We would like to acknowledge those who participated in this project, either through participating in a focus group or completing an online survey. Without your input, there would have been no rich data, and consequently no report. We would like to extend a special thank you to those individuals who helped organize the focus groups. Thanks also to those of you who provided comments on draft versions of this report, your feedback has contributed to the development of a stronger report. Finally, we would like to thank everyone on the Service System Advisory Committees’ Peer Support Project Committee for their tireless efforts in supporting and promoting this important work.

This project has been made possible through funding from the Mental Health Commission of Canada. The work of the Mental Health Commission of Canada is supported by a grant from Health Canada.

For citation purposes, please use the following:
"Beginning five years ago, I participated in a weekly support group over a two year period. It changed my life knowing other people who had struggled and overcome. Even though I have struggled with illness on and off since the age of fifteen, until that point in time I hadn’t realized what was lacking in my life. Eventually, three years ago, I made a career change and became a Peer Support Provider. I never could have done this without the metamorphosis that took place during my two years attending the support group. I love my work and have never attained this level of wellness before."

"I have learned that there are many roads to wellness and the simplest, most insignificant thing can be the catalyst for change in someone. I have learned that I am NOT alone and that there are others who are in my corner encouraging me to go on. I have also learned that by serving, by helping, by listening, that there is healing for me. It is kind of a selfish thing, but when you help others, you in fact are helping yourself."

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"It took me just over three years to recover. I have no idea where I would have been without my group. From the first time I went, I continued to hear and be encouraged by: Trust me. You will get better. Be patient. It will take time. Learn as much as you can. Set realistic goals and surround yourself with people that make you feel good. Above all, look forward. You cannot change the past but the future is yours for the taking."
People with lived experience of mental illness and mental health problems from across Canada have contributed to the Making the Case for Peer Support project. Together, we want to share what we heard and learned from many sources and many people.

We also reviewed Canadian and international research, government policy statements, evaluation reports and other grey literature. This report describes what we observed and learned from many sources and many people.

Peer support workers and consumers who have shared their lived experience of mental illness and mental health problems from across Canada have contributed to the Making the Case for Peer Support project. Together, we want to share what we heard and learned from many sources and many people.

A robust and growing research evidence base shows peer support is associated with:

- Improvements in social support,
- Reductions in hospitalizations for mental health problems,
- Reductions in symptoms/disease severity,
- Improvements in social support,
- Improvements in quality of life.

Canadian research has contributed significantly to our knowledge base. Several systematic and qualitative reviews of empirical studies have been conducted by the Mental Health Commission of Canada to examine the benefits of peer support and independent peer run crisis support services. Over 600 individuals from across Canada took part in focus groups and interviews. Another 220 people offered their input through written and online surveys.

Together, this wide variety of people with lived experience of mental health problems have worked together to develop the Commission’s framework for peer support. To describe it, to make the case for it, and to make recommendations on how the Commission can join with us to support its development.

We reviewed Canadian and international research, government policy statements, evaluation reports and other grey literature. This report describes what we heard and learned from many sources and many people.

Peers working in mainstream settings describe feeling dominated by formal mental health, medical and social services. By doing so, peer support can save money.

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Research is uneven across the provinces at the levels of legislation, policy, funding and provision. Ontario, British Columbia, New Brunswick and Quebec appear to be furthest ahead in the development and a support of peer support services, yet they still have a long way to go. While research shows that people from many backgrounds can benefit from the peer support process, we found that it was primarily white, middle-aged and urban mental health consumers who have access to peer support. Aboriginal respondents said that they have their own equivalents to peer support which have mental health benefits, but these are not recognised or funded by government or mainstream mental health service providers. This growth has been driven by the recovery philosophy, which policy makers and service providers have placed at the centre of mental health policy in many jurisdictions across the world. Whatever shape it takes in support, it is important that the establishment legitimizes the role of peer support in the recovery process.

Most respondents agreed that peer support needs to continue to develop both inside and outside the mainstream mental health system. Independent peer run organizations require policy, administrative and funding support to build and maintain strong infrastructures. Positive working relationships with mainstream service providers need to be cultivated through good communication and working honestly through differences.

The growth in the number of peer support workers and services in mainstream mental health systems can help build positive relationships between colleagues working in both end user and mainstream services. Recommendations are clear: however, there are also challenges inherent in the growth that cannot be ignored. Peer workers in mainstream mental health service organizations are often in large bureaucratic settings, where they may be little or no support, meaning there is risk of their value and roles being ignored. Several experimental and quasi-experimental studies have demonstrated not only the benefits to individuals involved, but also to mental health system and societal health outcomes.

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1. Develop guidelines on the definition of peer support as a core component of mental health systems, which includes:
   • definitions and types of peer support
   • peer support values
   • peer support standards
   • peer support performance and outcome measures

2. Develop guidelines for the funding of peer support which include:
   • a target and deadline for the percentage of mental health funding to go to peer support
   • a recommended level of funding for peer support initiatives and for staff that is equitable with other mental health services
   • recommended funding of development infrastructures for peer support

3. Create guidelines to support the development of peer support which include:
   • templates for peer workforce roles and competencies
   • curricula for peer support workers leading to a formal qualification
   • education guidelines for peer support and its values for the non-peer workforce
   • consumer/survivor led evaluation of peer support
   • support for consumer/survivor led organizational development, training and education for mainstream mental health services, funders and other key stakeholders on the roles, values, processes and structures of peer support

4. Use this report and/or the guidelines developed to:
   • highlight the need for peer support to be a core service available to everyone, in the Commission’s strategic framework for informal mental health services across Canada
   • promote peer support and to educate regional governments, health authorities and service providers about it until the Commission closes in 2017, through conferences, publications and other forms of communication
   • develop a national resource centre for peer support, where all the information is provided in both French and English and is accessible to disabled people

The Mental Health Commission of Canada (MHCC) was set up to be a catalyst for national mental health reform, one of its roles towards this end is to disseminate evidence on mental health systems, which includes: It is also developing a national mental health strategy and intends to use the information from this report to promote peer support in the strategy. The MHCC’s Service Systems Advisory Committee commissioned this report and established a project group of people with lived experience of mental health problems to lead it.

Peers, support initiatives have an emerging evidence base and are highly valued by the people who use them. There are many issues that need to be addressed, however before they can assume their full place in a reformed Canadian mental health system. The major issues surrounding peer support will be discussed in this report.

This report has three functions:
• To make the case for peer support, and
• To recommend to MHCC how it can drive the development of peer support in Canada

For our investigation, we conducted formal and grey literature searches and web searches, including an extensive search of language sources on:
• The international literature on peer support initiatives;
• The Canadian literature on peer support initiatives;
• Policy and funding frameworks relating to peer support in Canada and other countries.

Most importantly, we received over 220 online and written submissions and conducted interviews and focus groups with over 600 individuals throughout Canada. In total:
• The views and experiences of people who both provide and use peer support initiatives;
• The views and experiences of other stakeholders - mental health professionals, researchers and administrators.
Peer support is “a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement on what is helpful” (Mead, Holmes, & Coates, 2008, p. 185).

Peer support is about normalizing what has been named abnormal because of other people’s discomfort” (Dais & Gorman in Maaløe, 2006, p.137).

Peer support - “a process in which consumers/survivors offer support to their peers. Peer supporters experience their own mental health issues and therefore are in a unique position to offer support to others in order to improve the quality of their lives” (British Columbia Ministry of Health Services, 2001, p.3).

“This self-help movement specifically incorporates peer individuals with experiences of negative mental health, addiction, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the women’s, environmental, disability, or queer movements, rather than solely, or at all, dealing with psychiatric injustices, comparable to its use in other social movements such as the -12-
A more common type of framework offered in the literature is based upon the organizational structure that providers or deliverers of peer support. As highlighted in St-Amand (2008), peer support programs can be delivered by consumers or service providers, and what is the aim (mutual support or formal service provision) (Mowbray et al., 1997 in Mowbray et al., 2005a)? Thus this framework is based on process and structural criteria, in which four main options are:

- consumers running mutual support
- service providers running formal service
- people offering peer support for consumers
- service provider running peer support services

The proposed model echoes an earlier survivor created definition based on two questions: "Who holds the real power?" (Nelson et al., 2008) or "Is there a spirit of advocacy in the group?" (Solomon, 2004). Therefore, to some degree or another there is an expression of the ideology being used to determine the "type of self help group" (Dunn et al., 2006, p.187). While some consensus exists over the role of ownership, power and control as being essential factors in defining peer support run organizations, defining the meaning of "control" and "mutual help vs. service" remains elusive. As discussed in Mead et al., 2001, the meaning of 'control' and 'mutual help vs. service' remains elusive. As discussed in Mead et al., 2001.

A review of consumer-run programs, Mowbray and colleagues conclude that there is considerable heterogeneity among programs identified as consumer-run (2005a, p.279). As examples of this, they described the differences in a variety of programs focusing on mental health mutual support group, mental health self help organization, and mental health community mental health mutual support group, mental health self help organization, and mental health community. After a review of consumer-run programs, Mowbray and colleagues conclude that there is considerable heterogeneity among programs identified as consumer-run (2005a, p.279). As examples of this, they described the differences in a variety of programs focusing on mental health mutual support group, mental health self help organization, and mental health community. After a review of consumer-run programs, Mowbray and colleagues conclude that there is considerable heterogeneity among programs identified as consumer-run (2005a, p.279). As examples of this, they described the differences in a variety of programs focusing on mental health mutual support group, mental health self help organization, and mental health community. After a review of consumer-run programs, Mowbray and colleagues conclude that there is considerable heterogeneity among programs identified as consumer-run (2005a, p.279). As examples of this, they described the differences in a variety of programs focusing on mental health mutual support group, mental health self help organization, and mental health community. After a review of consumer-run programs, Mowbray and colleagues conclude that there is considerable heterogeneity among programs identified as consumer-run (2005a, p.279). As examples of this, they described the differences in a variety of programs focusing on mental health mutual support group, mental health self help organization, and mental health community. After a review of consumer-run programs, Mowbray and colleagues conclude that there is considerable heterogeneity among programs identified as consumer-run (2005a, p.279). As examples of this, they described the differences in a variety of programs focusing on mental health mutual support group, mental health self help organization, and mental health community.
activities, there is little literature speaking to the way in which advocacy activities might also function as a form of peer support by creating new meaning of the possible, providing a support system, and working towards common goals.

Quebec has developed some innovative models of peer support advocacy based organizations. Founded in 1990, Association des groupes d’intervention pour le rétablissement en santé mentale au Québec (AGIR) represents 28 organizations throughout the province. Some of these organizations are self-help groups that have developed advocacy practices. The rest are organizations found in each administration regional of the province that defend the rights of people with mental health issues. From its inception, AGIR-trained peers so they could become informed advocates. Since then, courses on advocacy are delivered by peers and peer support training and workshops are conducted. Lorraine Guay reports on her experience in providing training to prevention and crisis services, and peer matching support programs. Solomon’s categorization distinguishes therapeutically from “peer partnerships”, where primary control is with mental health peers but is shared with non-consumers (2000). Other criteria include that the service be a freestanding legal entity, usually employing staff and with volunteers, but with little role of AGIRD in the organization’s activities. Examples of supportive/caring functions include drop-in crisis services, and peer matching support programs. These approaches, agencies and innovations.

In Quebec, peer support is often comprised within the alternative approach in mental health. Although the distinctiveness of self-help is recognized, it shares some common values with alternative treatment, alternative community housing, and the creation of a community of peers through the day to day activities of the peer group or, may look different by degree.

Quebec’s Aliéné of AGIR.

