Defining "Peer Support": Implications for Policy, Practice, and Research

Darby Penney, MLS
Senior Research Associate
Advocates for Human Potential, Inc.

What is "peer support"?

Broadly defined, "peer support" refers to a process through which people who share common experiences or face similar challenges come together as equals to give and receive help based on the knowledge that comes through shared experience (Riessman, 1989). A "peer" is an equal, someone with whom one shares demographic or social similarities. "Support" expresses the kind of deeply felt empathy, encouragement, and assistance that people with shared experiences can offer one another within a reciprocal relationship.

Peer support as an organized strategy for giving and receiving help can be understood as an extension of the natural human tendency to respond compassionately to shared difficulty. A widow may offer comforting words, tea, and company to a woman grieving the death of her husband. Someone who has learned to cope with the effects of a serious injury explains how they manage to a newly injured person. Most people who have been through hard times empathize with and have an urge to help when they meet others who struggle with similar problems. It not only benefits the person receiving support, it makes the helper feel valued and needed (Riessman, 1965).

Sometimes referred to as self-help or mutual aid, peer support has been used by people dealing with different types of social circumstances, emotional challenges, and health issues, including those with alcohol or drug problems, bereaved individuals, and people living with physical illnesses or impairments (Penney, Mead, & Prescott, 2008). Peer support has a significant history among people with psychiatric diagnoses. This article will review recent literature on peer support among people with psychiatric diagnoses in the United States. It begins by addressing the substantial definitional issues involved and offering a brief consideration of the history of two types of peer support. This will be followed by an examination of recent review articles on peer support in mental health. An ongoing study of a peer-developed approach, Intentional Peer Support, within the context of peer-run programs, is described. Finally, policy and practice implications are discussed.

Defining Peer Support by and for People with Psychiatric Disabilities

In recent decades, there has been increasing attention in the professional literature to the study of peer support among people with psychiatric disabilities. But the ability to conduct a meaningful review of this literature is complicated by the fact that there is no agreed-upon definition of the term "peer support."

In the research literature, terms such as "peer support," "peer-delivered services," "self-help," "consumer services," "peer mentors," and "peer workers" are used interchangeably, making it difficult to draw meaningful distinctions among fundamentally different types of interventions (Repper & Carter, 2011; Rogers et al., 2010; Davidson, Chinman, Sells, & Rowe, 2006; Mead & MacNeil, 2005). Despite this confusion, upon examination of the history of peer support, one can differentiate between two major categories that are often conflated in the literature: *peer-developed peer support* and the practice of employing *peer staff in traditional mental health programs.* These are defined and discussed below.

Peer-Developed Peer Support

Peer-developed peer support is a non-hierarchical approach with origins in informal self-help and consciousness-raising groups organized in the 1970s by the ex-patients' movement. It arose within an explicitly political context, in reaction to negative experiences with mental health treatment and

dissatisfaction with the limits of the mental patient role (Van Tosh & del Vecchio, 2001; Kalinowski & Penney, 1998). While peer support for people with specific medical conditions, like cancer, focuses on coping with illness, peer support by and for people with psychiatric histories has always been closely intertwined with feelings of powerlessness within the mental health system and with activism promoting human and civil rights and alternatives to the medical model that defines extreme mental and emotional states as "mental illnesses" (Chamberlin, 1978). Deegan (2006) sees peer support as a "response to the alienation and adversity associated with being given a psychiatric diagnosis," by which diagnosed people are ostracized from the larger community and work to create their own communities by reaching out to others who share their lot.

The development of peer support was influenced by the human and civil rights movements of African Americans, women, and lesbians and gay men in the 1960s and '70s. It was also influenced by the Independent Living (IL) movement of people with physical, sensory, and cognitive disabilities (Deegan, 1992). Peer support was inseparable from human rights activism during the development of the IL movement and is one of four required services of federally funded Centers for Independent Living serving people with disabilities (White, Simpson, Gonda, Ravesloot, & Coble, 2010). The IL movement sees "disability" as the result of physical, attitudinal, and social barriers, rather than the consequences of deficits within individuals with impairments (De Jong, 1979). This formulation resonated with people who had negative experiences in the psychiatric system and used peer support as a means for coping with adverse effects (Penney & Bassman, 2004).

