individuals experience and make meaning of their lives in contrast to having all actions and feelings diagnosed and labeled.

Many people have learned roles that build a strong sense of identity as "mental patient." Because this becomes a primary identity we find affiliation with others who have also been labeled. Zinman (1998) refers to this as "client culture." This "identity" leads us to the assumption that the rest of the community can't understand us and creates an "us/them" split with others. An imbalance of personal and social power lies at the heart of mental illness and is the cornerstone of the theory of recovery that we wish to present. Recovery from mental illness lies in undoing the cultural process of developing careers as mental patients. We undo this by practicing relationships in a different way.

Peer support, therefore, becomes a natural extension and expansion of community rather than modeling professionalized caretaking of people defined as defective. As peers feel less stuck in their roles as "patients," they naturally come to understand their problems in the larger social and political context from which they emerge, rather than pathologizing themselves. Peer support is a simultaneous movement towards autonomy and community building. It is not based in deficits model thinking. It is a model that encourages diversity rather than homogeneity, and recognizes individual strengths rather than focusing on weaknesses.

Finally peer support is not about "joining a club for the mentally ill." It is not a competition of stories or symptoms or about being rescued or infantalized. Peer support is an inclusive model that creates room for all people to fully experience "being who they are," growing in the directions of their choice and, in the process of being supported in these goals, begin to help restructure larger systems.

Historically many consumer-run drop in centers have been "illness assigned" cultures in which people felt an affiliation based on their shared experience of "being mentally ill," labeled, infantalized, oppressed and marginalized. The assumptions about mental illness and the internalizations of "otherness" have significantly contributed to the cultural acceptance of "problems" as illness, or abnormal. We see ourselves in the role of the "mental patient" and learn to make meaning defined by the roles that keep us feeling hidden and separated from others (Mead & Palmer, 1997). Being labeled with mental illness, or even living with perceived unaccepted difference, creates a self image or central belief, that controls the way we live, the way we think about control over our behavior, and how we define and react to problems versus opportunities. It is the premise of this analysis

that, in the context of mutually empathic relationships in peer support environments, we can practice seeking and finding new ways of making meaning and see ourselves from vantage points of personal worth and social power (Friere, 1995).

Relationships that heal challenge the need to hide and the defensive, self-justifying explanations that peers become prone to providing in social encounters. Peer support can and should contribute to the challenge, not foster collusion with roles that consumers have defined themselves by in the past. At its best, peer support should begin a process of building "affiliation" but not end there. People have felt alone in their "otherness" for a long time and need to practice "their new identities" within a context of safety and mutual support.

Affiliations are a property of a successful, dynamic society. Affiliation helps us see our commonalities and builds consequent trust. It helps us understand each other as "whole" people with a range of experiences that are familiar and therefore acceptable. Without a sense of affiliating many people build a dual identity of "other-than," and "acting as if." One woman who spends time at a peer center describes this below:

There was a time when things were totally out of control. I would just be alone in my apartment and be bombarded by the voices. I felt like there was nothing I could do but be alone and get through it. Then I got told that if I wanted to have visitation with my kids that I would have to have a job. Having a relationship with my kids was really important to me. I was terrified about having a job but I did it. I got a job at an art supply store. Every morning I would get up and go watch every move of the people around me, on the bus, at the store and on the way home. I would imitate

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whatever I saw other people doing, trying my best to make sure that nothing about

me looked out of the ordinary. It was exhausting. I had everything in strict control. I

knew, over time, that I had to reach a balance of being "out of control" and "being

in too tight control (T. Thomson, personal communication, April 1996).

When new members of most peer programs first start attending, there is an obvious

reluctance to engage in activities because of feelings of vulnerability. As in any

community, feeling welcomed, learning the rituals and language are part of a larger process

of building trust. When new members hear stories about types of situations that they've

experienced, there is a sudden relief in knowing that they're not alone and that others share

the same concerns. Caring is offered and received. Where we have felt isolated most of our

lives, we begin to make friends and establish a sense of community. We build a deepening

commitment and a willingness to share in community growth.

Although peer programs would like to think we act differently than other providers,

we often run into the same quandaries around "managing" difficult, frightening behaviors.