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The theory and research on consumer run services organizations described in this review has been built out of the experiences of English-speaking developed countries. Throughout the rest of the works, there is a clear distinction between the roles of peer professionals “have a major role in the group” (Powell in Solomon, 2004, p.304). There are services oriented around self-help, peer support, and peer advocacy training and documentation with its publications. Lorraine Guay reports on her experience in providing training to prevention and crisis services, and peer matching support programs. Solomon uses the term “peer run or operated services” for those “services that are planned, operated, administered, and evaluated by people with psychiatric disabilities” (2000). A further criterion rules that the service be a freestanding legal entity, usually employing staff and volunteers, but with little role of AGIRD in the organization’s activities. Examples of supportive/caring functions include drop-in crisis services, and peer matching support programs. Solomon’s categorization distinguishes therapeutically from “peer partnerships”, where primary control is with mental health peers but is shared with non-consumers (2000). Other criteria include that the service be a freestanding legal entity, usually employing staff and with volunteers, but with little role of AGIRD in the organization’s activities. Examples of supportive/caring functions include drop-in crisis services, and peer matching support programs.

and colleagues’ category (described above) of the aim of the organization, which is to provide assistance to people in the mental health system. This essential value is about solidarity between the individuals of the

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Solomon’s categorization distinguishes therapeutically from “peer partnerships”, where primary control is with mental health peers but is shared with non-consumers. These are often located within mainstream (non-consumer specific) organizations, with the sponsoring organization having fiduciary responsibility for the program. Solomon compares this model to “hybrid self-help groups” where non-professionals “have a major role in the group” (Powell in Solomon, 2004, p.304). The alternative resources available to Canadian consumers. In these contexts, our categories of self-help, peer support, and peer advocacy training and documentation with its publications may or may not be useful for understanding, or may lose by different degree.

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And the role of AGIRD as a coalition of alternative agencies has been studied by Martine Dupérré in a recent publication (2009). Alternative organizations have the additieional advantage of defining what they do in comparison to mainstream service organizations and this includes peer support as well.

If one wishes to explore the wealth of peer support experiences and peer support. From the peer support grey literature reports available online: “L’Entonnoir” of the RRASMQ (recently replaced by “L’autre Espace”) is the main players in the alternative and advocacy movement in mental health. Some Quebec writers on this topic are: Ellen Corin, Martine Dupérré, and Lourdes Rodriguez. Unfortunately, few of these writings are available in English. Much research focuses on defining what an alternative practice is and what it its future will be (AGIR, 2009). The RRASMQ’s specific contribution or, may look different by degree.

Other European Experiences

France has undergone a major transformation of its mental health system over the last years. As stated by Cardinal, Ethibon and Thibaut, “l’effort est à la fois dévastateur et créateur de la destinée de l’individu .” (2007, p.813). In other words, services are organized around the individual and not the illness. Service user involvement ranging from having a majority sitting on the board of administrators to running the activities of the centre.

The RRASMQ and AGIR

RRASMQ was founded in 1983 and now counts 120 member organizations in the province of Quebec. Self-help groups, crisis centres, community case management, housing treatment centres and work integration are examples of member agencies. AGIR, founded in 1985 in the Quebec City region represents 31 organizations. These are organized by a coordinator and a network of member organizations of both coalitions are self-help groups. Few self-help groups are run solely by service users. However there is a strong tradition of self-help, peer support and cooperation and solidarity between the individuals of the

Association des groupes d’intervention pour le rétablissement en santé mentale au Québec (AGIR), et la richesse des expérience de chacune des ressources au sein du RRASMQ

Further criteria include that the service be a freestanding legal entity, usually employing staff and volunteers, but with little role of AGIRD in the organization’s activities. Examples of supportive/caring functions include drop-in crisis services, and peer matching support programs. Solomon’s categorization distinguishes therapeutically from “peer partnerships”, where primary control is with mental health peers but is shared with non-consumers.

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Strange to hear money spoken about so often. 350 Euro monthly in the country he lived in now. This demonstrates how peer work is seen as a right, not just economic self-help. The lack of formal role descriptions for the people who are paid and who exist to define their roles (2004).
The nature of the control of the organization or structure within which peer support occur is important to understand that research suggests that this structure shapes the processes and nature of peer support, or what authors call the 'active ingredients' (Davidson et al., 2006; Weaver, Randall & Salem cited in Smith, 1995 in Dennis, 2003). The formally structured and funded consumer/survivor initiatives in Ontario have been demonstrated to provide ‘service’ to another is debatable (Mancini & Lawson, 2009). However, the degree to which mutuality can be said to exist where one ‘peer’ is paid to provide services to another is debatable (Mancini & Lawson, 2009).

Many advocates explicitly warn against the creation of unequal roles in peer support, as peer workers are often paid to provide 'service' to another person, with the expectation that these relationships lack the reciprocity that is core to mutual support (Davidson et al., 2006, p.446). For those who would say 'no', the rationale includes that these relationships lack the reciprocity that is core to mutual support (Davidson et al., 2006, p.446).

Regardless of practical, methodological or philosophical challenges, a diverse and growing body of research has developed to measure the effectiveness of self-help groups, peer-run programs, and peer workers. A growing body of literature has increasingly been able to demonstrate positive outcomes for peer support workers in mainstream mental health services. Several projects conducted over the last decade have been demonstrating peer support organizations' recognition as evidence-based practice (Campbell & Leaver, 2003; Humphreys et al., 2004, p.363). However, the degree to which mutuality can be said to exist where one ‘peer’ is paid to provide services to another is debatable (Mancini & Lawson, 2009).

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The individual peer volunteers were trained, supervised and received ongoing peer support in this study represented an interesting hybrid of different models. Discharged much earlier from the hospital, on average 116 days sooner. This early discharge or use of hospital services for the group receiving peer support, they were dedicated peer support (Forchuk et al., 2005).

Connections Peer Support Program and Transitional Discharge Model Ontario Two significant research studies in Ontario used experimental and quasi-experimental methods to evaluate the effectiveness of several types of peer support activities. One study conducted in south-western Ontario looked at the impact of a transitional discharge model on outcomes for people being discharged from hospital after a long term stay. A "significant saving" of resources was observed before they were discharged and after in the community to support their return to community life. A control group consisted of people whose transfer to the community did not include dedicated peer support (Forchuk et al., 2005).

While there were no significant differences in quality of life, levels of functioning, or readmissions of hospital services, for the group with transitional discharge they were discharged much earlier from the hospital, on average 16 days sooner. This early discharge resulted in considerable hospital cost savings (Forchuk et al., 2005).

The peer role was described as an important life skill. The individual peer volunteers were trained, supervised and received ongoing support by part time volunteer coordinators from more than ten consumer run organizations, who received time limited funding project from a non-governmental source (Forchuk et al., 2005). The role of the peer volunteers was not technologically based and was based on the "human element" of helping others. They provided peer support across a range of mental health services (Forchuk et al., 2005, p.97). Peers met with their match to go to events or play 5 and 10 minutes a week or just talk. The consumer run organizations provided the infrastructure that allowed for the training and management of over 300 volunteers.

Longitudinal Study of Consumer/Survivor Initiatives, Ontario The Longitudinal Study of Consumer/Survivor Initiatives in Community Mental Health was a participatory action research study conducted by four consumer-run groups in south-western Ontario the provincial network organization of the Mental Health and Addictions Recovery Services and Education in Human Services, 2004). Using both qualitative and quantitative methods they examined the impact they had with new members. This study also looked at any impacts made by the consumer run groups at the 'system's level representing the 'advocacy' function of the groups. Over the 18 months that members of these groups were followed, improvements were noted in social support and quality of life, and reductions in hospital admission rates and use of emergency health services (Community Mental Health Evaluation Initiative, 2004, p.28). Consumer-run groups were also active at the systems level, taking part in political advocacy, creating connections with hospitals in order to increase access to peer support, as well as taking part in the research study itself.

Effectiveness of Peer Support Workers Much of the research that was first conducted on peer workers in mainstream mental health organizations focused on whether there was any risk to clients in using them. While often the research focused on people with level with expertise working in a traditional role (e.g. case manager), the evidence base is growing in recent years there is now more recognition that peer workers are equivalent for people receiving services from peer or non-peer workers (Chinnam et al., 2006; Davidson et al., 2008; Simpson & House, 2005).

One of the most recent studies has gone further to conclude that based on a pilot study of five main community services, the peer support workers are more likely to exercise a critical mental health role in Scotland, as well as providing a "peer based support and assistance, voluntary reliance on professionals, voluntary membership, egalitarian, non-bureaucratic, and informal structure affordability, confidentiality, and non judgmental support" (Tosh & del Vecchio, 2000, p.3).

Values that are claimed to be unique include empowerment, independence, responsibility, choice and dignity, and social action. Other features of self help such as peer support and the consumer involvement should be considered as valued (Tosh & del Vecchio, 2000, p.12). Another description comes from Ontario's Consumer/Survivor Initiatives, which are "gated by a set of values that include member empowerment, participation, social justice, sense of community and peer support, and mutual learning" (Centre for Research and Education in Human Services, 2004, p.11).

The term 'empowerment' is used liberally in the literature to describe the process and goals towards which policy and practice should be directed "because values suggest both the 'processes' and 'outcomes' towards which policy and practice should be directed" (Hendrart, 2007). Another description comes from Ontario's Consumer/Survivor Initiatives, which are "gated by a set of values that include member empowerment, participation, social justice, sense of community and peer support, and mutual learning" (Centre for Research and Education in Human Services, 2004, p.11).

Values described as "the driving forces behind its [self help] development and success" (Hodges & Hardiman, 2006, p.11). The authors distinguish between common 'definitions', 'processes', and 'outcomes'. Thus the term 'empowerment' is used primarily as an outcome (Segal, Silverman & Silverman, 2002, p. 304). Campbell, in her framework of the 'caring' and 'social justice' values, describes empowerment as the primary objective of self-help agencies (Segal, Silverman & Silverman, 2002, p. 304). Campbell, in her framework of the 'caring' and 'social justice' values, describes empowerment as the primary objective of self-help agencies (Segal, Silverman & Silverman, 2002, p. 304). Campbell, in her framework of the 'caring' and 'social justice' values, describes empowerment as the primary objective of self-help agencies (Segal, Silverman & Silverman, 2002, p. 304). Campbell, in her framework of the 'caring' and 'social justice' values, describes empowerment as the primary objective of self-help agencies (Segal, Silverman & Silverman, 2002, p. 304). Campbell, in her framework of the 'caring' and 'social justice' values, describes empowerment as the primary objective of self-help agencies (Segal, Silverman & Silverman, 2002, p. 304). Campbell, in her framework of the 'caring' and 'social justice' values, describes empowerment as the primary objective of self-help agencies (Segal, Silverman & Silverman, 2002, p. 304). Campbell, in her framework of the 'caring' and 'social justice' values, describes empowerment as the primary objective of self-help agencies (Segal, Silverman & Silverman, 2002, p. 304). Campbell, in her framework of the 'caring' and 'social justice' values, describes empowerment as the primary objective of self-help agencies (Segal, Silverman & Silverman, 2002, p. 304). Campbell, in her framework of the 'caring' and 'social justice' values, describes empowerment as the primary objective of self-help agencies (Segal, Silverman & Silverman, 2002, p. 304)...
value, speaks to the need to have to depend on others for basic aspects of living (Van Tosh & del Vecchio, 2000). Beyond a response to disenfranchisement, this "self-help value, speaks to the need not to have to depend on others for basic aspects of living (Van Tosh & del Vecchio, 2000). Beyond a response to disenfranchisement, this value is often seen as part of the caring function of peer support, yet it can also change society’s meanings of madness or mental illness.

Alternatively, businesses, also known as social enterprises, have developed a particular version of this mutual learning, “where people acquire new knowledge and skills through work (Church in Church, Fontan, 2008, p.20). Valuing experiential knowledge, mutual learning, & the process of “re-naming”

As with the Anglophone movements, there is international sharing of experiences, which can lead to similarities in values and processes. Over the years, Quebec’s community mental health activities have been training people in France, Belgium and Switzerland on mutual aid and the role of peer support. Quebec’s community mental health activities have been training people in France, Belgium and Switzerland on mutual aid and the role of peer support. Quebec’s community mental health activities have been training people in France, Belgium and Switzerland on mutual aid and the role of peer support.