Although peer support emerged in a political environment, it is also an interpersonal process with the goal of promoting inner healing and growth in the context of community (Mead, 2003). As a practice, it is characterized by equitable relationships among people with shared experience, voluntariness, the belief that giving help is also self-healing, empowerment, positive risk-taking, self-awareness, and building a sense of community (Budd, Harp, & Zinman, 1987; Harp & Zinman, 1994; Clay, 2005). Peer support, by definition, is "led by people using mental health services" (Stamou, 2014, p. 167; Faulkner & Kalathil, 2012).

Intentional Peer Support as an Evolution of Informal and Peer-Developed Peer Support

In the early days, peer support—more commonly called "self-help" in those years—was often informal and relatively unstructured. People met in apartments, in church basements, and in libraries, but rarely in spaces affiliated with the mental health system (Chamberlin, 1990). But, during the 1980s and '90s, independent, peer-run nonprofit organizations emerged (Chamberlin, 2005). Many of these groups began to offer more structured peer support, generally with some government funding.

The development of government-funded peer-run programs meant that these programs needed to more clearly define the vision, principles, and practices of peer support to meet government oversight requirements. Shery Mead has been a pioneer in this work for more than 20 years, developing an approach called Intentional Peer Support (IPS). While IPS grew from the informal practices of grassroots-initiated peer support, it differs from earlier approaches because it is a theoretically based, manualized approach with clear goals and a fidelity tool for practitioners (MacNeil & Mead, 2005). IPS sees its fundamental purpose as helping people unlearn the mental patient role, and defines 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. 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" (Mead, 2003, p. 1). It is posited as a non-clinical intervention whose benefits are primarily intrapersonal and social in nature (Mead & MacNeil, 2005). In working with individuals with psychiatric diagnoses, the goals of IPS are to move from top-down helping to mutual learning, from a focus on the individual as the locus of dysfunction to a focus on relationships as a tool for growth, and from operating from fear to developing hope (Mead, 2014).

IPS is a philosophical descendant of the informal peer support of the ex-patients' movement of the 1970s. What distinguishes it from earlier, less structured peer support is a focus on the nature and purpose of the peer support relationship and its attention to skill-building to purposefully engage in peer support relationships that promote mutual healing and growth. IPS recognizes that trauma plays a central role in the experience, diagnosis, and treatment of people with

psychiatric histories, and emphasizes the need for peer support to be trauma-informed (Mead, 2001). Other peer support practitioners have expanded this effort to bring a trauma-informed lens to the practice of peer support through guidebooks and training (Blanch, Filson, Penney, & Cave, 2012).

Peer Staff Employed in Traditional Mental Health Programs

The growth of this approach is illustrated by the recent, rapid expansion in the U.S. of "peer specialists" and similar positions in mental health programs (National Association of State Mental Health Program Directors [NASMHPD], 2012). While there is no standard definition or job description for a "peer specialist," a number of states, provider organizations, and government agencies have such titles, also known as peer mentors, peer support specialists, recovery support specialists, recovery coaches, and a host of other titles that usually involve the words "peer" and/or "recovery." The use of the word "peer" as part of job titles is a topic that deserves fuller discussion than can be offered here. The term is confusing at best; in general usage, a "peer" is an equal, one who shares characteristics or experiences in common with the subject. To employ the word as a euphemism for "service user" or "mental patient" poses both grammatical and philosophical problems.

What these job titles have in common is that they apply to employees with psychiatric histories working in paraprofessional roles in traditional mental health programs, often performing the same tasks as non-peer staff (Davidson, Bellamy, Guy, & Miller, 2012). Job descriptions vary: peer staff may provide clinical and/or paraprofessional services that are indistinguishable from those provided by non-peer staff, they may serve as clerical staff or van drivers, or they may have undefined roles that evolve based on the individual's aptitude or the perceived needs of the organization.

Peer workers in traditional programs generally do not provide "peer support" as this term is commonly understood by users and practitioners of informal peer support. In fact, peer staff working in traditional programs rarely receive training about or exposure to the principles and practices of peer-developed peer support (Alberta, Ploski, & Carlson, 2012). Peer employees are usually expected to disclose their psychiatric histories and serve as role models for people they serve. Relationships between peer staff and service users are usually hierarchical, similar to staff-service user relationships generally within the mental health system, in contrast to the horizontal relationships that characterize peer-developed peer support (Alberta & Ploski, 2014; Davidson et al., 2012; Rogers et al., 2010).

