

International Guidance on the Values, Principles, and Practice of Mental Health Peer Support

Since its inception in the late 1980s, peer support has become the fastest growing component of mental health service systems around the globe. As the peer support workforce continues to expand rapidly, there is increasing need for clarity about what precisely peer support is, and is not, and how it relates to other interventions offered by mental health practitioners from other professions. This Guidance, developed by peer support leaders from across the globe¹, seeks to offer such clarification.

Our purpose is to ensure that as peer support grows, it grows with integrity to its founding values and remains distinct from other mental health interventions that are not based primarily on the person's own life experiences. In addition to describing these values, this Guidance describes the key practices associated with peer support and considers how these practices differ from, but also inter-relate to, those provided by other mental health staff.

To start, we have identified several central issues that must be addressed in implementing peer support with integrity. These include:

- 1) Recognizing that peer support is based on a human/civil rights perspective.
- 2) Understanding that peer support is not intended to serve a social control function, but rather promotes the dignity, autonomy, and social inclusion of persons with mental health concerns.
- 3) Appreciating that the credibility and utility of the peer support role derives primarily from the person's own life experiences of adversity and recovery.
- 4) Grappling with the fact that peer support relationships are by definition reciprocal in nature.

As suggested by our use of the term “grappling” above, not all of these issues have been resolved definitively at this time. By describing, briefly, how peer support emerged from the mutual support central to the ex-patient/psychiatric survivor movement, though, we hope to highlight and preserve what is unique about this new form of support as it expands both outside and inside of mental health systems. It is with this history that we begin.

Advocacy for Rights and the Emergence of Mutual Support

The earliest known mental health advocacy organization was the Alleged Lunatic Friend Society established in England around 1845. Its founder, John Perceval, was a tireless advocate for the reform of asylums and referred to himself as ‘the Attorney General of all Her Majesty’s madmen’ (Podvoll, 1990). Mental health advocacy groups also formed in Germany in the late nineteenth century to protest involuntary confinement. The Mental Hygiene Movement, that promoted the development of community-based care as an alternative to hospitals, started in the early Twentieth Century by Clifford Beers—author of the classic *A Mind that Found Itself* (1908)—is another example of such collective advocacy.

Mutual support among persons with mental health concerns did not arise, however, until the early 1970s, around the same time as civil rights movements arose among people of African origin, women, the LGBTQ community, and indigenous peoples. All of these social movements had in common experiences of oppression and the quest for self-determination among a marginalized or “second class” population. In mental health, this new wave was based on a critical perspective on the role of psychiatry in society, arguing against practices that claimed to be therapeutic but that focused instead on making people conform or adjust to the needs of a society they had legitimate reasons to question (Chamberlin, 1978). While not a part of the mental health reform movement, the Reverend Dr. Martin Luther King, Jr., captured this sentiment well when he insisted that he would “never be adjusted to lynch mobs, segregation, economic inequalities, ‘the madness of militarism’, and self-defeating physical violence” (1981, p. 23). With the need for this movement stemming from the harm done by, and the limitations of, mental health systems, a primary focus was placed on changing the existing systems as well as providing mutual support alternatives to it (Archibald, 2008; Burstow et al., 1988; Everett, 2000; le Blanc, 2008; O’Hagan, 2004).

A Brief History of Peer Support in Mental Health

This form of mutual support continues to thrive outside of formal mental health systems in many parts of the world, continuing to advocate for change while offering alternatives to systems that continue to struggle to improve. At the same time, a somewhat natural extension of this work has been for the provision of peer support to move into the heart of these very systems themselves, with the hiring of persons with lived experience of mental health concerns and recovery to become staff within mental health settings and programs. As we discuss below, this development has not been without its own complications and challenges. In particular, there is considerable concern that mental health systems, with the inertia endemic to large organizations, will simply absorb peer staff into existing services without changing care in any substantive way, thereby co-opting new peer staff to old practices and compromising the ‘role integrity’ of peer support (Scott, 2011).