Valuing Experiential Knowledge, Mutual Learning, & the Process of “Re-Naming”

Peer support advocates often promote critical learning and the “experiencing of empowerment” based on peer leading and experiential knowledge (Mead & MacNeil, 2004). For people in recovery, “critical learning” doesn’t mean a medical diagnosis or a mental health role to emerge. It means offering pragmatic help—something that can offer as well as receive, our self-definitions are expanded” (Mead & Copeland, 2000, p.25).

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As with the Anglophone movements, there is international sharing of experiences, which can lead to similarities in values and processes. Over the years, Quebec’s community mental health activities have been training people in France, Belgium and Switzerland on mutual aid and the role of peer support.
The history of self-help groups in the "alternative movement" in Quebec is marked by high diversity in how to design and implement mutual aid. Self-help groups are often seen as a parallel and not as the对立 of other social movements. They can also be considered as a side activity, but it causes debate, confrontation, and concern over what should mutual aid (transitional) mean?

Involvement of Marginalized and Minority Consumer/Survivors in Peer Support Activities

Among people who experience mental health challenges and the mental health system is a wide range of experiences and identities, and which are reflected in the diversity of the consumer movement.

Some define consumer/survivor activism as equivalent to other social movements, such as anti-racism, feminism, and other identities, are their defining experiences (Brown, 2002; Shimrat, 1997).

As well, several self-help groups are successful in applying these values as opposed to competition, the right to make mistakes, recognizing and valuing differences, and the search for the harshest forms of oppression and discrimination in the centre of analysis, attending to the diversity of oppressions and their interlocking natures, an attempt to understand oppression in all its forms (Supportive Housing and Diversity Group, 2008).

Moreover, several self-help groups are successful in applying these values and understanding how such groups of disfranchised, stigmatized, and hurt users negotiate differences and create meanings of shared experiences through their social networks; all of which led to subjective improvements in their mental health (Leung & Arthur, 2004). The authors suggest that part of the success of the tightly knit group that developed was the need to develop support within communities where stigma against mental illness remained high.

Communities in other parts of the world have developed different explanations, such as the Maxon concept of triangulations or "self-determination": however, this approach is often criticized because it is recognized as existing within the consumer community, and the way in which policies and practices are applied to consumer/survivor experiences through peer support has not yet received much research attention.

The discussion is not simply academic. The meaning of identity is key to many notions of peer support. If the foundation upon which the "consumer" experience changes, for example, through the shift to a post-institutional mental health system located within the communities it serves, then how does the identity of "consumer change? As one service provider described, "Is it being a consumer about a shared label or a shared experience?" (Warner, 2003, p.87)

The experiences of marginalized consumers in peer support groups, both in mainstream mental health, and other mental health communities is also part of the shared language of the consumer movement. Research attention. British 'black' and minority ethnic' users have, for example, created a number of user-run organizations and developed a relatively significant amount of statistical data. Researchers have written about the prejudice and racism from other users, they still found that "the most productive and satisfying involvement of 'black and minority ethnic' users in mainstream mental health services has been the growth and support of their own organizations" (Peacock, 2004).

It is clear that consumers from a range of racial and cultural backgrounds participate in shaping the services that affect their lives but face increasing challenges. Support for this comes from other countries as well. In one of the few studies specifically on differences among members of consumer-run organizations, significant differences were found in the sense of community and social support dependency on the racial composition of the membership (Woodward, Holroyd, Brown, 2002). The communities in other parts of the world have developed different explanations, such as the Maxon concept of triangulations or "self-determination": however, this approach is often criticized because it is recognized as existing within the consumer community, and the way in which policies and practices are applied to consumer/survivor experiences through peer support has not yet received much research attention.

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In order to survive, activists need to develop support within communities where stigma against mental illness remained high.

Users from black and minority ethnic communities experience both the strengths and the challenges of the interconnectedness of identities. As they may often have unique experiences devalued or unrecognized by both mental health peers from other racialized communities and by service providers because of their identity, race, and society will not also exist in consumer run organizations. However, such differences are not all born the same way, do not operate under the same principles. This is by high diversity in how to design and implement mutual aid. Self-help groups are often seen as a parallel and not as the对立 of other social movements. They can also be considered as a side activity, but it causes debate, confrontation, and concern over what should mutual aid (transitional) mean?

Peoples with labels and experiences of mental illness may be active in peer support activities that are organized around another part of their personal identity, such as sexual orientation; race; or immigration experience. One review of the involvement of black and minority ethnic users in mainstream mental health services found that as the number of black and minority ethnic groups located in Michigan, United States, the study found that as the number of African-American consumers participating in these agencies increased, so did the perceived decrease in community with growing racial diversity. The authors noted that the growth of black and minority ethnic service users until race equality and anti-discrimination laws have been introduced. However, findings speak to the ways in which the identity of 'consumer' and the experience of madness or mental illness or society will not also exist in consumer run organizations. Support for this comes from other countries as well. In one of the few studies specifically on differences among members of consumer-run organizations, significant differences were found in the sense of community and social support dependency on the racial composition of the membership. Research attention. British 'black' and minority ethnic' users have, for example, created a number of user-run organizations and developed a relatively significant amount of statistical data. Researchers have written about the prejudice and racism from other users, they still found that "the most productive and satisfying involvement of 'black and minority ethnic' users in mainstream mental health services has been the growth and support of their own organizations" (Peacock, 2004).

Women living in seven different communities across Ontario, who were considered to be at 'high risk' for postnatal depression and who took part in one-to-one telephone supportive conversations with a peer, reported high levels of depression, life-threatening depression, and suicide ideation (Hodnett, Kelloway, & Anderson, 2008). It is clear that consumers from a range of racial and cultural backgrounds participate in shaping the services that affect their lives but face increasing challenges. Support for this comes from other countries as well. In one of the few studies specifically on differences among members of consumer-run organizations, significant differences were found in the sense of community and social support dependency on the racial composition of the membership (Woodward, Holroyd, Brown, 2002). The communities in other parts of the world have developed different explanations, such as the Maxon concept of triangulations or "self-determination": however, this approach is often criticized because it is recognized as existing within the consumer community, and the way in which policies and practices are applied to consumer/survivor experiences through peer support has not yet received much research attention.

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In user groups, raising issues related to race and identity sometimes generated accusations of dividing cliques with the group. The focus was on ensuring that the voice of diverse individuals was brought to bear on others’ ideas of what that voice was like (Katahali, 2008, p.3). The impact and interrelationship among diverse identities is particularly evident in the growing number of people with mental health problems who are coming to understand and make sense of the complex issues of race, class, and/or ethnicity in their lives. Researchers have identified the need to be aware of others’ ideas of what that voice was like (Katahali, 2008, p.3). The impact and interrelationship among diverse identities is particularly evident in the growing number of people with mental health problems who are coming to understand and make sense of the complex issues of race, class, and/or ethnicity in their lives. Researchers have identified the need to be aware of others’ ideas of what that voice was like (Katahali, 2008, p.3). The impact and interrelationship among diverse identities is particularly evident in the growing number of people with mental health problems who are coming to understand and make sense of the complex issues of race, class, and/or ethnicity in their lives. Researchers have identified the need to be aware of others’ ideas of what that voice was like (Katahali, 2008, p.3). The impact and interrelationship among diverse identities is particularly evident in the growing number of people with mental health problems who are coming to understand and make sense of the complex issues of race, class, and/or ethnicity in their lives. Researchers have identified the need to be aware of others’ ideas of what that voice was like (Katahali, 2008, p.3).
Peer support is sometimes known as self-help, mutual aid, co-counselling or mutual support. These terms are all used for processes that bring people with shared experiences together in a wide variety of structures, groups, organizations, online, and one-to-one.

Independent and mainstream

We refer to independent peer run initiatives as those which are run by consumer/survivor run organizations or who name themselves in a way that defines them in relation to the mental health system, with terms such as consumer or survivor. We define clients as people who use peer support services within mainstream agencies and members or participants as people who use independent peer run initiatives.

Definitions

In our consultations we came across uncertainties surrounding some definitions in peer support which will need to be clarified as the area develops. For instance:

• Should peers name themselves in a way that defines them in relation to the mental health system, with terms such as consumer or survivor?

• Does peer support become something else when it’s run from a mainstream organization?

• What is the difference in role between friendship and the peer support relationship?

• Who are the members in an independent peer run initiative?

• If services are defined by the traditional professional-client inequality, then should we even define independent peer run initiatives as services?

Origins of peer support

The origins of peer support lie in the social nature of human communities and more specifically in the consumer/survivor movement for the alternative movement as it is known in Quebec as well as in the recovery philosophy in mental health.

Consumer movement

The consumer/survivor movement exists mainly in democratic countries. It has changed in the past 40 years from a small, radical, radical movement to a larger, more diverse and diffuse collection of people. The movement originally worked independently of the mental health system on two main fronts – peer support and political action. In peer support people aim to change themselves and recover from their experiences. In political action people aim to change the people and systems that affect their well-being. The first Canadian peer support service, the Mental Patients’ Association, was established in 1971 in Vancouver. Since then Ontario has developed more independent funded peer support services than other provinces (Chamberlin, 1978).

The consumer/survivor movement has many forms in democratic countries. It has taken on a new dimension in the last decade with the development of online communities.

The earliest known peer support group in mental health was the Lunatic Friends Society established in England around 1845. Some peer run groups also run in Germany in the late nineteenth century which protested against involuntary confinement laws. In addition to this a number of individuals in the eighteenth and nineteenth centuries published their protests about their treatment in autobiographies and petitions (Peterson, 1982).

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The most well developed peer support network was established in 1937. Alcoholics Anonymous has spread to every country and its Twelve Step method has been adopted for other addictions and for mental health problems. Also in 1937 an American psychiatrist called Abraham Low established Recovery Inc. (now Recovery International) which uses cognitive behavioural techniques in a peer group setting. It currently supports 600 groups across North America.

A new brand of peer support and advocacy in mental health emerged out of the international consumer/survivor movement which began in the early 1980s around the same time as the civil rights movement, gay rights, the women’s movement and indigenous movements. All these movements have taken on a new dimension in the last decade with the development of online communities.

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could be argued that we are in a third wave of development in peer support – the use of peer support within mainstream mental health services, where peers are contracted or employed, usually to provide one-to-one support for people using the service. The development gives new opportunities for the growth and funding of peer support, but some respondents expressed concern that mainstream services may be adapting peer support to their own values rather than the values of the condition it is focused on.

Recovery philosophy

The recovery philosophy underpins mental health policy across all languages in the world. It is usually translated as ‘rehabilitation’ and is used in all areas of recovery.

We asked people what recovery means to them. These kinds of responses were typical:

- “Allowing yourself to fail and have setbacks.”
- “Madness is about gifts not symptoms.”
- “Not being a victim of my symptoms.”
- “Living a life worthwhile.”

Recovery evolved out of the consumer/survivor movement and progressive thinking in psycho-social rehabilitation in the late 1980s (O’Hagan, 1994). It is a philosophy where:

- There is recognition of the multiple determinants and consequences of mental health problems;
- There is recognition of the broad range of responses needed; and,
- There is recognition of the broad range of responses needed.

We asked all respondents about the values of peer support. Most believed peer support initiatives apply values that differ from those applied in mainstream services, including as part of the workforce. It strongly implies that we need a much broader range of services than is available now, including peer-run services. It puts service users at the heart of their own recovery and the recovery of their peers.

A good way to understand the recovery philosophy is to compare it and its application to traditional mental health services, as this table shows (Mental Health Advocacy Coalition, 2008). These tables need to be viewed as a continuum, most contemporary services sit somewhere between the two extremes.