Often the focus of both peer centers and traditional services is on relaxing, "calming own,"

and avoiding conflict or stressful situations. When people behave otherwise they are

sometimes categorized as "symptomatic," in need of more intensive based services, or

outside of "peer" jurisdiction. Even with training and dialogue it is hard to develop new

cultural norms. In other words, the spontaneous reaction to a situation that makes us feel

afraid is the need to take control. We develop an inability to explore or re-evaluate

someone's experience as his or her subjective experience; one that **we** are not comfortable

with. An example of this might be a person with first hand knowledge of hallucinations

feeling unable and afraid of another person who cuts themselves as a reaction to their abuse history. Another example is how we react to other peers in crisis by modeling how staff in the hospital reacted to us when we were in crisis, even, for example, suggesting that a peer might think about increasing his or her medication. Peers become afraid of each other because people have been afraid of us and, consequently, respond to each other, too often, out of fear.

Peer support training can help develop our ability to sit with discomfort while we explore the dynamics of our relationships. It is helpful to understand what people's "hot spots" are, and the kinds of situations that feel comfortable, tolerable, or absolutely intolerable. Peer support is about normalizing what has been named as abnormal because of other people's discomfort (Dass & Gorman, 1985). Discovering this in a peer community reveals a different way of understanding our behaviors and presents an excellent framework to explore personal and relational change.

If we are truly committed to the development of peer programming, we must take the time to consider the kinds of programs that we will most benefit from. Traditional services have generally been reactive to crisis. Prevention based services, which is the larger category within which peer support services fit, should include an array of services that meet a continuum of needs (Biss & Curtis, 1993). In that, it is useful to think of all the options really necessary to have effective peer-run programs. The use of warm lines, hot lines, peer programs, advocacy programs, outreach, mobile crisis teams and respite are all necessary if we really want to help people grow out of their patient roles. The prevention based peer center may offer resources, groups, activities and opportunities to give members

a chance to re-conceptualize their ideas and beliefs about mental illness and move ***beyond disability*** (Mead & Palmer, 1997). Some of the resources might include:

- Strengthening self advocacy (creating your own wellness and/or treatment plan, creating advance directives, negotiating with your psychiatrist, ways of getting out of the payee system, etc);

- Understanding the difference between advocacy "with" and than advocacy "for;"

- Developing advocacy and action skills for social and systemic change;

- Practicing mutuality and reciprocity -- building mutually empowering relationships understanding conflict as a tool for growth-full relationships;

- Recognizing and diminishing co-dependency in multiple forms and guises;

- Parenting classes for people trying to get back or keep custody of their children;

- Working through the damaging effects of past or current abuse and violence (understanding the personal, relational, and political);

- Generating Wellness Recovery Action Plans (WRAP) which can help people strategize ways to stay well (Copeland, 1997, 1998);

- Offering alternatives views and strategies for people who hear voices (Deegan, 1995);

- Creating music as a form of social action and a way to communicate difficult feelings (Mead, 1995);

- Developing a variety of social activities that break down isolation and help build community.

The above discussion has outlined the philosophical framework within which peer supports operate. Within that framework there are a number of concepts and values that have been identified over time by the actual process of "doing" peer support. The following section will attempt to specify what those concepts are and then offer ways to put them into action in peer services and in training curriculum. These components can be useful to any aspect of peer programs but particularly important to peer support (e.g. warmline, hotline, outreach etc.) and peer supervision where these same guiding principles would be utilized.

From Concepts To Action

Concepts

Turning Oppression into Consciousness

Self-Awareness and Self-reflection

Creating Dialogue

Understanding Mutuality and Reciprocity

Honest Direct Communication

Flexible Boundaries

Shared Power

Shared Responsibility

Creating New Ways of "Making Meaning"

Empathy and Accountability

Respect That Comes From Your Heart

Absolute Belief in the Recovery of Everyone

Valuing Community

Having Fun

Not Using Symptoms As An Excuse For Bad Behavior

Being Held Accountable

Mutual Validation

Taking Care of Yourself

Giving and Receiving Critical Feedback

Learning To Work Through Conflict

Understanding of Larger Cultural and Political Issues

Action 1: Participatory Listening

Participatory listening means that, rather than just listening to someone retell their story, the listener engages in a dialogue about the story and what it means (Rogers, 1999; White, 1990). The intent is to help a person develop a new sense of self in the larger social context of their peer community and hopefully in the general community in which they live. It requires an ability to take a fresh and critical look at oneself and each other and an openness to examine both our strengths and weaknesses. Rather than continually justifying ourselves, tugging and pulling another person into our way of seeing things, we share our perceptions and our critiques without worrying about the "fragility" or the stability of the other person.

