

## Harnessing the 'lived experience': Formalising peer support approaches to promote recovery

**Simon Bradstreet**

*Director*

*Scottish Recovery Network*

'First published in *The Mental Health Review*, Volume 11, Issue 2, June 2006'.

[www.pavpub.com](http://www.pavpub.com)

*"Every day at work is rewarding...I work side by side with others, peer to peer. I offer strength, support, experience, lend a listening ear, but most of all, I get paid to spread hope."*  
(Peer support worker, quoted in Ashcraft and Anthony, 2005)

Recovery is now commonly cited in mental health policy and planning documents. It signals a new approach to service delivery influenced by the lived experience of recovery, a focus on personal strengths and a more optimistic approach to long-term mental health problems. The concept has been extensively developed in the United States and New Zealand where attempts to translate recovery principles into practice are most advanced.

In the United States there have been two key federal policy documents of note. Firstly, the report from the Surgeon General recommended that all mental health systems have a recovery focus (Sacher, 1999). This report was followed by the President's New Freedom Commission on Mental Health which declared that recovery was the 'goal of a transformed system' (Fisher, 2003). This federal policy lead has led to individual states incorporating recovery elements into their state policy to varying degrees. In New Zealand the revised Blueprint for Mental Health Services promotes a recovery approach to service delivery (Mental Health Commission, 1998).

In Scotland one of the four key aims of the Scottish Executive's National Programme for Improving Mental Health and Well-being is 'promoting and supporting recovery' (Scottish Executive, 2003). In 2004 The Scottish Recovery Network was launched to work towards achieving this aim. The Network itself comprises a loose affiliation of organisations and individuals with an interest in raising awareness of recovery and in looking at new and innovative ways to promote recovery from long term mental health problems and mental illness.

The Network's main aims are:

1. To raise awareness of recovery from long term mental health problems
2. To gather and share information about the factors which people identify as having helped or hindered their recovery
3. To encourage local action and to highlight approaches which we believe to be particularly effective in promoting recovery.

Influenced by the international literature on recovery emphasising the central role of first person narratives (Anthony et al., 2003; Bradstreet, 2004; Lapsley et al., 2002; Reimann, 1982), we believe that recovery is about more than the mere absence of symptoms – it is

about having the opportunity to live a satisfying and fulfilling life (as defined by the person in recovery) in the presence or absence of ongoing symptoms. Put simply recovery is not about being ‘fixed’ or back to ‘normal’. It has been variously described as a ‘process’ or ‘journey’ and people often describe themselves as being ‘in’ recovery. This understanding of recovery also makes clear that because a person experiences a period of being unwell, it does not mean that they have stopped recovering or that they have gone back to square one:

*“Every problem and every hiccup was all necessary for me to arrive at where I am today.”*  
(Narrator Quote, Brown and Kandirikirira, 2006)

### **Elements of recovery**

International literature and information gathered in Scotland through the SRN’s Narrative Research Project both point to a number of key elements which are helpful to the recovery process (Anthony, 1993; Bradstreet, 2004; Onken et al., 2002). These include:

- Hope and optimism: the key role of promoting hope and taking a more optimistic outlook on the prospects of recovery, as defined by the individual, in tandem with a belief in change – the belief that things can get better
- Services and approaches which are holistic and inclusive: considering all elements of a person’s quality of life - recognising that the extent to which someone enjoys good health and well-being is influenced by a very wide range of social, environmental and individual factors and is about much more than the management of symptoms alone
- Wherever possible ensuring that people are able to be active participants in directing the recovery process rather than being passive recipients of care or treatments - this necessitates that people take control of, and responsibility for, their own recovery experience
- Promoting self management and developing coping strategies
- Accepting that episodes of illness can in fact be educative and developmental and can uniquely equip individuals with skills and knowledge to help others in their own recovery experience.

We believe that one way to translate these recovery principles into practice is to promote and develop formal peer support worker positions, training and employing people as peer specialists based on their own lived experience of recovery.

### **Formal peer support**

Peer support is a system of giving and receiving help founded on the key principles of respect, shared responsibility, and a mutual agreement of what is helpful (Mead et al, (2001). It is a model of provision that champions the use of personal knowledge and experience of a particular issue to help and support others who are experiencing that same issue. Of course this already exists in a number of mental health settings. Some are informal, for example, the type of mutual support many people describe from friends and acquaintances who have had similar experiences. Elsewhere, people who identify as having experienced mental health problems are involved in providing mental health services, perhaps most notably in organisations providing advocacy, befriending and self-help type services. However, formal peer support differs from both of these examples in that it involves creating specific roles within existing mental health services which are designed to be filled only by people who have experienced significant mental health problems – this in effect is their qualification.

These peer specialist posts would be taken by people who have completed an accredited training programme and peer specialist workers would perform a specific, clearly defined role within the service.