In summary, there have been three waves of peer support over the last century – the twelve step approaches starting in the 1930s, the more politicized independent consumer/survivor peer groups starting in the 1970s, and the introduction of a peer support workforce into mainstream services in the 2000s. These developments have been reinforced by the emergence of the recovery philosophy in mental health services, starting in the late 1980s.

Values of peer support

- “In three words peer support is: humanize, depathologize and normalize.”
- “Your support is about providing all the tools besides medication – the tools for the other 80% of your life.”
- “Peer support is about providing all the tools besides medication – the tools for the other 80% of your life.”
- “We don’t have to fake it at a peer service.”
- “In three words peer support: depathologize, humanize and normalize.”

In contrast, respondents often described the power relationships operating in mental health services as controlling, directing, hierarchical, patronising or authoritarian. It was a philosophy where:

- There is recognition of the broad range of responses needed; and,
- There is recognition of the broad range of responses needed.

In other words, the recovery philosophy is alive and well, and it is up to each person to decide what is best for them and for the peer support service to enable choice in how people use them.

In contrast, respondents often described the power relationships operating in mental health services as controlling, directing, hierarchical or authoritarian. It was much less common for them to experience mainstream services as empowering or egalitarian.
Self-determination was seen to be reflected in the following kinds of practices:

- When peer members participate in the running of independent peer-run organizations or peers are free to shape the services provided within mainstream services;
- When members or clients are encouraged to choose their goals and supports in both independent and mainstream settings; and,
- When there is a commitment to social justice, especially in independent peer support initiatives.

Mutuality and empathy

“It's a peer support we can see what professionals can't see.”

“They don't deal with deep and personal issues in mental health system but we do.”

“I want to be listened to and validated in my pain; I want to express my distress and NOT shut up and locked up.”

“Been there, done that, going back to help.”

Respondents often described the importance of shared experience in peer support. They used expressions such as camaraderie, empathy, reciprocal, mutual, acceptance, community and belongingness when asked about peer support values. Many also valued confidentiality. Even paid peer support workers talked about mutuality in their relationships with clients or members. Respondents felt peers could be more honest with each other than people in the traditional client professional relationships. On the one hand people didn’t have to fake it in peer support settings and could deal with deep personal issues. On the other hand, others who understood could challenge people if they were stuck. Positive role modelling is also an important feature of mutuality.

Mental health services were described by some as focusing just on a person’s illness, as trying to fix people rather than work with them, and as valuing book learning over lived experience. Respondents believed that peer support environments are more accepting and less threatening or intimidating than some mental health services. They spoke of non-judgmentalism, dignity, safety, respect, dignity, compassion and unconditional positive regard.

People talked how mutuality is reflected in the following types of practices:

- When peer support involves reciprocal roles of helping, learning and responsibility; and,
- When there is less role distinction between peer staff and members or clients than there is in the traditional relationship between professionals and clients.

Recovery and hope

“Peer support is not about how ill we are but how well we are.”

“Professionals forget how to live with mental illness as we do it each day.”

“Recovery and hope is reflected in the Aboriginal world view; holistic health being the balance with the spiritual, mental, emotional and the physical.”

Respondents described peer support initiatives as holistic and encompassing the psychological, social and spiritual domains of life and as offering hope and tools for recovery and personal growth. Peer support helps people gain a sense of purpose and self-responsibility. It encourages people to reframe their personal stories to move beyond an illness or victim identity. It needs to enable them to be the architects of their own wellbeing.

The dominance of the deficits approach and medical model in mental health services was criticized, as either limited or harmful by respondents who talked about peer support helping them to regain a healthy identity as well as roles and relationships disrupted by their mental health problems and use of services.

Recovery and hope is reflected in the following types of attitudes and behaviour:

- When people believe in each other;
- When they feel better about themselves;
- When they feel optimistic about their future; and,
- When they are making positive changes in their lives.
A ‘MAP’ OF PEER SUPPORT IN CANADA

Canada is geographically the second largest country in the world with a population of 33 million people. It is a wealthy, developed country, rich in resources, with a nationalized health service and welfare provision. Canada has a diverse population, including an Aboriginal population consisting of approximately four percent of the population (Kirmayar & Valaskakis, 2008).

Types of peer support

One way of understanding the variety within the peer support landscape in Canada is to view it in various dimensions, including the different types of provision, interest groups, organizational structures, methodologies, technology and funding.

Types of provision

We found a huge variety of peer support resources, responses and services across Canada. The most common are self-help support groups where peers meet regularly to provide mutual support, without the involvement of professionals; and one to one peer support such as co-counseling, mentoring or befriending.

There are also many types of peer support services that are more specialized. Many of these types of services or resources are also delivered by mainstream providers. There are examples of most of these types of services across Canada but most are not commonly available. These other peer support services include:

- Support in housing, education and employment;
- Support in crisis (e.g., emergency rooms, acute wards and crisis houses);
- Traditional healing, especially with indigenous people;
- System navigation (e.g., case management);
- Material support (e.g., food, clothing, storage, internet, transportation);
- Artistic and cultural activities;
- Mentoring and counseling;
- Recovery education for peers;
- Social and recreational activities;
- Small businesses staffed by peers;
- Systemic and individual advocacy;
- Paper and online information development and distribution;
- Community education and anti-discrimination work.

Interest groups

We also found that some peer support initiatives for people with a diagnosis of mental illness specialize in the populations they serve, for example there are initiatives that are specifically for:

- Life stage (e.g., young people, new mothers);
- Gender (e.g., women);
- Sexual orientation;
- Ethnic groups (e.g., Chinese);
- Language groups (e.g., French, Creole).

Organizational structures and arrangements

There are a range of organizational structures that peer support initiatives can sit within:

- Informal grass roots networks run by volunteers;
- Funded independent peer run initiatives staffed and governed by consumers/survivors;
- Mainstream agencies with peer support programs within them and;
- Mainstream agencies that employ or contract individuals to provide peer support.

The distinction between these three types is not always clear cut. There are occasional examples of peers who are employed by independent consumer/survivor agencies but work in mainstream settings, or of mainstream boards with a majority of consumers/survivors on them.

There is also a very recent trend for employers to create peer support initiatives. Veterans Affairs Canada and the Department of National Defence have set up a peer network for the armed forces, veterans and their families who have Operational Stress Injury. We also heard that car manufacturing firms have set up a peer support network for employees with mental illness but we have been unable to verify this.

Methodologies

Some of the oldest methodologies that equate to peer support come from Canada’s Aboriginal peoples in the form of sharing circles and sweat lodges. Some Western practice methodologies or technologies in peer support are emerging. Perhaps the best known ones are the Wellness Recovery Action Plan (WRAP) (Copeland, 1997) and “Intentional Peer Support” (Mead 2005).

WRAP is a self-administered template that provides a structure for people to monitor their distress and wellness, and to plan ways of reducing or eliminating distress. Many peer support initiatives and some mainstream mental health services train people to do their own WRAP, in Canada and elsewhere.

Intentional peer support is a philosophy and a methodology that encourages participants to step outside their illness and victim story through genuine connection, and mutual understanding of how they know what they know, provides help as a co-learning and a growing process, and help each other move...

Self-stigma workshops for consumers/survivors in development in New 39

39 funding that goes into peer support and peer run initiatives but we know that the team or employee.

Because of the variety of types of peer support and the variety of organizational available to the most disadvantaged consumers/survivors.

peer support will become much bigger in the future, especially in rural areas 2009; Nicholson, & Rotondi, 2010). Despite this there is little doubt that online use if for health related purposes (Borzekowski, Leith, Medoff, Potts, Dixon et al., health problems do not have access to the internet, and those who do seldom opening up new ways of delivering it, such as 'skype' (online telephone audio and video calls, video conferencing, instant messaging, interactive websites and video conferencing, instant messaging, interactive websites and meditation.

The Provincial Health Services Authority (PHSA) has a province-wide mandate for training in intentional peer support is available in a number of countries, including Canada.

The Mental Health Services Act of New Brunswick, 1997, paves the way for peer support when it states in its preamble that the purpose of mental health services is to promote self-reliance and a less dependence on formal systems of care. The contribution of families, persons with mental disorders and community agencies are The Mental Health Services Act of New Brunswick, 1997, paves the way for peer support when it states in its preamble that the purpose of mental health services is to promote self-reliance and a less dependence on formal systems of care. The contribution of families, persons with mental disorders and community agencies are

Newfoundland and Labrador have four regional health authorities. Current peer support is funded in two of the four health authorities – Eastern and Central. The need for mental health and addictions services.

The Eastern Regional Health Authority provides funds for a peer worker in the specialized health services. PHSA services are provided either directly through PHSA agencies or through funding and collaboration within six regional health authorities.

The Vancouver Mental Patients Association was established in 1971 and was the first peer second wave mental health user run service in Canada. Independent self-help initiatives include the West Coast Mental Health Network, the Mental Health Resource Centre, the Richmond Mental Health Centre and Friends Society and the Eureka Clubhouse (not the 'clubhouse model') which is in Vancouver Island. They are funded from a variety of sources.

Since the early 1990s the health authorities have all funded various forms of peer support. Depending on the health authority these include self-help groups, education programs, drop in centres, social recreation and peer on Peer support started to receive annulled health funds in parts of British Columbia in 2004.

Curiously some of the health authorities fund peer support services within community mental health teams but others have contracts tied to specific local authorities while others are contracted through community organisations. The peer workers are on disability income benefits and work for two to three hours per week. They are funded from a variety of sources: health authorities, miscellaneous organizations, and individual contributions.

There is a peer advocacy/support training program run out of one of the independent agencies and training for the peer support workers in mainstream agencies.

Manitoba

Manitoba has a mental health self help policy. Manitoba Health is the umbrella agency for the eleven regional health authorities. Each Regional Health Authority is responsible for funding services within their area. A few mainstream services employ peer support workers. All self-help initiatives are funded through Manitoba Health but a few mainstream services employ peer workers. Various agencies and programs employ peers in a variety of settings.
assessive community treatment (ACT) team; and for the only mental health peer support service in the province, the Community Health Awareness Network (CHANNAL). Nova Scotia has nine district health authorities and the IWK Health Centre for Nova Scotia. Nunavut residents’ has a generic peer support component. However, the Embrace Life Council, an interagency collaboration for the Aboriginal populations or the general population, though the current Mental Health Act and Addictions Strategy Framework (2002) does provide supportive services.

Nunavut

Nunavut has one health region – Nunavut Health Region. Nunavut is the least populated territory in Canada and the largest geographically, with a high proportion of Inuit. As far as the consultants can find, there is little specific peer support funding in the province for the Aboriginal populations or the general population, though the current Mental Health in the province for the Aboriginal populations or the general population, though the current Mental Health and Addictions Strategy Framework (2002) does provide supportive services.

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Prince Edward Island

There have been changes in the provincial level organizations. In 2001 CDSI (Canadian Mental Health Consumers/Survivors Association) was established by the then Ministry of Health. Funding was made available to support the expansion of the provincial organization, the Ontario Psychological Association Council of Mental Health and Addictions, and some of which define themselves as ‘alternative’ mental health providers. These activities are not funded.
Support is not a business but an ancient protocol that involves individual communities, family, and community and that understand the balance of mental, spiritual, emotional, and physical quadrants.

Due to oppression, our ceremonies were outlawed and have just been reinstated. Many of the people who used to use the support networks in their own families and ethnic communities. However, ethnic minorities are not always immune from discrimination against people who have a mental illness diagnosis, and peer support initiatives and networks may also face social, ethnic identity, or understanding of other groups who belong to the same or more marginalized groups. For instance, consumers/survivors in ethnocultural communities can be devalued by their own ethnic community.

Francophone people

Although Quebec and New Brunswick are relatively well supplied with peer support initiatives in comparison to other provinces, Francophone people living in English-speaking areas of Canada do not have reliable access to peer support in their own language.

Rural people

I have to take two buses to get here [to the peer support service]. Sometimes that takes hours.

