

Two Perspectives on Peer-to-Peer Support from the Center for Psychiatric Rehabilitation at Boston University

The Center for Psychiatric Rehabilitation has long been an advocate of Peer-to-Peer Support. Current efforts at the Center include:

- Training for peers specialists in psychiatric vocational rehabilitation.
- A series of webinars on peer-support specialist training for rural centers for independent living.
- Helping consumer organizations understand and use research to develop products for peer-use.
- Developing a curriculum for Latino peer providers to engage other peers.

For this issue of the CPR newsletter, Steve Harrington, a peer, founder, and Executive Director of NAPS , the National Association of Peer Specialists (NAPS), answered questions about his experience, peer-specialists, and peer-support. Also included is the Plain Language Summary from the Center's recent systematic review—a comprehensive rating and analysis of existing research—of peer-to-peer support studies. These two perspectives are part of the ongoing conversation regarding the role of Peer Providers as part of the future of Psychiatric Recovery. **Questions for Steve Harrington, Founder and Executive Director of the National Association of Peer Specialists (NAPS)**

1) As a peer, you helped start the NAPS, a national peer specialist organization. How did the idea for such an organization develop?

A small group of peer specialists from Grand Rapids, Michigan wanted to find out what was going on elsewhere in the country. We thought the best way to do that was to create a national organization and sponsor an annual, national conference. Last August, we had our fourth national conference. We have about 1,200 members from every state, Guam, Japan, the United Kingdom, Australia, and Canada.

2) NAPS created a peer specialist curriculum that has been adopted in a number of states and countries. Where has it been adopted? What are your hopes for the curriculum going forward?

The curriculum has been adopted, in whole or in part, in about 15 states and by the Veterans Administration. It is also used in the United Kingdom, Australia and was just translated into Japanese. The curriculum was written in 2007 and is now being updated and revised. Instructors' and student editions are available through a consumer-owned and operated micro-enterprise. My hope is that sales continue to be brisk so the business can continue to employ persons in recovery where they learn a variety of valuable employment skills. Proceeds are used to help people with rent, transportation, dental care and other basic needs.

3) What in your own experience as a peer drives you to change the way recovery is understood?

Recovery is unique to the individual so whenever I talk to a fellow peer, I learn something new about recovery. Recovery to one person is often different to other people and the means of achieving recovery goals is also unique. My recovery journey has taught me that life is full of challenges that are really learning opportunities. It would be great for everyone in our society to have that approach to life. Imagine if we were all learners with empathy for those struggling.

4) In your experience, what has been the greatest challenge to the acceptance of peer specialists?

The biggest challenge has been lack of understanding of the role of a peer specialist. This feeds fear among incumbent staff and administrators. The reality is that peer specialists are *not* therapists or case managers. They provide ancillary services, such as facilitating support groups, recovery training such as Wellness Recovery Action Planning, or helping connect people with community resources. The reality is that peer specialists often encourage peers to engage in other services and make the work of other staff more efficient and effective. Often, peer specialists will engage in one-on-one support where they simply listen, empathize, encourage and inspire hope. With these "tools," peers can move forward and make better use of others' services.

5) In your opinion, what is the most important thing that new peer specialists learn?

Telling one's story in an appropriate manner is vital. There is a real urge for peer specialists to share their own experiences and, if not properly done, can turn the relationship into one about the peer specialist and not the peer. One good way to share one's experience is to let the peer drive the conversation. For example, the peer specialist often only needs to say, "I'm John, a peer specialist at this agency. I'd like to learn about your circumstances." Most peers—almost without fail—will ask, "What is a peer specialist?" When the peer specialist says, "I'm a person with a psychiatric condition who helps others on their recovery journeys," a flood of questions from the peer about the peer specialist's experiences often results. In this way, the peer specialist can keep the focus on the peer and the peer feels empowered because he or she is driving the conversation.

6) For the person with no experience of peer to peer services, what is the first thing they should know?

If you are talking about the peer specialist, that person should know their experience is incredibly valuable and by simply modeling recovery, they can have a profound effect on a peer. That doesn't mean they have all the answers. It means they have the right questions to ask the peer. Peers who engage in peer-to-peer services should understand that peer service providers are there because of their compassion and passion to help others. In one survey, we discovered that a great many peer specialists do their work because it helps them (the peer specialist) in their own recovery. I believe it is also important for everyone to know that setbacks (I hate the term "relapse") are part of the recovery process. A setback—even if it means a stay at a psychiatric unit—can make one's recovery stronger and more complete. A setback is not something to be ashamed of. It is an opportunity for learning and personal growth.

7) Could you briefly describe the core process of your Peer-to-Peer Curriculum?

NAPS no longer trains peers. We developed a curriculum in 2007 in response to some states that were seeking quality and less expensive training. What we are seeing is a system emerge where peer specialists take a core training and then specialize in such areas as forensic (courts and correctional institutions), in-patient, substance use

disorders and holism specialties. This is an important development in the profession. BU's work in developing a vocational peer support curriculum is both timely and useful.