### **Formalised peer support and recovery**

This approach to service provision is not intended to replace existing services or professional roles, rather it is designed to complement them. Service users benefit from a service which uses a recovery approach and there are also benefits for those people who become trained and employed as peer specialist workers. The relationship between peer specialist and service user has, at its heart, the individual and empathetic relationship that develops between both parties; peer specialists are in effect sharing part of their own lived experience to offer hope and practical assistance of recovery to others.

<b>Service user gains</b>	<b>Peer specialist worker gains</b>
The empathetic and therapeutic relationship that can develop between peer specialist worker and service user is not always possible between service user and professional.	People with experience of long-term mental health problems are the most likely of all disability groups to be unemployed (Social Exclusion Unit, 2004). Peer specialist posts could offer much needed training and employment opportunities.
By the nature of the relationship peer specialist workers offer hope, a key element of recovery, to people using the service - 'if I got through this then so can you'.	PSWs value the lived experience of recovery and offer a chance for people with experience of mental health problems to contribute or 'give back'. This is commonly identified as being helpful in promoting recovery.
Peer specialist workers could offer a new service alternative. Knowing that the person who is helping you has had similar experiences to you in the past could be particularly helpful where someone has previously found it hard to engage with services.	Peer specialist posts offer a supportive and well managed work environment for PSWs where disclosing a history of mental health problems is seen as a qualification and positive attribute.
Peer specialist services are innovative and progressive services emphasising learning through training and the promotion of self management skills.	
Peer specialist services are based from the outset around recovery principles and values. These are achieved, for example, through valuing the lived experience of the peer specialists, the use of person-centred planning, recovery tools and techniques.	

### **Evidence for peer support**

*“The rationale for a more consumer-centric approach to managed care derives from a clinical prediction that services provided in this manner will lead to improved outcomes.”*  
(Sabin & Daniels, April 2003)

There has been little research into peer support or the use of peer specialist workers. However, from the evidence that is available, it has been argued that these services are as

effective, if not more so, than non-peer provided services. There is further evidence that where peer worker specialists are added to existing mental health teams the outcomes for service users are enhanced (Solomon, 2004). One of the measures most commonly used in evaluating peer support is reduced hospitalisation. Consistently positive results on this measure clearly imply a cost saving as hospitalisation is the most expensive means of providing mental health services (Solomon, 2004). If peer support services are to be further developed it is of paramount importance that a culture of evaluation and learning be promoted from the outset so as to allow the sharing of experience.

### **Peer support services in the United States**

In December 2005 the SRN invited three US-based peer support service representatives (from META Services, Arizona, and Georgia Certified Peer Specialist Project, GCPSP) to take part in a major conference to raise awareness of and to encourage interest in models of peer support. During the conference the Scottish Executive undertook to support the development of accredited training for a new peer specialist role to complement existing mental health services. The SRN are now working with local partners to identify opportunities to take this forward in Scotland.

For some time the mental health service community in the United States has been debating how to realise the vision of a recovery-orientated mental health system and the role of peer employees within mainstream psychiatric services has emerged as a key component. Formal peer support initiatives are increasingly becoming part of mainstream service provision, providing people with a wider range of options (GCPSP, 2006).

Since embracing peer support, Arizona-based META Services have trained over 500 peer support specialists and currently provide over \$5 million a year in peer services (Johnson & Ashcraft, 2005). Over half (196) of current staff within META are peer workers (SRN & SDCMH, 2005). In a six year period, primarily through the introduction of peer specialists, and taking an educational focus, META has gone through what their Chief Executive Officer, Gene Johnson, describes as a transformation from a 'traditional behavioral health organization' with a mission statement that articulated their commitment to 'stabilize and maintain' people to one based on recovery principles (Ashcraft & Anthony, 2005). META Services describe the key elements of peer support as follows:

1. Mutuality: giving and receiving help and support with respect based on a shared experience
2. Empathy: understanding through the personal experience of having "been there"
3. Engagement: sharing personal recovery experiences - "If she/he can do it, so can I."
4. Wellness: focusing on each person's strengths and wellness
5. Friendship: promoting recovery through relationship and friendship (Ashcraft & Johnson, 2005).

The Georgia Certified Peer Specialist Project started when the state threatened to ask for a repayment of existing rehabilitation funds. The change in services to peer provided care came as a result of lobbying from the service user movement (GCPSP, 2006). It is now the fastest growing mental health service in Georgia with over 200 trained, employed, peer specialist workers.

Several arguments have persuaded the federal and state administrations of the value of peer employees. The experience in Georgia and Arizona is that training and employing peer support workers has made the mental health services more efficient and effective. Initial evaluation of the Georgia service confirms findings from other studies of peer support by identifying improved outcomes for service users on a number of measures.

Both META and GCPSP are clear that the experience of introducing peer specialist workers is one part of a wider agenda to refocus mental health services around recovery. Quoting Mazade (2005), Gene Johnson described what has happened in META, and what they hope will happen across the USA, as “a profound, deep, intense, and penetrating alteration in the status quo”. It is something which has spread from the belief that “recovery is a fact”, but like all transformations it has faced resistance and required hard work, vision and strong leadership.