Canada covers a large area; most of its population lives within one hundred miles of a city. Rural areas of Canada do not have reliable access to peer support.

People with disabilities, especially deaf people, have high rates of mental health problems stemming from stigmatization and discrimination. One dedicated group for First Nations and Métis group was consulted for this project. The respondents stated that they need to develop their own networks and services, by their own people. Aboriginal people do not practice peer support in specific mental health groupings, but in their natural communities. In the province of Quebec, which has the highest population density in Canada, we have 12,000 peer support workers.

People involved in the criminal justice and forensic systems

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People with learning, sensory, physical and developmental disabilities

You need to match peer support with the culture of the person you are healing. Our peer support does not offer access to support in inaccessible formats. Mental health peers may not always understand other disability issues.

Gay, lesbian, bisexual and transgender people

Most of the peer support workers I have seen are straight, middle-aged, and white and straight, leading to not much diversity, but such chance to meet someone who comes from your background.

People involved in the criminal justice and forensic systems

Consumers/supporters involved with the criminal justice system or forensic mental health services do not have access to peer support. Peer-run initiatives could not rely on any peer worker because it had not been evaluated and could not provide anything to people involved in the criminal justice system at all stages, from prevention services through to parole and reintegration. A peer support service was never funded, and a consumer operated service in Ontario is funded to provide these services as part of the larger provincial cross-ministerial response to the growing numbers of the group of consumers.

The background.

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Respondents raised a variety of issues which are proving to be a challenge for the development of peer support. These include access, funding, organizational structures, development issues, and stakeholder relationships as well as internal issues from governance to the involvement of members.

**Access to peer support**

“Most people who could benefit have never heard of peer support.”

“I don’t think many people know it exists, it seems like people stumble on to it.”

“700,000 people in Alberta are living with mental illness. Our organization which is the only provincial mental health consumer organization has a budget of less than $100,000.”

“Yikes – we have only two options for independent peer support, and a few mainstream peer support positions for 1.5 million people in our locality. So tiny percentage [have access to peer support].”

Most respondents said that a ‘very low’ percentage of people in Canada with mental health problems use peer support. There are however, very few statistics on the use of peer support. Vancouver Coastal Health in British Columbia, which has one of the most developed peer support services inside community mental health teams in Canada, noted that less than 5% of their community mental health clients have access to a peer support worker. In a Canadian health survey, up to 9% of people with mental health and/or substance abuse problems used self-help groups, telephone hotlines, or internet support groups (Statistics Canada, 2002). In addition to this, mental health services can be slow to refer people to peer support initiatives, even when they are available. Respondents told us that some professionals didn’t know what peer support is, or discouraged people from associating with other people with mental health problems.

In an ideal world everyone should have the same access to peer support services as they do to clinical services and medications. Respondents told us that many people who could benefit don’t know about peer support and may not live near a peer support initiative, especially if they live in a rural area. If people didn’t know about peer support there would be far too few peer support initiatives to meet demand. Respondents told us that they wanted more peer support to be available everywhere. People were particularly keen to see peer support workers in emergency rooms.

**Funding and planning**

“I find it odd that while everyone thinks peer support is a great thing, they don’t want to pay for it!”

“There is an inconsistency with funders saying we value you, but please volunteer as there is no money. Do we ever ask social workers, O&N nurses and psychiatrists to volunteer as there is no money for them?”

“We get about 1 million in funding for 25 to 26 activity centres, consumer networks, support groups and our Voice. The activity centres work out to be about $10k per head per day, versus a bed in the unit at approx $740 per day!”

“Listen to what people have to say about what actually works rather than continuing to fund what doesn’t.”

“There has been much success in New Brunswick and Ontario because of the support the governments there give.”

“They have given it a very low priority in their immediate plans. I was part of a committee that was asked by the managers at this province to write a paper on peer support so that standards could be created. That paper sits gathering dust because the new peer support is not yet on the radar. Until the political will is there, nothing will be done.”

There will always be a place for unfunded self help networks run by volunteers, but many of the networks we consulted were frustrated at their over work, lack of recognition and lack of funding for development and provision. First Nations and Métis people particularly felt that their own healing strategies were not recognized by funders. There are simply not nearly enough peer support services of any kind to meet demand. Virtually everyone agreed that funding for independent peer support initiatives is close to unsustainable. Many people working in independent and mainstream peer support initiatives are on government disability pensions which the agency topped up with the allowable amount, before abatement started.

Once funded, people often stated that funders tried to reshape peer support.
There is still no comprehensive transparent funding formula in many of the Peer practices (e.g., WRAP, intentional peer support, alternative businesses); working with or within mainstream services; Respondents said poor funding results in recruitment and retention problems, sub-standard peer funding results in recruitment and retention problems, sub-standard locations, high stress, and reduced ability to meet all contract requirements.

Some provinces have had an injection of funding into peer support services. This was seen as helpful but not nearly enough to meet demand. There was a general consensus that clinical services get the lion’s share of funding when they cater for only a small portion of people’s needs.

Organizational structures

Peer support initiatives in the provinces are not coordinated, and so lack the political contacts and know how to get their voice heard by planners and funders. Some respondents believed workers should be employed by peer run agencies and either work with them or be seconded to mainstream services. They told us that the best types of agencies for peer support services are small, non-profit, community or peer driven with a flat hierarchy and control that includes decision making. However, these organizations need to be structured, with plans and procedures, training and supervision, and more peer leadership.

Some respondents believed peer support workers who work mainstream should never work alone in a system of professionals, due to the differences in philosophy and power and the sense of alienation this can set up for some consumers. People were also very critical of the supervision and performance appraisals of peer workers inside mainstream agencies which should be done by other peers and not professionals.

Service and workforce development in peer support

There are some peer support development initiatives in Ontario, British Columbia and Quebec which we described in the previous section. Respondents agreed across the country that there is not nearly enough development activity going into the peer support workforce and peer support initiatives, and standard workforce training could steer peer workers into mainstream settings and take on the language and culture of mainstream mental health services (The Consumer/Survivor Movement). ‘Professionalizing’ peer workers could erode the reciprocal relationships in peer support initiatives, and standard workforce training could steer peer workers into mainstream settings and take on the language and culture of mainstream mental health services (The Consumer/Survivor Movement).

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Several training topics that may be unique to peer support initiatives, or be of interest differently for them are:

- History and culture of mental health services
- Mainstream and critical perspectives on mental health issues
- History and principles of the consumer/survivor movement
- Values and culture of peer support
- People’s stories: how peer support works
- Peer boundaries, ethics and shared risk taking
- Peer-run initiatives, including the role of peer support, alternative/traumatized
- Delivering recovery education
- Group facilitation and meeting skills
- Goal setting and recovery planning
- Assisting people self-manage medication, self harm, voices, and other unwanted symptoms.

Barriers to education and training include lack of funding and/or failure to create a dedicated budget for education, lack of training and education, and excluded when they have attended mainstream training. There is also little or no training specifically for peers whose first language is not English, including Francophone people outside of Quebec.

Relationships with non-peers

One doctor said – we would have consumers on staff if they had something to say. Our peer support worker is completely appreciated by all professionals and para-professionals. It’s the peer support who are your friends and seek out by the healthcare team, which includes uninvited ‘symptoms’.

Some people talked about professional development initiatives which include professionals and para-professionals. Some people talked about professional development initiatives which include professionals and para-professionals.
may have lower expectations of peer support initiatives than professionally led services. If this is the case, however, there can be the impact that the attitude cannot be overstated. Lower expectations, at whatever level of consciousness, can lead to an oscillation between neglect of peer support initiatives and too much interference when things go wrong.

Others said that people in the mainstream mental health system do not understand consumer/survivor history and values. This means they are likely to regard peer support initiatives as either second rate or just like mainstream services that happen to be run by consumers/survivors. They asserted that peer support initiatives need to be regarded as equal but different.

Perhaps the biggest barrier to the development of peer initiatives around the world has been the longstanding inequality and marginalization of people who have received a mental illness diagnosis and its impact on consumers/survivors as well as the people who work in the mental health system.

Many of the people involved with peer initiatives have not felt helped by the mental health system and may feel alienated and sometimes harmed by it. They are now taking an active role alongside or within the same system. Because of their experiences, they are also likely to be aware of exclusion and control. They often feel some degree of ambivalence about engaging with the system they see as treating them as second-class citizens, even though they may not understand the roles of power and influence that the people who run the system are familiar with; or that the networks to tap into are the most powerful people.

The people who have always been relatively privileged in the mental health system, and some have felt deeply harmed by it. They are now taking an active role alongside or within the same system. Because of their experiences, they are also likely to be aware of exclusion and control. They often feel some degree of ambivalence about engaging with the system they see as treating them as second-class citizens, even though they may not understand the roles of power and influence that the people who run the system are familiar with; or that the networks to tap into are the most powerful people.

Independent peer support initiatives

“Successful peer services know the polices and how to dance”

“Customer organisations have to see themselves as not just customers or users”

(They have) excellent relationships with other services and organizations:

“...I have seen many success. Stigma is alive and well in this field.”

Peer initiatives in mainstream settings are governed by boards that do not necessarily have any consumer/survivor members on them.

Respondents reported mixed experiences with mainstream boards. They felt they had little or no influence over their boards or had to rely on the management, who do not always understand the issues to make direct representations to boards. They felt they only had influence if the board requested it, not when the peer workers requested it. Some felt they had limited influence on boards. It helped if the organization was small and there was good consumer/survivor representation on the board. Cooperative/governance arrangements are set up so the workers and board have minimal conflict and all parties feel that they have understood this. However, these comments may reflect a preference from peer workers to work in a less defined operational/governance split.

Management

Management issues also differ markedly between independent and mainstream services so they will be dealt with separately.

Independent peer support initiatives

“...We work at an organization that is not run by consumer/survivors but we do have a number of consumer/survivors working here and we are all seen as competent at our work as non-consumer/survivors.”

“...we got scrutinized around budgets and governance questions and the way they implement peer support.”

Some boards have a minority of people who are not consumers/survivors while others do not observe the direct separation of governance and operations that exist in some peer organizations. The separate and large consumer/survivor contexts. Some boards of peer run initiatives have members, volunteers and staff on them. They are just governed by the members. Some other initiatives are staffed by people from the wider community. At the very least, the board of an independent peer run initiative should have a majority of consumer/survivors on it.

Peer initiatives in mainstream settings

“...The influence peers have on consumer organizations is... It’s a way of life, it’s a culture and it’s a sort of spiritual, very powerful things and if you get them right they’ll have a great deal of influence. Unfortunately, this is not usually the case.”
Consumer support organizations have historically been underfunded and at times not been able to recruit trained and experienced staff to deliver quality peer support and poor benefits. Sometimes this has also resulted in insufficient board training to fully understand their role and the role of the staff.

There tends to often be a lack of trust and in the ability of the peer support service to be responsible and credible in carrying out important management functions. Often the initiatives are only paid as staff to be seen as to their capabilities.

Many people believed that independent peer run initiatives are well managed but that the difficult challenges of peer support work, fundraising, and recruiting and retaining high-calibre, trained and experienced staff, were often underestimated.

Staff

"We feel that our superiors are following their agenda and carrying out important management functions. Often the staff doesn't have sufficient board training to fully understand their role and the role of the staff." Staff

There was widespread agreement that peer support work needs to become an established and a core service with peer support. Lived experience of mental health problems is not the only requirement for peer workers; they also need work related skills and attributes.

"One thing that makes it easy to volunteer is that it looks good on a resume." Volunteers

"The main challenge with volunteers is that they can leave at any time for any reason. This causes huge challenges to create a good team." Peer run initiatives in mainstream settings

People were very clear that the mainstream management of peer support initiatives could only work if it was done in a spirit of partnership rather than of a power imbalance [with clients] but the system needs to be adequately funded as a core service like clinical services that consumers/survivors should have access to. People were overwhelmingly in favour of fully paying peer support staff. Paying people a fair wage is a sign that their work is valued by the system that pays for the service. It also provides employment and financial independence for people who might otherwise be still on a disability income benefit.