Many people get stuck in their need to feel safe and good about themselves and stunt their social success through protective behavior that avoids responsibility for personal actions and the effects they have on others. This dynamic gives rise to a number of problem

behaviors that require confrontation, examination and reform. Participatory listening

creates a dialogue that pursues a mutual commitment to personal and social improvement

(Friere, 1995). One begins by admitting that personal change is necessary and that one's

peers will be able to assist in that process.

Action 2: Understanding Perceptional Frameworks: Story Telling and the Re-Construction

of Self

People have different ways of looking at the world. We each come from a context

of community and family, or culture, that defines how we think about things, how we

describe ourselves and ultimately, how we understand and live our lives (Gergen, 1991).

The medical model is the dominant perceptual framework in the mental health

environment. We have learned how to language and think about our experiences within the

context of that model. Because of this imposed way of making meaning we become unable

to experience life to it's fullest.

One of the ways that we help each other to grow beyond the "mental patient" or

"sick person" identity is by examining the interior models that we have constructed. These

models have shaped how we think about ourselves and how we perceive the world. Peer

support environments help us safely examine our assumptions about who we are and where

we've come from by learning new ways of interpreting what has happened to

us. Introducing people to the idea that we have "perceptual frameworks" is a key

contribution to helping people get well. The following teaching metaphor is one way to

help people revisit their self-concept and begin to change it into a more positive and

fulfilling self-image (White & Epston, 1990).

The House as Self

Each of us lives within a house. It has an outside that others see as well as an inside that no one else can see or fully know. Its basic framework is the physical, emotional and spiritual self that we are born with. Over the years, many changes are made to the house – both inside and outside. Its rooms become are "decorated" by all the messages and experiences we've had. If early in life we are adored, talked to, held and told that we are the most wonderful person on earth, our house might include plush rugs, attractive furniture and a fireplace. If an important person comes into our life and gives us different messages (e.g. "you're bad, crazy, stupid, sick, inappropriate), the interior of our house changes. Often negative messages and fears are relegated to our "basement" where dark secrets are kept. More positive messages create upstairs rooms with windows and doors where it is more sunny, relationships are more transparent, and communication goes back and forth. Messages of "otherness" might create an attic.

Our perspective changes, depending on the view as we move from room to room. The view from the basement is different from the view from another room. If we spend too long in the basement we may find ourselves defining ourselves solely from that dark perspective, and even forget there are other rooms in our house. Bachelard (1958) writes about this phenomenon in the following description:

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All inhabited space bears the essence of the notion of home. Whenever the human

being has found the slightest shelter we see that the imagination build "walls" of

impalpable shadows, comfort itself with the illusion of protection – or just the

contrary, tremble behind the thick walls, mistrust of the staunchest ramparts. In

short, in the most interminable of dialectics, the sheltered being gives perceptible

limits to his shelter. An entire past comes to dwell in a new house (p. 5).

Furthermore no one can actually see the interior of our house. We can try to

describe it to others, but language is not the reality (Gergen, 1991). We often use language

as a way to recognize similarity and then we sometimes make the mistake of "over-

relating." We say: "I know what you mean, I've had the exact same experience." This is

one of the mistakes often found in peer support groups where we over-identify and keep

relating to each other from the mental patient role.

Describing our "house" to another person is a broader description of our whole self

-- if we don't get stuck in one room or view (e.g. mental patient identity). If we find

ourselves stuck in one room, effective peer support environments can help us break out of

this room and begin to explore the rest of our house and the community in which it sits. If

we think about our houses in the context of relationship, we see that we are constantly

changing and re-constructing the house and the contents of its rooms based on our

interactions with other people and environments, and the meaning we attribute to our past

and present experiences.   If we think about our house as being in a neighborhood of

similar looking houses, we can begin to understand how our "stories" about ourselves are

embedded in the culture and language of the "neighborhood." This dialogic process opens the "windows" to both self-exploration and to the deepening of relationships.

Action 3: Considering Trauma Worldviews: An Alternative Perceptual Framework

Trauma worldview is one way that people have learned to be in relationship. Those of us who have experienced trauma in the form of sexual and physical violence, don't trust, we blame ourselves as innately bad, we are afraid of conflict and we "act as if" in our relationships. Understanding the impact that trauma has had on our lives and relationships gives us an alternative perceptual framework and provides a more accurate context or understanding of the dynamics in peer communities.