This concern, unfortunately, is based on knowledge of the past as well as on hope for the future. For peer support has actually existed in various forms inside of the mental health system since its inception in the late 18th Century. In fact, it appears that the development of peer support was one of the most important advances made in the 1790s that allowed for the founding of psychiatry as a branch of medicine to become possible in the first place. Most histories credit the founding of psychiatry to Philippe Pinel, the French physician who became the Chief Medical Officer of the Bicetre Hospital in Paris shortly after the French Revolution began. It was taken as an embodiment of this revolution, and of the Enlightenment that gave it birth, that Pinel unshackled the inmates of this asylum and treated them instead with dignity and respect, ushering in what came to be called the “moral treatment” era.

If one returns to the facts, though, a different picture emerges; and one that we suggest is relevant for considerations of both the present and the future of peer support. The inmates of the Bicetre were being freed from their shackles prior to Pinel’s arrival, and one of the central strategies that had been developed by the Governor of the Bicetre that enabled him to transform this hospital into a moral treatment asylum was his strategy of hiring recovered patients to staff the wards. The Governor of the psychiatric wards, Jean-Baptiste Pussin, had himself been a patient of the Bicetre (although for a physical affliction) and had

subsequently been hired as a staff member for one of the youth wards. As he moved his way up the administrative ladder of the hospital to become its Governor, he had increasingly used this strategy to replace the abusive staff of the psychiatric wards (who he fired when they refused to cease their mistreatment) with people who had recovered from their own mental illness. As he wrote in an introductory letter to Pinel:

As much as possible, all servants are chosen from the category of mental patients. They are at any rate better suited to this demanding work because they are usually more gentle, honest, and humane (Pussin, 1797, p. 1132).

We point out Pussin's instrumental role in creating "moral treatment" through the hiring of peers not to diminish Pinel's importance, but rather to highlight how the founding of psychiatry became possible, in large part, due to the gentility, honesty, humanity, and wisdom that both Pussin and Pinel had come to recognize in their recovering patients. Pinel (1806) was the first to point out Pussin's central role in this development, writing as follows:

I am indebted to a fortunate concurrence of circumstances. Amongst these may be first enumerated, the eminent qualities, both of body and mind, of the governor of the Asylum de Bicêtre. He possesses the principles of a pure and enlightened philanthropy ... [By observing him] I discovered, that insanity was curable in many instances, by mildness of treatment and attention to the state of the mind exclusively, and when coercion was indispensable, that it might be very effectually applied without corporal indignity ... The method which he adopted for this purpose was simple, and I can vouch my own experience for its success. His servants were generally chosen from among the convalescents, who were allured to this kind of employment by the prospect of a little gain. Averse from active cruelty from the recollection of what they had themselves experienced; disposed to those of humanity and kindness from the value, which for the same reason, they could not fail to attach to them ... such men were peculiarly qualified for the situation ... (pp. 108-109).

Although not always acknowledged so directly, the wisdom accrued through the lived experience of mental ill health and recovery channeled through peer support has been and remains critical to the development and delivery of humane and healing mental health care. We suggest that it is important to recognize the importance of both lived experience and peer support in creating psychiatry so that they can continue to play humanizing and salutary roles in transforming mental health care. History has shown us how these crucially important elements can be crowded out of care in under-resourced and over-crowded institutions and systems. We must be vigilant in not allowing this to happen again.

So while current forms of peer support may have not arisen until the late 1980s, peer support itself has been around in more or less visible ways within the mental health system since the birth of mental health care itself over 200 years ago. How this particular component of care relates to other aspects of our contemporary scene—such as medication, involuntary treatment, and an array of psychosocial interventions—is one issue to be discussed in what follows, as we try to optimize and preserve the contributions peer support can make. We envision these contributions as not being limited to the recovery of individuals and families in distress, but also to the recovery of a broader field that many think has lost its way due, at least in part, to the silencing of the very same voices we are now interested in hearing and learning from.