Peer support workers may be paid or unpaid in both mainstream and independent settings. What determines the peer status is often paid up to the maximum rate before they start to be abated. Respondents said that paid workers had more data than volunteers. They were often more skilled with cleaner accountability than volunteers.

Staff with mental health problems often need different kinds of supports and workplace accommodations than other workers, due to the fact they are in precarious positions that currently lack traditions and standards, as well as the sometimes lingering presumption and potential medicalization of a mental health status.

The downside of fully paying peer support staff was the possible power and status that could result. Training Burnout was often very high and unacknowledged in management roles are not the best people for the job; they could be inconsistent, by blameworthy or self-serving and treat others badly.

There was sufficient evidence to suggest that peer workers are more standardized, with nationally recognized training and standards that can be adapted at the provincial level. At the moment there is no career pathway in peer support and peer workers tend to get stuck on low wages which discourages good people from staying in it.

People have different experiences of paid positions. Some people were paid well below the minimum wage as a top up to their disability income benefit. Some people were paid very low because of an assumption that if we're paid it may change the nature of peer support.

"I'm in two minds because if we're paid it may change the power imbalance (with clients) but the system needs to value the support and it's not deemed legitimate if it's not paid." Everyone should get paid - we shouldn't have to rely on volunteers.

"It is unconscionable that funding for mental health workers is based on how much they become. People who are paid more often without benefits. Creation of properly paid positions within our movement needs to be built in." It's unreasonable to view peer support as the effective and efficient tool that it is. People who make up 50% of the new peers that need to be built in.

"I don't believe they view peer support as the effective and efficient tool that it is. I believe at least 50% of the new peers that need to be built in. It is important that we are paid. A lot of people could see the benefits of volunteering for people who were in transition from a consumer role to a full working role, volunteering enables them to build up skills, confidence and working hours. However, there is a dichotomy in the opposite direction where there are more paid positions and standards that can be adapted at the provincial level. At the moment there is no career pathway in peer support and peer workers tend to get stuck on low wages which discourages good people from staying in it.

People are concerned about the stigma of identifying as a peer worker. There was a story of a man who missed out on his food at a food bank so he could attend a meeting as a consumer representative in a voluntary capacity with well paid staff. He was afraid that peer support workers can be viewed as volunteers.

Volunteers

There are two Chinese peer support initiatives in Vancouver and Toronto. Both said that Chinese people found it much easier to identify as volunteers than as members because a volunteer was a more socially valued role, in a cultural context where it is social to openly acknowledge mental health problems. They considered it an honor to be a volunteer. On the other hand, we heard a story of a man who missed out on his food at a food bank so he could attend a meeting as a consumer representative in a voluntary capacity with well paid professionals. These kinds of situations are unacceptably inequitable.

"One thing that makes it easy to volunteer is that it looks good on a resume." One thing that makes it easy to volunteer is that it looks good on a resume.

"There is an important role for volunteers." There is an important role for volunteers.

Our organization the board of directors has a firm philosophy that volunteer participation is a key component to staff well being and recovery. There is a spiritual need amongst our consumers to feel that they are ‘giving back.’ Any task they are qualified for an Kawiden to providing direct support to a mental health consumer in crisis to testifying before parliament. This is a spiritual need amongst our consumers to feel that they are ‘giving back.’ Any task they are qualified for an Kawiden to providing direct support to a mental health consumer in crisis to testifying before parliament.
These changes led to more concrete outcomes for people, including:

- Increased quality of life; and
- Reduced crises and hospitalization.

It can be more difficult to create a supportive work environment for peers working in mainstream services. At the very least peer support workers in mainstream organisations may experience peer workers who are uncomfortable with, and may have a less supportive workplace culture. Peers may be isolated from each other, and mainstream colleagues may not understand or appreciate their role. There is also a high turnover in peer support workers, which are usually available to mainstream workers and to beneficiaries. People believe that these situations could be avoided if these peer workers were employed by peer run initiatives that contracted them out to work in mainstream services. At the very least peer support workers in mainstream organisations need mutual support opportunities.

Peers are often part-time due to lack of funding, and to allow people to keep receiving a welfare benefit. Peer run initiatives often cannot afford to employ part-time staff, as these services may operate in ways that other staff members with extra work.

Work conditions

Peer run initiatives and mainstream employers try particularly hard to create a supportive work environment. They need to negotiate workplace accommodation for staff, such as flexible work hours and sick leave entitlements, as well as lack of management skills at times. For instance one person told us that accommodations for one staff member had overburdened other staff members with extra work.

There are many thriving peer support initiatives in Canada and elsewhere. Below we present some examples of good practice where people could 'talk openly', 'feel validated' and 'share stories', exchange information and learn from each other. People valued the sense of community and belonging peer support creates – a rich understanding from those who have been there. This atmosphere allowed people to recover self esteem, hope, meaning and purpose, empowerment, self-responsibility and to experience personal growth through both the helper and the one who is helped.

Some examples of good practice

- There are many thriving peer support initiatives in Canada and elsewhere. Below we present some examples of good practice

Benefits

The benefits of being in a peer support context were very important to people. A key benefit was the trusting, safe and accepting environment of peer support which encouraged people to talk openly and share distress, exchange information and learn from each other. People valued the sense of community and belonging peer support creates – a rich understanding from those who have been there. This atmosphere allowed people to recover self esteem, hope, meaning and purpose, empowerment, self-responsibility and to experience personal growth through both the helper and the one who is helped.

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There are many thriving peer support initiatives in Canada and elsewhere. Below we present some examples of good practice

Benefits

The benefits of being in a peer support context were very important to people. A key benefit was the trusting, safe and accepting environment of peer support which encouraged people to talk openly and share distress, exchange information and learn from each other. People valued the sense of community and belonging peer support creates – a rich understanding from those who have been there. This atmosphere allowed people to recover self esteem, hope, meaning and purpose, empowerment, self-responsibility and to experience personal growth through both the helper and the one who is helped.

- It can be more difficult to create a supportive work environment for peers working in mainstream services. At the very least peer support workers in mainstream organisations need mutual support opportunities.

- Peers are often part-time due to lack of funding, and to allow people to keep receiving a welfare benefit. Peer run initiatives often cannot afford to employ part-time staff, as these services may operate in ways that other staff members with extra work.

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A holistic and integrated approach to business development.

- Food;
- Sacred space;
- A recovery clearing house.
- Sport and recreation;
- Arts; and,
- Community support; and
- Education for people with mood disorders.

- Education for members;
- Self-help recovery education.
- Harm reduction for drugs and alcohol;
- Public education and media.

Talking the taboo;
Showings and discussions on 'Extra Ordinary People' – an anti-
Consumer led research.

Creative writing;
Music and wellness;
Double trouble in recovery (for people with 'dual diagnosis');
Gaining Autonomy with Medication (GAM) approach.

Negotiating peer relationships;
The opportunity to learn from peers to give and get support;
One-to-one coaching supplemented by group learning.

Support to find food, clothing, and other essentials;
One-to-one peer support work;
Service co-ordination and referral;
Sessions, training other service users and offering support according to the GAM

philosophy. Its evolution and implementation are led by the RRASMQ and being studied by the research team. Equipe de recherche et de santé sur l’âme autonome de l’âme, Quebec.

Another influential complement to GAM is ‘The Other Side of the Pill’, teaching on psychiatric medications from a critical perspective from RRASMQ and GAM, taught by GAM staff to other users and/or providers GAM and ‘The Other Side of the Pill as a warning due for the empowerment of people regarding psychiatric medications.

A-HVY Courier, Toronto
A-HVY is a unique enterprise courier service that was established over 20 years ago. It employs full and part-time people, all survivors. The Board is made up of a majority of mental health consumers, veterans, and people who have experienced homelessness. Recovery-supporting services and programs are governed and delivered by people with lived experience and are staffed by people with lived experience.

A-HVY offers same-day service guarantees. Couriers use public transportation rather than vehicles or bicycles and are paid on a commission basis per delivery. For this, the courier receives a monthly pass that can use any time. They have a strong business ethic.

At the same time, A-HVY is a model of mental health accommodations in the workplace and offers partnerships in the workplace. Employees work flexible hours and varied hours, depending on their preferred hours.

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The Mood Disorders Association operates throughout the province of Manitoba supporting those affected by mood disorders and to their friends, families and caregivers. It provides:

- Peer support;
- Public education and media;
- Advocacy;
- Education for people with mood disorders.

http://www.mooddisorders.mb.ca

GAM – Gaining Autonomy with Medication/Gestion autonome des médicaments has been supported by government via capital funding to buy the building they own.

The ongoing GAM project has been in place for almost two years and is an innovative new service, a hospital to home transition team. The team receives referrals from the hospital and works with people on whatever is needed for the first 28 days after their discharge. A peer led external evaluation tool has been developed by Victorian Mental Illness Awareness Council, a state wide nonprofit organization, to evaluate the service. Run by paid staff who are required to complete a peer support training program (developed by Australian and American consumers), they undergo regular supervision. The service also runs a recovery centre and a national warm line telephone service.

www.cmantalhealth.org.au

Mind and Body Ltd. Auckland, New Zealand
Mind and Body is a limited company. It provides:

- One-to-one peer support work;
- Support to find food, clothing, and other essentials;
- Consumer advisors to mainstream statutory services;
- Community support for individual and group networks; and,
- Consumer led research.

Mind and Body has a strong philosophy that underpins everything it does. It invests in a lot of training and supervision for staff.

www.mindbody.nz

A wide range of examples of successful peer support programs with:
The first Quebec initiative to offer training and support to certified peer specialists and firing organizations. Through PAR, 60 peer specialists and 30 firing organizations across Quebec have received training. This program recognized by Université Laval, awarded academic credits to consumers. Furthermore, the gaging of.encoder.uk, with the GMH is integrated into the curriculum. GMH highlights the expertise of people with lived experience regarding managing psychiatric medications. PAR is sharing its experiences with several Francophone countries.

www.par.org/en/proj/par.png

Certified Peer Support Specialists, Georgia
Certified Peer Support Specialists are responsible for the implementation of peer support services, which are Medicaid reimbursable under Georgians Habilitation Program. They are the backbone of the Peer Supported Habilitation Program (PSHP). The program provides PSHP training and certification process prepared Certified Peer Support Specialists to promote hope, personal responsibility, empowerment, education, and self-satisfaction in the recovery-oriented system of care. This program is for people with a lived experience of mental illness and provides them with the skills and confidence to live independently and to find meaningful ways to contribute to their community. The program is designed to train and support people with a lived experience of mental illness to become certified peer support specialists. The program is a rigorous 12-month commitment that includes theoretical and practical components.

www.sweetser.worldpath.net/peers.aspx

The Centre has been engaged in narrative evaluation of the service since it opened. www.penumbra.org.uk/craigmillarpeersupport.htm

Laing House, Halifax
Laing House is a youth-driven, community-based organization for youth with serious mental health issues. The Centre offers a range of programs and services, including peer support, outreach, and peer and family support. Laing House programs include employment, healthy living, education, outreach, and peer and family support. Help to youth recognize and develop their strengths, talents, and resources. Many people said that peer-run initiatives need a structure that looks after the needs of clients. The staff also need to be accountable. In mainstream settings, non-peer staff need to be supported, and workplace accommodations are necessary. The service provides peer support in emergency rooms, weekly peer meetings, and community partnerships.

Organizational support for values
Independence from mainstream services helps peer run initiatives to deliver their values. If complex organizational independence is not possible, they are absorbed into mainstream agencies, then there needs to be a clear agreement on the line of accountability.

www.gacps.org

Ask: “When peer support is not done quite right, it still works better than the system.”

We searched the literature, asked the people we consulted, and asked people involved with the innovative initiatives above—what makes a successful peer initiative? There was a lot of congruence in the literature and in people’s responses.