Violence is a fact in our society. We implicitly and explicitly condone violence and then we blame the victims. Although the sequelae of violence and abuse are profound, mental health professionals have often either neglected to ask or ignored the situation. Lately more educated professionals (with the help of domestic violence and sexual assault programs) are recognizing and understanding the long term damaging effects of past violence. Questions like "what happened to you?" vs. "What's wrong with you?" are being asked in the more trauma informed systems of care (Bloom, 1997, p.191).

Peer programs are the natural resource to help synthesize our knowledge of domestic violence and mental health. Grass roots, advocacy, empowerment-centered peer organizations have long grappled with the labeling of oppressed groups and have focused on choice, rights and systems change (Friere, 1995). Translating this philosophy into the development of trauma informed peer organizations is not a stretch. The difficulty is that many members of peer programs have been taught to think of their difficulties as mental

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illnesses and been treated with medications and offered no explanation of the correlation between past violence and current life difficulties. Consequently a parallel "dissociation" occurs as a result; a secondary level of abuse takes place. Often, the discovery that this has happened takes place in peer programs. Therein lies the opportunity to re-educate and liberate the individual from the place in their house where they have been imprisoned by society and the coercive practices of the mental health system. Conversations and education about the extent to which trauma and past abuse impact self-concept, relationships and community is a way to break down people's sense of victimhood -- feeling responsible for making the abuse happen, incapable of mutually supportive relationships, or discomfort with their bodies. When we begin to speak the truth of our lives, express our pain, and find out the depth of the embedded messages common to abuse survivors, the language of symptoms is replaced by the deepening of personal relationships and our ability to advocate for a more politically astute mental health system.

Action 4: Accepting Flexible Boundaries

Boundaries are often cited in peer programs as an arbitrary construct for negotiating the terms of a relationship (Mead & Copeland, 2000). Rather than exploring each individual interaction and developing relationships, people have learned to set traditionally clinical boundaries when some situation might be difficult to negotiate. Being honest has long been associated with "hurting someone's feelings" or even getting in trouble. Clinical boundaries have been the model for what is "appropriate" in particular circumstances. For example, when asked in peer training if people would give out their home phone numbers to members they are being paid to serve, the response is often an emphatic no. We forget

that the people we serve are also long-term friends we've been receiving and making phone calls to for years. Without these flexible and individually negotiated boundaries we perpetuate the power structure of a more formal professional relationship (Curtis & Dupre, in press).

Action 5: Building Mutually Empowering Relationships Through Shared Responsibility and Shared Power

Assumptions about power define the dynamics of any community. It is no different in peer communities. Many peer support center mission statements include statements about everyone being equal with no one having power over anyone else. While fine in theory, there are often overt or covert hierarchies. Some members are considered staff, some supervisors to staff (directors), and some just members. Where there is money, and where there are titles, there are power differences, even if they are minimized. If this power dynamic goes unrecognized it leads the community members to being less than honest and saying or not saying things from fear of retribution.

Many power inequalities are less visible than the ones to do with money and title. Some of these include: level of education, professional type job (or having any job), financial means, charisma, service level (e.g. Assertive Community Treatment (ACT) team recipient vs. someone no longer in the system), confidence, and the more obvious ones such as gender, race, age, sexual preference and background. In communities of people who have been marginalized, there is an embedded sense of powerlessness that goes unrecognized. Identifying and talking about power dynamics is a beginning step toward breaking them down.

This is also true for sharing responsibility in relationships. When one person is the "helper," it is often difficult to switch roles and ask the other person for help. Sometimes people are afraid to say what they really mean because they worry about what the other person might do (for example, "If I say that, maybe he/she will get symptomatic…commit suicide"). Shared responsibility is a fundamental operating principle for peer programs to maintain a non-clinical, growth-oriented philosophy.