A Definition of Peer Support

Peer Supporters, as we will discuss in this Charter, are defined as people who have experienced mental ill health and are either in or have achieved recovery. In their role as peer supporters, they use these personal experiences, along with relevant training and supervision, to facilitate, guide, and mentor another person's recovery journey by instilling hope, modeling recovery, and supporting people in their own efforts to reclaim their own meaningful and self-determined lives in the communities of their choice.

Key Principles in Operationalizing Peer Support

For peer support to retain its unique role and preserve its integrity as a peer-driven process, it will need to embody the following principles:

- 1) Peer support is based on a human/civil rights perspective. A primary focus of peer support is on empowering persons with mental health concerns to view themselves as the central agent of their own recovery. Peer support is offered in a respectful manner that enables persons with mental health concerns to have a sense of being a worthwhile and contributing member of their community.
- 2) Peer support does not serve a social control function, but promotes the dignity, autonomy, and social inclusion of persons with mental health concerns. As agents of empowerment, peer supporters strive to preserve and enhance the autonomy, self-determination, and decision-making capacity of the people they support. Even in times of crisis or when coercive measures are being taken, the role of the peer supporter is first and foremost to be an advocate for the person and his or her dignity, preferences, and desires.
- 3) The credibility and utility of the peer support role derives primarily from the person's own life experiences of adversity and recovery. Peer supporters use the lessons they have learned and the strengths they have acquired through their own overcoming of adversity to inspire, encourage, role model, and mentor others who face similar challenges. While they may acquire additional skills and knowledge through training and supervision, these are used to augment and expand of their lived experiences, not to replace or override them.
- 4) Peer support relationships are by definition reciprocal in nature. For peer support to be effective, peer supporters must relate to the people they support as "peers," that is, as whole human beings who share with them a common sense of humanity and equality. These relationships therefore cannot be one-sided or hierarchical in the ways in which relationships with mental health staff have been historically, even though the peer supporter is being paid (or volunteering) for the role. Peer supporters recognize that they grow and benefit from their relationships with the people they support just as much as they contribute to these relationships.

Guiding Values of Peer Support

The provision of peer support is based on the following guiding values:

- 1) Equity. Peer supporters view the people they support as their equals in terms of human worth, dignity, and membership in society.
- 2) Hope. Peer supporters communicate, embody, and instill hope in others by offering tangible proof that recovery and membership in society remain possible for persons with mental health concerns.
- 3) Trust. Peer supporters work hard to earn and preserve the trust of the people they support. In turn, they also demonstrate trust in the people they support, believing that people are doing their best to live their lives on a daily basis.
- 4) Respect. Peer supporters demonstrate a deep respect for the people they support, believing in their worth as fellow human beings.
- 5) Acceptance and Understanding. Peer supporters strive to accept and understand the people they support in a non-judgmental, non-critical way.
- 6) Shared Experiences and Shared Responsibility. Peer support is based on the belief that overcoming adversity becomes possible through the combination of personal effort with the support of caring and compassionate others. Coming out of a history of shared experience, peer supporters share the responsibility for recovery with those they support, working collaboratively together to fashion lives they have reason to value.

Core Practices of Peer Support

Regardless of the specific role a peer plays or the specific settings in which he or she works, the offering of peer support is based on the following core practices:

- 1) Peers elicit and promote each person's own resilience, gifts, and talents.
- 2) Peers support people in taking ownership of their own lives and decisions.
- 3) Peers focus on those health and quality of life outcomes most important to the people they support.
- 4) Peers advocate for changes, both in systems of care and in the broader society, to eliminate discrimination; expand opportunities, resources, and supports; and improve the quality of care offered to persons with mental health concerns.

¹ Representatives were drawn from Australia, Brazil, Canada, England, Hong Kong, Indonesia, Ireland, New Zealand, Scotland, Singapore, Tanzania, Thailand, Uganda, and the United States.