Some success factors had a lot to do with holding to the values of peer support.

A very clear throughout the consultation was that people did not see peer support as just a job but as a calling with a passion for making a difference to people’s lives.

Translation of peer run initiatives into action
The ultimate challenge of any peer support initiative is to translate its values and principles into practice. Peer workers and initiatives in mainstream services have the biggest challenges in translating these values when independent but peer-run initiatives also need to check they have not drifted from their values base and failed to be as innovative as they wished.

Successful peer run initiatives combine their values and sound HR practice with a peer support initiative can be developed and sustained but cannot be efficient and viable, as well as stay true to their egalitarian and empowerment values. In mainstream settings the challenge is more likely to be the other way around—how to accommodate peer colleagues.

A peer understanding of what peer-run initiatives are or need to become, and to build up the evidence base that people who use the service were very satisfied with it and had been able to exceed their own expectations of recovery.

www.par.org/fairplay/peer-support.htm

Success factors

Even when peer support is not done quite right, it still works better than the system. The outcome was that people who use the service were very satisfied with it and had been able to exceed their own expectations of recovery.

www.penumbra.org.uk/craigmillarpeersupport.htm

Successful peer run initiatives are adequately funded for their purpose. With funding, peer-run initiatives can be accountable and efficient. Peer-run initiatives that have succeeded are those that have gained the trust and control over their funding. They have been able to develop a strong relationship with people to assist them in finding a way forward in life, as well as involved in social activities. They have maintained a structure that looks after the needs of clients than professionals are taught to. Though formal definitions of these ethics and boundaries have yet to be developed successful peer initiatives in mainstream and independent initiatives have sometimes been slow to adopt sound business practice, which for some have created tensions with their values (e.g., Slirogas, 2004). Most recognize that successful peer initiatives have to develop the discipline and control and to be efficient and viable, as well as stay true to their egalitarian and empowerment values.

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Peer evaluation: As a relatively new type of resource, responses need to go into the evaluation of peer run initiatives to assist them to keep improving, to refine our understanding of what peer-run initiatives are or need to become, and to build up the evidence base on their effectiveness. These evaluations must be designed and undertaken by peer-run initiatives and can be delivered by external professionals or agencies who have experience in providing support and guidance. The process of evaluation needs to be seen as integral to the ongoing development of peer support.

In conclusion, this document discusses the importance of peer support initiatives and the challenges they face in mainstream settings. Peer support initiatives are effective in helping people with mental health issues achieve hope and self-determination. They also provide a structure that looks after the needs of clients, but this is still a challenge. An evaluation of the pilot showed that people who use the service were very satisfied with it. Successful peer run initiatives combine their values and sound HR practice with a peer support initiative can be developed and sustained but cannot be efficient and viable, as well as stay true to their egalitarian and empowerment values. In mainstream settings the challenge is more likely to be the other way around—how to accommodate peer colleagues. Peer evaluation: As a relatively new type of resource, responses need to go into the evaluation of peer run initiatives to assist them to keep improving, to refine our understanding of what peer-run initiatives are or need to become, and to build up the evidence base on their effectiveness. These evaluations must be designed and undertaken by peer-run initiatives and can be delivered by external professionals or agencies who have experience in providing support and guidance. The process of evaluation needs to be seen as integral to the ongoing development of peer support.
Finally, the rest of the success factors emphasised equalising, empowering relationships.

Empowering leadership and management
Successful peer run initiatives have leaders, who are trusted, know how to translate their values into actions that permeate the essence and operation of the organization and have the business skills to run an organization. They are transparent and include staff and members in decision making. In mainstream organizations the higher level leaders are often not peers. Successful leaders in this context recognize peer support as different from mainstream service delivery and make the adjustments needed for the initiative or the worker to be empowered to express the values of peer support.

Empowerment of members and clients
Empowerment of members is a core value of peer run initiatives and this can be achieved in many ways, such as easy access or self-referral to the initiative, the freedom to choose the supports they want, the ability to give as well as receive support, involvement in decisions about the initiative, an atmosphere that offers validation and hope and programs that offer genuine opportunities for recovery, personal development and social inclusion. In mainstream settings it means that the client chooses the supports they want in collaboration with the peer worker and that the peer workers are never involved in any coercive practices such as compulsory goal setting or medication drops to clients under forced treatment.

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Equitable partnerships with mainstream services and community organisations
Successful peer run initiatives create equitable partnerships with mainstream services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement and how to promote peer run services and agencies. They do not exist in silos. They have political understanding and know the rules of engagement...
a consumer/survivor and family organisation lobbied the French government to ensure equal opportunities and citizenship rights for people with mental health problems. This resulted in the passing of Law No 2005-102 in February 2005, which enabled the formation of over 300 self-help groups in France within the following three years. The French government funds these self-help groups at a total of €20,000,000 per year with an average of €75,000 going to each agency.

New Zealand
New Zealand's current mental health strategy (Ministry of Health, 2005) mentions peer support services as part of a broader range of services. New Zealand also has a service user workforce development strategy (Mental Health Commission [New Zealand], 2005). There is not much evidence that the peer related actions in these two strategies are being implemented. The growth of peer run initiatives in New Zealand is being driven by district level funders rather than policy.

New Zealand's Blueprint for Mental Health Services in the only government document that has quantified the services needed to implement the mental health strategy, including peer support and advisory services (Mental Health Commission [New Zealand], 1996). The blueprint states that consumer advisory services and consumer run initiatives are to be funded at four full time equivalent positions per 100,000 population. Peer run initiatives have recently been added as an optional service in New Zealand's National Service Specifications, which are the Ministry of Health’s list of services that are eligible for funding.

Queensland, Australia
The overarching mental health policy documents in Australia do not mention peer run initiatives. There are very few peer run initiatives in Queensland. Queensland is the only state in Australia that mentions peer run initiatives in its state-wide mental health plan. Queensland has recently set a funding benchmark for peer run initiatives at three places for consumer/survivor and family organisations per 100,000 population (Queensland Government, 2008).

Scotland
Scotland's latest mental health policy document states that a pilot training program and employment for peer support workers would be in place by 2008 Scottish Executive, 2006. Six boards have implemented the pilot; most employed peer support workers directly and one contracted them through a peer run organization. A recent report of the pilot published by the Scottish government has evaluated the pilot as a success and recommended the roll out of peer support services across Scotland (McCuskey, Bigg, Whittington, Pratt, & Maxwell, 2009). The Scottish Recovery Network has been instrumental in promoting peer run initiatives, as well as the value of recovery.

New States, National level in the United States
In the U.S. the President’s New Freedom Commission on Mental Health stated its second goal that ‘consumers will play a significant role in shifting the current system to a recovery-oriented one by participating in planning, evaluation, research, training, and service delivery’ (New Freedom Commission, 2003). Peer run initiatives were already established in many states before the Commission, and they have continued to grow since then.

In 2007 the US Centres for Medicare and Medicaid Services declared peer support as an evidence-based model of mental health service delivery, and specified requirements for Medicaid funded peer support services (Eiken & Campbell, 2008). Medicaid has documented the definition and description of the service, the staffing requirements, referral sources and the targeted population. The impetus for including peer support as a reimbursable service came from the Surgeon General’s report in 1999, consumer/survivor lobbying and high level support for the development of peer support services. The relative funding stream enables people to both train and get work as peer support specialists. These positions are paid a living wage but some of the people who lobbied for the introduction of peer support specialists in Georgia now regret that they did not push for a higher rate of pay when the program began.

In summary, funded peer support integral to the mental health system is in its infancy not just in Canada but worldwide. In most countries progress is fragile but this stage also full of opportunities to shape the future of peer support initiatives.
Mental health problems in Canada

Over ten percent of Canada’s experience mood conditions (49%), anxiety conditions (47%), or substance dependence (13%), in a 12 months period according to a 2002 survey (Statistics Canada, 2002). The prevalence of these conditions decreased over the lifespan:

- 15-24: 16%
- 25-44: 12%
- 46-64: 8%
- 65+: 3%

According to a survey, 37% of these people sought professional help for this condition or dependency from an order of frequency: a family doctor, psychiatrist, social worker, psychologist, or a religious or spiritual leader.

A much smaller percentage used other forms of help:

- 5% used self-help groups
- 2% used internet support groups
- 2% used telephone hotlines

Although young people were more affected, they were the least likely age group to seek help.

In this survey about 2% of people with mood conditions, anxiety conditions and substance dependence believed their needs were unmet. The percentage with unmet needs reduced slightly over the lifespan.

Of all the Canadians surveyed:

- 48% responded that they were dissatisfied or very dissatisfied with their health;
- 69% rated themselves as having fair or poor mental health.

In another survey 2 percent of Canadians reported having a psychological disability which limited the amount of kinds of activities they could do, due to a psychological or emotional psychiatric condition or substance dependence. Psychological disability affected females more (2.9%) than males (2%) (Statistics Canada, 2003).

The findings from other similar countries are consistent with Canada (Te Rau Hinengaro 2006, U.S. Department of Health and Human Services, 1999). All these studies show similar prevalence for mental disorders as defined by the Diagnostic and Statistical Manual.

- Around half of the population will experience a mental disorder at some point in their lives.
- About 20% of the population experiences mental disorder in any year.
- About 10% of people experience significant functional impairment in any 12 month period.
- Around 2 to 3% have what is described as “severe and persistent mental illness”.
- Prevalence is higher in young people and people from low socio-economic groups.

According to the World Health Organization, five of the ten leading causes of disability worldwide are related to mental disorders. It predicts that depression will become the second leading cause of disability by 2020 (Statistics Canada 2002). The prevalence of these conditions decreased over the lifespan:

- 6.9% rated themselves as having fair or poor mental health.
- According to a 2002 survey (Statistics Canada, 2002). The prevalence of these conditions decreased over the lifespan:
- 12% for mood conditions
- 7% for anxiety conditions
- 3% for substance dependence

In another survey 2% used internet support groups

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In summary, mental health problems are common. Young people, people with trauma histories and people from disadvantaged backgrounds tend to be more vulnerable. Only a minority seek help from professionals or peers. Mental health problems are usually personally distressing, reduce people’s life chances and have very high social and economic costs.

Responses to mental health problems

The range and quality of society’s responses to mental health problems has historically been hampered by stigma and discrimination, human rights breaches, social exclusion and powerful interest groups. Some people have remained trapped in mental health services while many in need have not sought or received help from them. However international policy trends (Compagni, Adams, & Compagni, 2009) are signaling a new direction - to recover focused mental health services that are:

- part of a whole government approach;
- integrated with other sectors and with mental health promotion efforts;
- set up to service users can determine the services, supports and resources they use and;

The social and economic consequences of mental health problems include:

- poorer relationships;
- poorer productivity;
- poorer physical health; and
- a shorter lifespan, by up to 25 years.

The World Health Organization has estimated that mental health problems cost every household in Europe €10.4b (CAD 14.6b) in 2005. (McDaid et al., 2008, p. 1).

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This report has provided a high-level description of peer support in Canada and in other countries. This has shown that peer support is an enabler in every country, full of promise but woefully under-recognized and under-resourced. Not the evidence base for peer support grows every year and our consultations confirmed what the research evidence states – peer support is beneficial to people, it can save lives, it can help people get back the lives they have lost.

We have also made the case for peer support through assembling the evidence on the increasing prevalence of mental health problems, its high personal, social and economic costs, the limitations of the dominant biomedical responses, and peoples views on what assists their recovery. All this evidence points to the mental health system that often doesn’t help people recover and is coming under more strain as people stay in it longer than they should and population demography and services increases. The solution has to be a broader range of cost-effective responses that get to the root of recovery – increased personal resourcefulness, self-belief and hope. Peer support directly assists people to develop these attributes.