Action 6: Managing Conflict

Within all communities there are tendencies to faction or split. There are internal conflicts (on-going internal self criticism), interpersonal conflicts and community conflict. Often our own internal conflict informs all the other types of conflict. If we are struggling with the internal turmoil that voices itself through messages like: "you're so stupid, you don't know anything," interpersonal conflict style becomes one of avoidance and submission. If the message is "if you don't win, you're dead," conflict can become a battle of wills and blaming. The form that this then takes is a covert conflict within the whole community with the formation of cliques or factions that vie with each other for control and authority. Gossip becomes the main mechanism for communication and the atmosphere becomes filled with tension. When conflict or difficulties arise we often fall back into old roles of silence and avoidance, or of power and control. For many, conflict is linked to stressors that lead to escalating symptoms and therefore, in the medical model, should be avoided. However, in this model, learning to confront conflict is a way of building and deepening relationships and community. It is an unavoidable dynamic, part of the real world, present in all programs, but people in peer support programs have learned how

dangerous it's supposed to be and the potential results for engaging in it. Yet, if conflict is

addressed pro-actively, people learn ways to negotiate, facilitate, and manage it. This

approach moves beyond the medical model definition of struggle as symptoms to be

avoided and leads to building respect, reciprocity, and tolerance for others (Shore & Curtis,

1997).

Action 7: Strengthening Peer Supervision, Reflection and Evaluation

Every peer program starts out with the best intentions. There comes a time,

however, when conflicts arise, gossip is out of control and communication and

relationships at the center break down. Our communities tend to retreat to what we've

known in the past. Peer supervision that transcends roles is helpful in revealing to the

community how it self-destructs. Peer supervision needs to model the concept of

reciprocity (everyone gives and receives critical feedback). Supervision helps the

community learn to sustain its commitment to personal change. In addition, supervision

can create a framework to begin the evaluation and long-term research needed to document

how peer support works.

Self-reflection and critique are tools to help one another keep from defining any one

way as "right." Being able to deliver and receive difficult messages, as common practice,

maintains the peer support philosophy and supports the stability and integrity of the center

and its community of members and staff. Fostering this level of mutuality, supervision

assumes a proactive role in creating an environment in the peer support program that

supports the dynamics for personal change described above.   Supervision maintains the

program philosophy and interpersonal skill building that enables the membership to deal

with the fear, the conflict, and the power dynamics essential for our personal and social growth.

Implications for the Future

We are developing peer programs at an exciting time in mental health care reform (Jacobson & Curtis, 2000). Warmlines are run in almost every region of every state, protection and advocacy groups are part of every system, and peer support respite programs (offering an alternative to traditional hospitalization), are starting to appear around the country. Peer support centers are emerging in a variety of forms serving diverse interests.

Unfortunately there is little funding for peer support services compared to other mental health care funding. Rarely, if ever, has funding for peer support services comprised even one percent of a state mental health budget. Peer centers are competing with each other for the little money states are willing to invest. Research dollars have not been allocated for examining the effectiveness of peer supports and state government will remain reluctant to invest significantly until this approach has been validated by the mental health establishment.

We find ourselves in the same battles that any other competing organizations might have. As in any movement there will be "turf" battles and a struggle to develop the solidarity required to move the research agenda and achieve true systemic acceptance of the peer support model and thereby justifying its inclusion in state mental health care budgets.

If peer programs can standardize their models, build them on effective values and principles as we have described in this paper, they will draw more from each other as

resources, but also will be a powerful voice in the future design of services. Already we've helped to reduce people's dependence on professional supports, learned effective ways to help people go back to school and return to work. We have helped many learn how to stay out of crisis and thereby stay out of the hospital.

As an evolving culture, peer support has the opportunity to forge not just mental health system change but social change as well. As we eliminate the notion of "otherness" as deviant and support each other in healing, assumptions must change (Aronson, Wilson & Akert, 1994). The locus of responsibility for healing and change will be on a culture that currently condones violence and supports homogeneity. Instead of social control, perhaps there will be social responsibility. It is at this level of change peer programs must come together. It is at this level of development that "we can change the world."

References

Bachelard, G. (1958). <u>The Poetics of Space</u>. Boston MA: Beacon Press.

Biss, S.M. & Curtis, L.C. (1993). Crisis Service Systems: Beyond the Emergency Room. <u>In Community: Innovations in Housing and Support for People with Psychiatric Disabilities</u>, 3:1. Burlington, VT: Trinity College of Vermont, Center for Community Change through Housing and Support.

Bloom, S. (1997). <u>Creating Sanctuary: Toward the Evolution of Sane Societies</u>. NY: Routledge.

Copeland, M.E. (1997). <u>Wellness Recovery Action Plan</u>. Brattleboro, VT: Peach Press.

Curtis, L.C. (2000). Practice Guidance for Recovery-Oriented Behavioral Healthcare for Adults with Serious Mental Illnesses. <u>Personal Outcome Measures in Consumer-Directed Behavioral Health.</u> Towson, MD: The Council on Quality and Leadership for Persons with Disabilities. pp. 25-42.