8) What do you think are the next steps for Peer-to-Peer Support?

Even despite economic challenges, I believe we are going to see a continued expansion of peerdelivered services of all types. Peer support is becoming more accepted and recognized as an integral part of services. The next steps are likely to be efforts to increase wages and working hours available. We still have many challenges; however, as peers all over the world are saying that although they are included on boards, committees, task forces and other policy-making bodies, their voices are not really heard. That is a huge barrier and with the SAMHSA-funded Recovery to Practice project, which is bringing together leaders of all mental health professions, the peer voice is likely to emerge as more meaningful.

9) Attainable goals are a key component of recovery. Yet the gulf between provider expectations and patient goals can be wide—and detrimental to recovery. Have you ever encountered a practitioner who disbelieved in your goals?

I would like to see the word "unrealistic" banned from mental health. I was once told by a psychiatrist that my life was over. He said I would never again work, have a home of my own, a car, write even one more book or obtain another college degree. It was devastating. I sat on a sofa for five years with no hope because I believed him. After I met a supportive clinician who suggested I start volunteering, I discovered recovery. I proved that psychiatrist wrong on every count—except writing one more book. I've written three since then. Failure to reach one's goals is really not a failure at all. It is an opportunity to learn and grow. Too often, clinicians judge peer goals. That is not a role for anyone except the individual with the goals. We simply have to move beyond that.

Plain Language Summary from Systematic Review of Peer-Delivered Services:

Peerdelivered services for individuals with severe psychiatric disabilities are based upon the premise that an individual with a "lived experience" is uniquely able to contribute to the rehabilitation and recovery of a person needing services. Peer delivered Peer-delivered services have proliferated greatly in the past decade to the point where they

are now an accepted component of mental health services and programs in many states. Peer services are an outgrowth of the consumer movement which emphasizes that mental health policies and services should embrace a philosophy of "nothing about us without us" and that there should be dignity, equity and mutuality in all helping relationships. Despite the proliferation of peer run services, there is no accepted or widely used typology of peer-delivered services which both hampers the field and complicated this systematic-review. For this review, we divided the studies of peer services into the following categories and report the plain language summary in the same way: peerdelivered services added to traditional services; peer-delivered services offered in mutual support groups; peer-delivered services in the context of drop-in centers; peer-delivered services offered primarily in a one-to-one service, and peer-delivered residential services and other. Results of this review suggested that adding peer-delivered services to traditional mental health or to case management services does not result in significant differences in outcomes that favor the peer-delivered services over traditional services. A small number of studies indicate advantages of peer-delivered services in engagement and retention of individuals in services, but not in outcomes. These results suggest that peer providers may offer unique and distinctive skills and experiences that can be helpful in the engagement and retention of individuals in services however, that evidence is modest. There is also evidence that peers provide services differently in terms of the focus on face-to-face interactions outside of the traditional office milieu. Taken together, these studies do not provide clear evidence that peer-delivered services provide advantages in terms of client outcomes such as employment, perceived social support, criminal justice involvement, housing stability, working alliance, service use, re-hospitalizations, quality of life, or substance abuse. Several authors have suggested that these results should be interpreted as supportive of the notion that peer providers can deliver equivalent services to those of professionals, rather than expecting peer-delivered services to outperform traditional services. There is some evidence that peer-delivered services, provided in a group context, can be effective in engaging individuals and in improving outcomes. The peer-delivered group interventions vary substantially one from one another, making conclusions difficult to draw in this category. The data do suggest that individuals who adhere to group interventions (i.e., attend a substantial number of sessions) appear to benefit whether the intervention is more traditional in nature, is similar to AA, or a different model altogether. However, conclusions from randomized designs using intent-to-treat analyses (i.e., involving all subjects randomized) do not reveal significant positive outcomes. Observational and correlational studies, such as those done in dropin centers or in Double Trouble for Recovery groups, suffer from problems with attrition and loss to follow-up. Despite this, it is safe to conclude that of those people who engage in peerdelivered interventions in groups regularly, benefits do accrue in the areas of abstinence from substance abuse, stability of psychiatric

symptoms, self-esteem, self-efficacy, empowerment, quality of life, perceived social support, satisfaction with services, medication adherence, reduced criminal justice involvement. The extent to which attrition and selection factors affect these outcomes cannot be estimated, but do pose a threat to these conclusions. For the one large study of peer-delivered interventions using multiple models (drop-in centers, mutual support groups, and education and advocacy) and multiple sites, there is evidence that participation in a peer-delivered intervention was associated with global positive changes in well-being. In terms of peer-delivered residential interventions there is equivocal evidence of outcomes when examining level of functioning, quality of life or other outcomes. In two studies of a primarily one-to-one peer-delivered service focusing on social supports there is no consistent evidence of effectiveness. Service satisfaction, however, does appear to favor individuals receiving peer-delivered services.

The full Peer Services Systematic Review can be viewed

at <http://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/peer-delivered-services/>