An early study of peer specialist services in Bronx, New York, funded by the National Institute of Mental Health (NIMH) in 1990, found that several components of well-being were positively affected by the work of peer specialists (Felton, Stastny, Shern, Blanch, Donahue, Knight & Brown, 1995). Using a quasi-experimental design, the study demonstrated that adding three peer specialists to a team of ten intensive case managers (ICMs) resulted in stronger beneficial effects for service recipients, compared to two control groups (adding three paraprofessionals or no extra staff). The most significant benefits for the group served by the ICM teams with peer specialists were in quality of life, specifically greater satisfaction with living situation, finances, personal safety, and fewer overall life problems (Felton et al., 1995).

Based on initial findings of this study, the New York State Office of Mental Health (NYS OMH) established a Peer Specialist civil service title in 1993, the first state to do so. As of 2014, NYS OMH employed about 100 individuals in that title and at least 500 people worked in similar jobs in publicly funded voluntary sector agencies in the state. In both the Bronx ICM study and the Peer Specialist civil service title, the emphasis was initially on bringing the values and principles of peer-developed peer support into paid peer staff roles, but the ability to keep the focus on these values was often compromised by clinicians and administrators who did not understand or support the principles (Stastny & Brown, 2013).

The practice of using peer staff in traditional programs has been accompanied by state peer specialist certification programs in 38 states as of 2014 (Kaufman, Brooks, Bellinger, Steinley-Bumgarner, & Stevens-Manser, 2014). These certifications require completion of a state-approved training course, using either a curriculum designed by the state or one of a number of proprietary training programs. There are currently no national standards for peer specialist training, and the length, intensity, and content of the courses vary widely (Kaufman et al., 2014).

The expansion of peer staff in traditional programs accelerated when the federal Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Directors' letter in 2007 clarifying the conditions under which "peer support services" could be reimbursed by Medicaid. As of 2015, 31 states and the District of Columbia offered Medicaid-reimbursable peer support services, and it is likely that, under provisions of the Affordable Care Act, many other states will follow (Ostrow, Steinwachs, Leaf, & Naeger, 2015). The State Medicaid Directors' letter defined "peer support services" as "an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders" (CMS, 2007, p. 1). While this policy clarification spurred an increase in the use of peer specialists, it also added to the definitional confusion, stating that any service provided by a "qualified peer support provider" was, by definition, "peer support." Stastny and Brown (2013, p. 459) observed: "It appears that clinical services have come full circle to incorporate peers as providers in interventions that have moved far away from the original transformative role that was envisioned by the empowerment movement."

Recent Findings from the Literature

Following are brief summaries of six recent review articles or syntheses of research on peer support in the United States since 2006. Table 1, below, highlights key features of each review. These are primarily studies involving employment of peer staff in traditional programs, because, while informal and peer-developed peer support has been extensively described in the non-research literature (for example, Blanch, Filson, Penney, & Cave, 2012; Clay, 2005; Mead, Hilton, & Curtis, 2001; Chamberlin, 1990), its effectiveness has not been studied.

SAMHSA's Assessing the Evidence Base Review/ Chinman et al., 2014

This review looked at the effectiveness of three types of peer support services (peer staff added to traditional services, peer staff in existing clinical roles, and peer staff delivering structured curricula) and found 20 relevant studies between 1995 and 2012 (Chinman et al., 2014). An argument can be made that two of the three types of peer support defined by the reviewers (peers in existing clinical roles and peers delivering structured curricula) are not really "peer support services" in the commonly understood sense of the term.

Inclusion criteria included randomized controlled studies, quasi-experimental studies, single-group time-series designs, and cross-sectional correlational studies of peer support services for adults diagnosed with serious mental illness and/or co-occurring mental health and substance use disorders. This review was sponsored by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), which defined "peer support services" as "a direct service that is delivered by a person with a serious mental illness to a person with a serious mental disorder" (Chinman et al., 2014, p. 1–2). This definition is at variance with the definition of the term that grew out of peer-developed peer support; it does not recognize the centrality of equitable, mutual relationships based on shared common experience that is the hallmark of peer-developed peer support.

The authors found that peer support services met moderate levels of evidence, and that effectiveness varied across service types, with "peers in existing clinical roles" showing less effectiveness than the other two service types.

The review noted that many of the studies had methodological problems. Because the studies under review used disparate outcome measures (e.g., hospitalization days, social support, quality of life), comparisons were difficult. As with most of the review articles discussed in this section, the authors decried the quality of many of the studies, pointing to a need for "studies that better differentiate the contributions of the peer role and are conducted with greater specificity, consistency, and rigor" (Chinman et al., 2014, p. 11).