Curtis, L.C. (1999). Modeling Recovery: Consumers as Service Providers in Behavioral Healthcare. <u>National Council News</u>. Rockville, MD: National Council for Community Behavioral Healthcare.

Curtis, L.C. & Dupre, P. (in press). Guidelines for Relationships Between Consumer Staff, Non-Consumer Staff, Clients and Friends.

Dass, R. & Gorman, P. (1985). <u>How Can I Help?</u> New York: Alfred A. Knopf.

Deegan, P. (1995). <u>Coping with Voices: Self Help Strategies for People Who Hear Voices that are Distressing</u>. Lawrence, MA: National Empowerment Center.

Denzin, N. (1997). <u>Interpretive Ethnography: Ethnographic Practices for the 21st Century</u>. Thousand Oaks, CA: Sage Publishing Co.

Friere,P. (1995). <u>The Pedagogy of the Oppressed</u>. New York: Continuum.

Gergen, K. (1998). <u>Realities and Relationships</u>. Cambridge, MA: Harvard University Press.

Gergen, K. (1991). <u>The Saturated Self: Dilemmas of Identity in Contemporary Life</u>. New York: Basic Books.

Harding, C.M., Zubin, J., & Strauss, J.S. (1992). Chronicity in Schizophrenia: Revisited. <u>British Journal of Psychiatry</u>, 161, 27-37.

Hertz, R., (Eds.). (1997). <u>Reflexivity and Voice</u>. Thousand Oaks, CA: Sage Publishing.

Jacobson, N. & Curtis, L.C. (2000). Recovery as Policy and Practice: How States Are

Implementing the Concept. <u>Psychosocial Rehabilitation Journal</u>. 23:4, p. 333-341.

Mead, S. (1995). <u>Re-Visioning Ourselves: A Model of Group Work for Trauma Survivors</u>.

Burlington, VT: University of Vermont, Department of Social Work. Masters Thesis.

Mead, S. & Curtis, L.C. (2000). <u>Measuring Healing Cultures: Toward Building</u>

<u>Environments that Stimulate, Enhance, and Support Recovery</u>. Unpublished document.

Mead, S. & Copland, M.E. (2000). <u>What Recovery Means to Us: Consumers Perspectives</u>.
Community Mental Health Journal, Vol. 36, No. 3 June 2000

Mead, S. & Palmer, H.P. (1997<u>). Recovery: Beyond Disability, Transcending Difference</u>

Burlington, VT: Trinity College of Vermont, Center for Community Change through

Housing and Support.

Miller, J.B. & Stiver, I. (1997). <u>The Healing Connection</u>. Boston, MA: Beacon Press.

Podvoll, E. (1990). <u>The Seduction of Madness: Revolutionary Insights into the World of</u>

<u>Psychosis and a Compassionate Approach to Recovery at Home</u>. NY: Harper Collins

Publishers.

Polkinghorne, D. (1988). <u>Narrative Knowing and the Human Sciences</u>. Albany, New York:

State of New York University Press.

Ralph, R., Risman, J., Kidder, K., Campbell, J., Caras, S., Dumont, J., Fisher, D., Johnson, J.R., Kaufmann, C., Knight, E., Loder, A., Penny, D., Townsend, W., Van Tosh, L. (1999). Recovery Model. The Recovery Advisory Group Work in Process.

Rogers, A. (1993). Voice, play, and a practice of ordinary courage in girls' and women's lives. Harvard Educational Review. 63, 265-295.

Rogers, S. & Palmer-Erbs, V. (1996). Participatory Action Research: Implications for Research and Evaluation in Psychiatric Rehabilitation. Boston University, Center for Psychiatric Rehabilitation: (in press).

Shore, S.E. & Curtis, L.C. (1997). Managing Workplace Conflict: A Skills Training Manual for Mental Health Consumers and Supervisors. Chicago, IL: University of Illinois at Chicago: National Research and Training Center on Psychiatric Disability.

Thompson, T. (1996) Personal Communication.

White, M., Epston, D. (1990). Narrative Means to Therapeutic Ends. New York: W.W. Norton and Company.

Zinman, S. (1998). Client Culture. Sacramento, CA: California Network of Mental Health Clients.

Zinman,S. & Harp, H.T. (1987). <u>Reaching Across: Mental Health Clients Helping Each Other</u>. Sacramento, CA: California Network of Mental Health Clients.