### **Making it happen**

*“I told them that I'd like to work in mental health and I was speaking to the [person] who was in charge of mental health and she felt that I'd be a risk to other clients if I was on medication, which was really quite upsetting - because I've never been a risk to myself or others; and I felt she was being quite judgmental really.” (Narrator Quote, Brown & Kandirikirira, 2006)*

There are many hurdles and practical considerations to be considered before a peer specialist workforce can be developed in Scotland, not least of which is the challenge to our understanding of professional boundaries and roles. We also need to consider the design and content of accredited training, how best to support, train and employ peer specialists, how to identify teams where they might be best placed, and how to ensure that they are valued team members.

However, peer specialists have enormous potential to help us realise in practice many of the increasingly well defined principles of recovery. The development of formal peer support services and the wider use of peer specialist employees in Scotland could, and should, offer one means of better realising the principles of recovery in mental health services.

For more information on the:

Scottish Recovery Network see [www.scottishrecovery.net](http://www.scottishrecovery.net)

National Programme for Improving Mental Health and Well-being see [www.wellscotland.info](http://www.wellscotland.info)

### **References**

Mental Health Commission (1998) *Blueprint for Mental Health Services in New Zealand. How Things Need to Be*. Available at <http://www.mhc.govt.nz/publications/1998/Blueprint1998.pdf> Accessed 17 February 2006.

Anthony W, Rogers ES & Farkas M (2003) Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal* **39** 101-114.

Anthony WACPP (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal* **16** 11-23.

Ashcraft L & Anthony WA (2005) A story of transformation: an agency fully embraces recovery. *Behavioral Healthcare Tomorrow* **14** 12-14.

Johnson E & Ashcraft L (2005) Recovery through an integrated workforce. Available at <http://www.scottishrecovery.net/content/mediaassets/doc/META.pdf> Accessed 17 February 2006.

Bradstreet S (2004) Elements of Recovery. In: S Bradstreet & W Brown (Eds) *SRN Discussion Paper Series*. Glasgow: Scottish Recovery Network.

Brown W & Kandirikirira N (2006) *Recovery Narrative Research: Narrator Quotes*. Glasgow: Scottish Recovery Network.

Fisher D (2003) Report of the Subcommittee on Consumer Issues: Shifting to a Recovery-Based Continuum of Community Care. *President's New Freedom Commission on Mental Health: A Recovery-Oriented Mental Health System*. Available at <http://www.mentalhealthcommission.gov/> Accessed 17 February 2006.

GCPSP (2006) Georgia Certified Peer Specialist Project. Available at <http://www.gacps.org/Home.html> Accessed 17 February 2006.

Johnson E & Ashcraft L (2005) The challenge of recovery. Available at [http://www.scottishrecovery.net/content/mediaassets/doc/METAs%20Story\\_for\\_SRN.pdf](http://www.scottishrecovery.net/content/mediaassets/doc/METAs%20Story_for_SRN.pdf) Accessed 17 February 2006.

Lapsley H, Nikora L & Black R (2002) "*Kia Mauri Tau!*" *Narratives of recovery from disabling mental health problems*. New Zealand: Mental Health Commission. Available at [www.mhc.govt.nz/publications/2002/](http://www.mhc.govt.nz/publications/2002/) Accessed 17 February 2006.

Mazade NA (2005) *Concepts of "Transformation"*. National Association of State Mental Health. Alexandria, Virginia: Program Directors Research Institute.

Mead S, Hilton D & Curtis L (2001) Peer support: a theoretical perspective. *Psychiatric Rehabilitation Journal* **25** 134-41.

Onken S, Dumont J, Ridgway P, Dornan D & Ralph R (2002) *Mental Health Recovery: what helps and what hinders? A national research project for the development of recovery facilitating performance indicators*. United States: National Technical Assistance Center for State Mental Health Planning.

Reimann G (1982) On the Usability of Narratives for Discovering Biographical Structures among Psychiatric Patients. *International Sociological Association*.

Sabin JE & Daniels N (April 2003) Managed Care: Strengthening the Consumer Voice in Managed Care: VII. The Georgia Peer Specialist Program. *Psychiatric Services*. American Psychiatric Association.

Sacher D (1999) *Mental Health: A Report of the Surgeon General*. In: *Department of Health and Human Services*. Rockville, US Public Health Service. Available at <http://www.surgeongeneral.gov/> Accessed 17 February 2006.

Scottish Executive (2003) *National Programme for Improving Mental Health and Well-Being Action Plan 2003-2006*. Available at <http://www.scotland.gov.uk/library5/health/npmh-00.asp> Accessed 16 February 2006.

Social Exclusion Unit (2004) *Mental health and social exclusion*. London: Office of the Deputy Prime Minister. Available at <http://www.socialexclusion.gov.uk/> Accessed 16 February 2006.

Solomon P (2004) Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients. *Psychiatric Rehabilitation Journal* **27** 392-401.

SRN & Scottish Development Centre for Mental Health (2006) *Conference summary report: Celebrating and Developing Peer Support in Scotland*. SRN National Conference. Glasgow: Scottish Recovery Network.