Cochrane Review/Pitt et al., 2013

A Cochrane review of 11 randomized controlled studies of what the authors referred to as "consumer services" (Pitt, Lowe, Hill, Prictor, Hetrick, Ryan & Berends, 2013, p. 4) found that the outcomes of such services are neither better nor worse than professionally provided services, although there is some evidence that peer services reduce the use of crisis and emergency services. Among the studies examined, the definitions of "consumer services" varied, making comparisons among and between

Table 1. Key Features of Peer Support Review Articles

Authors/Date	# of Studies	Inclusion Criteria	Peer Support Definition	Summary of Findings	Study Limitations
Substance Abuse and Mental Health Services Administration (SAMHSA)/Chinman et al., 2014	20	Randomized controlled trial (RCT); quasi-experimental	Direct service delivered by a person with a serious mental illness to a person with a serious mental disorder	Moderate levels of effectiveness for peers added to traditional services, but not for two other service types (peers in existing clinical roles and peers delivering structured curriculum)	Lack of comparable outcome measures across studies; insufficient differentiation of the effect of peer roles; lack of specificity, consistency, and rigor
Cochrane/Pitt et al., 2013	11	RCT	Past or present consumers of mental health services employed as providers of mental health care services	Outcomes (e.g., quality of life, hospital days) not better or worse than professional services	Lack of standard definitions hampered comparisons; many studies lacked rigor
Walker & Bryant, 2013	27	Qualitative; mixed methods	People who survived a psychiatric disability offer useful support, encouragement, and hope to others in similar situations	Increased self-esteem and community integration; poor working conditions	No study of peer service recipients; lack of standard definition
Davidson et al., 2012	14	RCT; mixed methods	Peers providing ancillary or clinical mental health services in traditional programs	May reduce hospitalization rate/ days	Appropriate research methodologies not yet developed to study nature and effect of peer relationships
Rogers et al., 2010	53	Pre-/post-; experimental; correlational; quasi-experimental; observational; survey research	Services provided by a consumer of mental health services	Some positive evidence for peer support groups; equivocal for other services	Lack of standard definitions; lack of information about program contexts, intensity of services, and fidelity to models
Davidson et al., 2006	4	RCT	The use of consumers as providers of services and supports	Few differences in outcomes between peer-provided and professional services	Methodological problems

the studies' findings difficult. For example, some were studies in which peer workers provided services identical to those provided by professionals (usually case management), while others concerned services that were based on peer providers' experiential knowledge. The review looked only at studies that compared outcomes of peer services (e.g., quality of life, hospital days) to outcomes of services delivered by professionals.

Walker and Bryant, 2013

Walker and Bryant (2013) conducted a metasynthesis of the findings of 27 published qualitative studies and mixed methods studies that examined peer support services provided within traditional mental health programs; studies of peer support provided within peer-run organizations were excluded. Their review reported on the experiences of peer staff and their non-peer colleagues, as well as on the experiences of people using services. Peer staff faced numerous challenges, including low pay, insufficient hours, negative or rejecting attitudes from non-peer staff, and being treated as "patients" instead of colleagues. They also reported positive benefits for peer staff, such as increased self-esteem, larger social networks, and increased community participation. Non-peer staff reported increased empathy for and understanding of people with psychiatric disabilities due to interactions with peer colleagues; however, non-peer staff feared that the presence of peer staff would result in job losses for non-peer staff. People who received services experienced better rapport with peer staff than non-peer staff and reported increased hope and motivation, as well as increased social networks, as a result of working with peer staff.

Davidson and Colleagues, 2012

Davidson and colleagues (2012) identified three categories of research on peer support that occurred sequentially over the past 25 years. First, there were feasibility studies of peer-provided services in the 1990s, which showed that peer staff could function adequately in ancillary roles and produce outcomes on a par with those of professional services. Second, a number of studies compared peer staff and professional staff providing conventional services in conventional roles. These studies generally reported that peer staff functioned at least as well as professionals, with comparable outcomes. Some studies found that peer staff had better outcomes than professionals on a few measures, including increased engagement among "hard-to-reach" clients, reduced hospitalization rates, and decreased substance abuse rates among people with dual diagnoses. Third, there are nascent investigations into the unique qualities/contributions of peer services and the outcomes these produce. The authors acknowledge that this research endeavor is in its infancy. They report on two of their own studies in this area. One compared "usual care" with "usual care" plus two different types of peer services, finding that the two peer services conditions resulted in increased participant satisfaction on quality of life measures. The other suggested that peer support may reduce re-hospitalization rates and number of hospital days.

Rogers and Colleagues, 2010

Rogers and colleagues (2010) reviewed 53 studies that met a minimum threshold for research quality as determined by a system developed by Rogers, Farkas, Anthony, and Kash (2008) rating the rigor of disability research and reported outcomes of peer services. They found no evidence that adding peer services to traditional services improved outcomes (neither did it worsen them); some evidence that peer support groups improved a number of outcomes for people who participated regularly (but not for occasional participants); and equivocal findings in other categories, such as one-to-one peer support and residential peer services. The authors noted a number of methodological problems that left them unable to draw firm conclusions related to the effectiveness of peer support and peer-delivered services.

Davidson and Colleagues, 2006

Davidson and colleagues (2006) examined four randomized controlled studies of peer-delivered conventional services and supports that compared case management teams with and without peer staff members. Two of the studies reviewed found no significant difference in outcomes between the groups. In contrast, one study found that clients receiving services from the team with a peer worker reported increased satisfaction with services, while another found that clients receiving services from the team with a peer worker had fewer hospitalizations and longer community tenure.

Discussion

Study Design and Outcome Measures

In the aggregate, the reviews and studies described above found minimal to moderate evidence that

adding peer-delivered services of various types to traditional mental health services may be effective on a range of outcome measures. However, there are a number of methodological concerns that raise questions about these findings, including the underlying design of many of the studies, the type of peer support studied, and the relevance of the outcome measures selected.

Most of the studies reviewed compared the outcomes of peer-delivered services with those of professionally delivered mental health services, and used traditional clinical outcome measures, such as symptom reduction, decreased hospitalization, and reduced substance use (Sledge et al., 2011). Both these factors raise issues about the appropriateness of these studies' designs. Peer support was never conceptualized as a substitute for—or interchangeable with—clinical services (Chamberlin, 1990; Campbell et al., 2006); neither are its goals the same as those of clinical services (Mead, Hilton, & Curtis, 2001; Harp & Zinman, 1994). Peer support staff generally do not have clinical training and are usually paid substantially less than credentialed mental health professionals. Since peer support was a) never envisioned as a substitute for clinical services—and, in fact, arose out of negative experiences with clinical services (Van Tosh & del Vecchio, 2001; Kalinowski & Penney, 1998)—and b) has different goals and thus outcomes than those of clinical services, it is not methodologically sound to compare the outcomes of peer support with those of clinical services.

The review articles noted serious methodological problems that interfered with the authors' ability to draw firm conclusions about the strength of the evidence in the research literature for a wide variety of peer-delivered services. Many of the authors had unresolved questions about exactly what types of interventions and services were actually involved in the studies they reviewed. For example, Rogers and colleagues (2010, p. 24) concluded that their review "was hampered by a lack of description of the peer delivered activities, services and supports being provided, a lack of information about the intensity of those services and supports, and little information about the models and contexts of the service delivery…. If the field is to move forward and be adequately reviewed as an evidence-based practice, future research activities should focus on improving the state of our understanding of peer delivered services."

It should be noted, however, that one of the review articles discussed above (Walker & Bryant, 2013) looked at qualitative and/or non-clinical outcomes that may have bearing on community participation and social inclusion. This approach shows promise for the development of outcome measures that actually track with the goals of peer-developed peer support as originally envisioned by the pioneers in this field.

It should also be noted that none of the review articles—nor the research they reviewed—reflected on cultural considerations in the delivery of peer support services, nor about the development of peer support services in communities of color.

Definitional Concerns

Rogers and colleagues' (2010) statement quoted above is a call for more rigorous studies of peer-delivered services. This call is useful as far as it goes, but, like most of the comments on methodological shortcomings expressed by the review authors, it fails to address the serious definitional issues associated with this body of research. Despite the fact that the studies reviewed used a wide range of confusing and often incompatible definitions, none of these authors addressed the question of whether what they were studying was, in fact, "peer support" at all. The authors do not discuss or take into consideration the history and philosophy of the consumer/survivor/ex-patient movement or the theories, principles, and practices of peer-developed peer support approaches.

Many of the review authors—and the researchers whose work they examined—essentially defined "peer support" as any service or activity provided by a person with a psychiatric history. For example, Davidson and colleagues (2006) defined "peer support as an asymmetric, one-directional relationship" (Fuhr et al., 2014, p. 2), in stark contrast to the mutual, bi-directional relationships conceptualized by Intentional Peer Support (Mead, 2014). The people who have developed and practiced peer-developed peer support over the past 40 years understand it as a specific type of relationship-based approach with a philosophical basis in the potential for mutual growth and healing, and with clear principles and practices reflecting equality and respect. IPS, for example, defines peer support as "connecting with someone in a way that contributes to both people learning and growing… the intention is to purposefully

communicate in ways that help both people step outside their current story" (Mead, 2014, p. 8). The development of this type of horizontal relationship is quite different from using peer staff within a traditional program to perform functions such as traditional case management services or driving people to appointments. Simply hiring people with psychiatric histories to do some of the usual tasks of the traditional mental health system is not the same as practicing peer support. By not exploring the true bi-directional relationship of peer support (the peer-developed definition), the extent to which the studies above truly identify the effectiveness of peer-delivered services is questionable.

A New Peer-Led Study of Intentional Peer Support

One approach to addressing the methodological and definitional issues discussed above is through peer-led research of a peer-developed approach using non-clinical outcome measures that track with the stated goals of peer support. An ongoing three-year quasi-experimental study funded by the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) is meeting this challenge by examining the comparative effectiveness of Intentional Peer Support in improving community integration, community participation, and quality of life for adults with psychiatric disabilities. This study is led by a principal investigator (PI) with a psychiatric history studying a peer-developed approach (IPS) delivered within the context of peer-run programs. This contrasts with earlier studies, which primarily looked at peer-delivered services (not specifically peer support services) within traditional mental health programs.

The study compares outcomes of participants receiving IPS in a peer-run program to those of participants in a peer-run program that does not practice IPS. Outcome data are collected through in-person interviews that assess self-esteem, self-stigma, social connectedness, community integration, community participation, and quality of life at baseline and six months after the initial interview. A new scale developed by the PI, the IPS Core Competencies Scale, assesses the extent to which study participants perceive that peer support staff are practicing the core competencies taught to IPS practitioners.

Secondary data sources include staff self-assessments and supervisory assessments, as well as focus groups of staff and service users. Quarterly, the IPS-trained staff at the intervention site complete a self-assessment of their skills and practices using the IPS Core Competencies Scale; supervisors rate staff using this tool biannually. Focus groups with peer support participants and with staff at both sites gather qualitative information on receiving and providing peer support prior to IPS training, 9 months after training, and 12 months later.

Randomized regression models and content analyses will be used to examine whether any significant differences in outcome measures occur between the groups. These findings will be supplemented by qualitative findings from the focus groups and staff self-assessments. Study results will provide important information on how an innovative approach to peer support, designed by people with psychiatric histories and delivered within independent peer-run programs, may enhance community integration, community participation, and quality of life for adults with psychiatric disabilities.

Implications for Practitioners and Future Research

As noted above, peer-developed peer support is a non-hierarchical interpersonal process promoting mutual healing in the context of community, characterized by equitable relationships among people with shared experiences and a commitment to growing beyond the limits of the mental patient role. However, in clinical and psychiatric rehabilitation service settings, the term "peer support" has been used to describe activities and jobs that are not necessarily congruent with the peer-developed definition. Peer specialist and similar titles describe staff with psychiatric histories working in paraprofessional roles in traditional mental health programs. These staff may provide clinical and/or paraprofessional services; work as clerical staff, janitors, or van drivers, or they may have relatively undefined roles that vary based on the perceived needs of the organization.

Because peer-developed peer support approaches are not generally available in clinical settings, perhaps it is not surprising that the literature reviewed above conflates a variety of peer-delivered services with "peer support." It is important that policy makers and administrators develop clear job descriptions for a variety of peer-delivered services, and that they understand that these services are not the same thing as "peer support." This will provide administrators,

clinicians, and researchers with the opportunity to educate themselves about the distinctions between peer-developed peer support approaches and the varied ways that peer staff are employed in traditional programs, so that they can accurately describe what they are providing and studying.

Other peer support-related topics that would be fruitful directions for future research include studying the implementation of Intentional Peer Support with peer staff working in traditional programs, as well as comparing Intentional Peer Support training with some of the state and organizational training curricula for Certified Peer Specialists currently in use.

The ongoing study of Intentional Peer Support described earlier is looking at the effects of a peer-developed approach to peer support implemented in a peer-run program, using non-clinical outcome measures that correspond to the principles and practices of peer-developed peer support. It is hoped that the results will help the field clarify its understanding of peer support and promote the expansion of services that are congruent with the original, peer-developed meaning of peer support.

Darby Penney is a long-time activist in the human rights movement for people with psychiatric histories. A Senior Research Associate at Advocates for Human Potential, Inc., she is Principal Investigator of a federally funded study of the effect of Intentional Peer Support on community integration, and co-author of *Engaging Women in Trauma-Informed Peer Support: A Guidebook.* She was formerly Director of Recipient Affairs at the New York State Office of Mental Health, where, for 10 years, she brought the perspectives of people with psychiatric histories into the policymaking process. She is co-author with Peter Stastny of *The Lives They Left Behind: Suitcases from a State Hospital Attic* and serves on the boards of the National Association for Rights Protection and Advocacy (NARPA) and the Campaign for Trauma-Informed Policy and Practice (CTIPP).

References

Alberta, A., & Ploski, R. (2014). Cooptation of peer support staff: Quantitative evidence. *Rehabilitation Process and Outcome*, *2014*(3), 25–29.

Alberta, A. J., Ploski, R. R., & Carlson, S. L. (2012). Addressing challenges to providing peer-based recovery support. *The Journal of Behavioral Health Services & Research*, *39*(4), 481–491.

Blanch, A., Filson, B., Penney, D., & Cave, C. (2012). Engaging women in trauma-informed peer support: A guidebook. SAMHSA's National Center for Trauma-Informed Care. Available at http://www.ahpnet.com/Files/PeerEngagementGuide_REVISED_10_2012.aspx

Budd, S., Harp, H., & Zinman, S. (1987). *Reaching across: Mental health clients helping each other.* Riverside, CA: California Network of Mental Health Clients.

Campbell, J., Lichtenstein, C., Teague, G., Johnsen, M., Yates, B., & Sonnefeld, J. (2006). *The Consumer-operated Service Programs (COSP) Multisite Research Initiative: Final report*. Saint Louis, MO: Coordinating Center at the Missouri Institute of Mental Health.

Centers for Medicare & Medicaid Services (CMS) (2007). State Medicaid Directors' letter #07-011 [guidance to states interested in peer support services under the Medicaid program]. Baltimore, MD: CMS, Department of Health and Human Services.

Chamberlin, J. (1978). *On our own: Patient-controlled alternatives to the mental health system.* New York: McGraw-Hill.

Chamberlin, J. (1990). The ex-patients' movement: Where we've been and where we're going. *Journal of Mind and Behavior*, *11*(3–4), 323–336.

Chamberlin, J. (2005). User/consumer involvement in mental health service delivery. *Epidemiologie Psichiatria Sociale*, *14*(01), 10–14.

Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services*, *65*(4), 429–441.

Clay, S. (Ed.) (2005). *On our own together: Peer programs for people with mental illness*. Nashville, TN: Vanderbilt University Press.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin, 32*(3), 443–450.

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11*(2), 123–128.

Deegan, P. E. (1992). The independent living movement and people with psychiatric disabilities: Taking back control over our own lives. *Psychiatric Rehabilitation Journal*, *15*(3), 3–19.

Deegan, P. (2006, July 24). The legacy of peer support. [Web log]. Retrieved from https://www.patdeegan.com/blog/posts/legacy-peer-support

DeJong, G. (1979). Independent living: From social movement to analytic paradigm. *Archives of Physical Medicine and Rehabilitation, 60*, 435–446.

Faulkner, A., & Kalathil, K. (2012). The freedom to be, the chance to dream: Preserving user-led peer support in mental health. Together. Available at http://www.together-uk.org/wp-content/uploads/2012/09/The-Freedom-to-be-The-Chance-to-dream-Full-Report1.pdf

Felton, C. J., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. *Psychiatric Services*, *46*(10), 1037–1044.

Fuhr, D. C., Salisbury, T. T., De Silva, M. J., Atif, N., van Ginneken, N., Rahman, A., & Patel, V. (2014). Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review and meta-analysis. *Social psychiatry and psychiatric epidemiology*, *49*(11), 1691–1702.

Harp, H., & Zinman, S. (1994). *Reaching across II: Maintaining our roots/The challenge of growth*. Sacramento, CA: California Network of Mental Health Clients.

Kalinowski, C., & Penney, D. (1998). Empowerment and women's mental health services. In Levin et al. (Eds.), *Women's mental health services: A public health perspectiv*e (pp. 127–154). Thousand Oaks, CA: Sage Publications.

Kaufman, L., Brooks, W., Bellinger, J., Steinley-Bumgarner, M., & Stevens-Manser, S. (2014). *Peer specialist training and certification programs: A national overview – 2014 update.* Austin, TX: Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

MacNeil, C., & Mead, S. (2005). A narrative approach to developing standards for trauma-informed peer support. *American Journal of Evaluation*, *26*(2), 231–244.

Mead, S. (2001). Peer support as a socio-political response to trauma and abuse. Available at https://docs.google.com/document/d/1trJ35i4dXX5AIWRnbg78OaT7-RfPE9_DbPm5kSST9_Q/edit

Mead, S. (2003). Defining peer support. Available at https://docs.google.com/document/d/1WG3ulnF6vthAwFZpJxE9rkx6lJzYSX7VX4HprV5EkfY/edit

Mead, S. (2014). *Intentional Peer Support: An alternative approach*. Bristol, VT: Intentional Peer Support.

Mead, S., & MacNeil, C. (2005). Peer support: A systemic approach. Available at http://www.intentionalpeersupport.org/wp-content/uploads/2014/02/Peer-Support_A-Systemic-Approach.pdf

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, *25*(2), 134.

National Association of State Mental Health Program Directors (NASMHPD). (2012). Fact sheet on promoting peer support services: The SMHA role. Available at http://www.nasmhpd.org/sites/default/files/Workforce_Fact%20Sheet%20on%20Promoting%20Peer%20Support%20Services.pdf

Ostrow, L., Steinwachs, D., Leaf, P. J., & Naeger, S. (2015). Medicaid reimbursement of mental health peer-run organizations: Results of a national survey. *Administration and Policy in Mental Health and Mental Health Services Research*, 1–11.

Penney, D., & Bassman, R. (2004). The independent living movement and people with psychiatric disabilities: Searching for common ground. Albany, NY: The Community Consortium. Available at http://community-consortium.org/pdfs/ILC.pdf

Penney, D., Mead, S., & Prescott, L. (2008). *Starting peer support: A manual for people with mental health and physical health issues*. Draft technical assistance manual. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adult clients of statutory mental health services. *The Cochrane Database of Systematic Reviews*, 3.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*(4), 392–411.

Riessman, F. (1965). The "helper" therapy principle. *Social Work*, *10*(2), 27–32.

Riessman, F. (1989). *Restructuring help: A human services paradigm for the 1990's*. New York, NY: National Self-help Clearinghouse.

Rogers, E., Farkas, M., Anthony, W., & Kash, M. (2008). Standards for rating program evaluation, policy, survey, pre-post, or correlational human subjects studies. Boston, MA: Boston University, Center for Psychiatric Rehabilitation. Available at http://www.bu.edu/drrk/files/2011/11/ms-syntheses-rigor-scale.doc

Rogers, E. S., Farkas, M., Anthony, W. A., Kash, M., Maru, M., & Brucker, D. (2010). Systematic review of peer delivered services literature 1989–2009. Boston, MA: Boston University, Center for Psychiatric Rehabilitation. Available at http://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/peer-delivered-services

Sledge, W. H., Lawless, M., Sells, D., Wieland, M., O'Connell, M. J., & Davidson, L. (2011). Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatric Services*, *62*(5), 541–544.

Solomon, P. (2004). Peer support/peer provided services: Underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, *27*(4), 392.

Stastny, P., & Brown, C. (2013). Peer specialist: Origins, pitfalls and worldwide dissemination. *Vertex*, *24*(112), 455.

Stamou, E. (2014). Reclaiming user leadership in peer support practice. *The Journal of Mental Health Training, Education and Practice*, *9*(3), 167–176.

Van Tosh, L., & del Vecchio, P. (2001). *Consumer/Survivor-operated self-help programs: A technical report* (Publication No. SMA01-3510). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal*, *36*(1), 28.

White, G. W., Simpson, J. L., Gonda, C., Ravesloot, C., & Coble, Z. (2010). Moving from independence to interdependence: A conceptual model for better understanding community participation of centers for independent living consumers. *Journal of Disability Policy Studies*, *20*(4), 233–240.