In someone else’s words:

No single treatment model should dominate the policy environment; it is people with mental illness themselves who should lead the real delivery of the services that are made available. People and families living with mental illness are turning more and more to self help and peer support as a substitute or adjunct to hospital community and professional services. A new and benefic additional to the mental health and addiction system, the future of self-help and peer support programs remains insecure.

These words come straight from Out of the Shadows at Last, the Senate Committee report that was the catalyst for the formation of the Mental Health Commission of Canada. Our recommendations will ensure that the ‘new and beneficial’ addition to the mental health and addiction system becomes well-established and secure. The Mental Health Commission of Canada needs to assist the sustainable development of peer support across Canada. It is difficult to think of any other single course of action it could take to optimize the chances of recovery for the mental health sector’s most important stakeholders.
RECOMMENDATIONS

“If you want to know what’s best for me, ask. I know what’s best for me.”

“Health Ministers need to be proactive about mental health rather than reactive about mental illness.”

“We feel the Mental Health Commission of Canada is focusing on mental illness and NOT on mental health.”

“If peer support is seen as best practice by the Mental Health Commission of Canada then fund it as such.”

“Do not use us as window dressing.”

Please don’t put the report on the shelf.

Respondents were very clear about the contribution they wanted from the Mental Health Commission to the development of peer support. The Mental Health Commission of Canada, with the leadership of consumers and survivors, including their national and provincial organizations, needs to create the building blocks for the incremental development of peer support initiatives. These need to be specific but flexible enough to be adapted to all provinces and territories in Canada, and its diverse communities including Aboriginal, Francophone and disabled people.

We offer these recommendations below in the hope that this new and tenuous addition to the mental health and addiction system becomes well established and secure. The Mental Health Commission of Canada needs to lead the sustainable development of peer support across Canada with the following actions.

1. Develop guidelines on the definition of peer support as a core component of mental health systems, which include:
   - definitions and types of peer support
   - peer support values
   - peer support standards
   - peer support performance and outcome measures.

2. Develop guidelines for the funding of peer support which include:
   - a target and deadline for the percentage of mental health funding to go to peer support
   - a recommended level of funding for peer support initiatives, and for staff that is equitable with other mental health services
   - recommended funding of a mix of independent and mainstream peer support initiatives
   - templates for contract specifications and accountability requirements
   - recommended funding of development infrastructures for peer support

3. Create guidelines to support the development of peer support, which include:
   - templates for peer workforce roles and competencies
   - curricula for peer support workers leading to a formal qualification
   - options for affordable training opportunities
   - education guidelines for peer support and its values for the non-peer workforce
   - consumer/survivor led evaluation of peer support
   - support for consumer/survivor led organizational development, training and education for mainstream mental health services, funders and other key stakeholders on the roles, values, processes and structures of peer support

4. Use this report and/or the guidelines developed:
   - to highlight the need for peer support to be a core service available to everyone, in the Commission’s strategic framework for reformed mental health services across Canada
   - to promote peer support and to educate regional governments, health authorities and service providers about it until the Commission closes in 2017 through conferences, publications and other forms of communication
   - to develop a national resource centre for peer support, where all the information is provided in both French and English and is accessible to disabled people.


Inverness, Scotland: HUG.


Katz, J., & Salzer, M. (n.d.). Certified peer specialist training program descriptions


Author. (formerly the Consumer/Survivor Development Initiative, C.S.D.I)


manual: For mental health services and addiction treatment services funded by Ontario Ministry of Health and Long Term Care. (2003, December).

the delivery of mental health services and supports


Ontario Ministry of Health (1993). Putting People First: The reform of mental

Healthcare. Making it Happen: Implementation plan for mental health services.

Toronto, ON: Ontario Council of Alternative Businesses.


ery_empower_bit/e/m/leave.html


London, UK: Palgrave MCM.


Our manifesto for a 3 year campaign dedicated to tackling inequality in mental healthcare.

Norwich, UK: Norwich City Council.


Peer Support Service: Development Project Management (Brooklyn, L.) Chestnut Health Systems.


Toronto, ON: Author.

Regroupement des ressources alternatives en santé mentale du Québec.
APPENDICES

APPENDIX 1: OVERVIEW OF THE MENTAL HEALTH COMMISSION OF CANADA AND THE “MAKING THE CASE FOR PEER SUPPORT” PROJECT

The Mental Health Commission of Canada (MHCC) was established by the federal government in 2007 to focus national attention on mental health issues and to improve the health and social outcomes of people living with mental illness.

In 2009, the Commission launched the Making the Case for Peer Support project in order to better understand in order to share the value of mental health peer support with a wide range of stakeholders, as well as to provide guidance on how to strengthen peer support in communities throughout Canada.

The findings of the Making the Case for Peer Support project will be available to inform the Commission’s national mental health strategy and other initiatives. A database of peer support initiatives across Canada is in development and may become part of the MHCC Knowledge Exchange Centre. This literature review supports the findings from interviews and focus groups with consumers, advocates, policy makers, mental health service providers, government funders and other stakeholders.

Together, these sources of information will be available in a final project report including descriptions of peer support activities across Canada and internationally, the project report includes recommendations on successful strategies to fully include peer support into provincial/territorial and a national mental health framework.

The Mental Health Commission of Canada (MHCC) is funding the project to provide an evidence-based understanding of peer support in Canada and to make recommendations on how to strengthen peer support initiatives across Canada. The findings of the Making the Case for Peer Support project will be available to inform the Commission’s national mental health strategy for the health and social outcomes of people living with mental illness.

The Commission launched the Making the Case for Peer Support project in order to better understand in order to share the value of mental health peer support with a wide range of stakeholders, as well as to provide guidance on how to strengthen peer support in communities throughout Canada.

The consultants and staff at the Mental Health Commission of Canada (MHCC) who lead your comments are bound by confidentiality. We will do our best to ensure any comments of yours that we use in the report will not traceable to you or your organization. Any recordings of focus groups or interviews will be placed in a locked environment at the MHCC offices in Calgary. The data (without any identifying information) may be made available to other researchers if they comply with security and confidentiality requirements.

We are inviting all people in Canada who use mental health peer support, deliver peer support or have some relationship with a peer support initiative to fill in the questionnaire.

The information you provide will be summarized in the report to MHCC and comments will not be attributed to any individual or group. Your answers can be as short or as long as you like. There is no limit to the space for typing under each question. You do not have to answer as a representative of any organization or initiative; personal views are just as welcome.

This is a long questionnaire. You may not want to answer all the questions. This is in order. Just move on to the next question.

The consultants and staff at the Mental Health Commission of Canada (MHCC) who lead your comments are bound by confidentiality. We will do our best to ensure any comments of yours that we use in the report will not traceable to you or your organization. Any recordings of focus groups or interviews will be placed in a locked environment at the MHCC offices in Calgary. The data (without any identifying information) may be made available to other researchers if they comply with security and confidentiality requirements.

We are inviting all people in Canada who use mental health peer support, deliver peer support or have some relationship with a peer support initiative to fill in this questionnaire.

More information on project

For more information about the project, and the consultation questionnaire, please read on.

About the Project

The Mental Health Commission of Canada (MHCC) is funding the project to provide an evidence-based understanding of peer support in Canada and to make recommendations on how to strengthen peer support initiatives across Canada. The findings of the Making the Case for Peer Support project will be available to inform the Commission’s mental health strategy for the health and social outcomes of people living with mental illness.

The investigation will consider the factors that influence the situation of peer support initiatives across Canada. Factors inherent to peer support initiatives include values, benefits, governance, management, and delivery and membership. External factors include: legislation, policy funding, as well as mental health cultures and attitudes. The consultants are seeking contact with peer support initiatives throughout Canada.

What is peer support?

We are using a broad definition of peer support so we can discover the full diversity of peer support initiatives within Canada.
We define peer support as any organised support provided by and for people with mental health problems. Peer support is sometimes known as self-help, mutual aid, co-counselling or mutual support.

Consumers/survivors are people with lived experience of mental health problems. We define peer support initiatives as the programs, networks, agencies or services that provide peer support. They can be:

- Funded OR unfunded
- Operate out of psychiatric consumer/survivor run organisations OR other agencies
- Delivered by a group of peers OR by an individual peer in a team of professionals
- A primary activity of the initiative OR a secondary benefit eg in a consumer/survivor business.

Please read on to find out if your initiative fits this definition.

We want to hear your views!

How we're finding the information

The information for this project will be gathered through:

- Focus groups, interviews and written submissions from across Canada
- International and Canadian literature searches
- Data collection on the characteristics of peer support initiatives in Canada

We define peer support initiatives as the programs, networks, agencies or services that provide peer support. They can be:

- Funded OR unfunded
- Operate out of psychiatric consumer/survivor run organisations OR other agencies
- Delivered by a group of peers OR by an individual peer in a team of professionals
- A primary activity of the initiative OR a secondary benefit eg in a consumer/survivor business.

The Mental Health Commission of Canada was established by the federal government in 2007 to focus national attention on mental health issues and to improve the health and social outcomes of people living with mental illness. It is based in Calgary, Alberta.

The MHCC has acknowledged the importance and effectiveness of peer support in a reformed mental health sector in its draft framework of a mental health strategy for Canada.

For more information visit the website www.mentalhealthcommission.ca/english/Pages/servicesysteminformation.aspx

Visit the website

The schedule of consultation visits

Updates on the project

Email

Contact Robyn Priest

robpriest13@gmail.com

Demographic information form

We need this information to check that we are consulting with a wide enough cross-section of people in Canada. We will not distribute this sheet from your answers so we ask you to please do not put your name on this sheet.

Age Group (please mark with an X)

- 19 or under
- 20 - 30
- 30 - 40
- 40 - 50
- 50 - 70
- 71 or over

Gender (please mark with an X)

- Male
- Female
- Transgendered

Ethnicity (please mark with an X - you can mark more than one)

- Aboriginal
- Caucasian
- Asian
- Middle Eastern
- African
- Latin American
- Other (please state)

Province or Territory (please mark the province you live in now with an X)

- NL
- NT
- NU
- YK
- BC
- MB
- SK
- AB
- MB
- PE
- NS
- NS
- ON
- QC
- PE
- NS
- Other (please state)

The schedule of consultation visits

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- AB
- MB
- PE
- NS
- NS
- ON
- QC
- PE
- NS
- Other (please state)

The Questions

Definitions

1. In your own words, how do you define peer support?

2. What are the different types of peer support initiatives that you know of? (please mark with an X)

- Support for people with mental illness or problems from across Canada, and their allies. The members include: Louise Forest (Co-Lead), Laurie Hall (Co-Lead), Carol Adair, Mary Bartram, Andy Cox, Alan Edwards-Karmazyn, Susan Lynn Hardie (MHCC Associate Research Officer), Joe Legger, Steve Lura, Tanya Shute.

3. In your own words, what is your understanding of recovery in mental health?
What are the values that underlie peer support?

Values

1. Supportive and welcoming environment
2. Respect for individual autonomy and choice
3. Confidentiality and privacy
4. Non-judgmental attitudes
5. Empowerment and self-determination
6. Inclusion and diversity
7. Accessibility and universal design

What other supports, services and opportunities could be offered by peer support initiatives, within consumer run orgs and in mainstream health services? (for instance employment, workplace accommodations, performance problems, workplace conflict, training)

Management

10. What successes or challenges do peer support initiatives face by consumer/ survivor organizations have with their management (for instance: strategic planning, budget control, management of staff relationship with membership, improving the service, relationships with funders)

11. What have been the benefits of being involved in peer support for you, or others you know?

12. How important has peer support been in your recovery, or the recovery of others you know, compared to the importance of formal or mainstream health services?

13. What are the opportunities and barriers for members or ‘clients’ to participate in delivery and decision making in the different types of peer support initiatives you know of?

14. Assuming that peer run initiatives can afford to hire paid staff in what circumstances is it better to use volunteers instead of paid staff?

15. What are the opportunities and barriers for volunteers for peer support? (for instance: recruitment, retention, reimbursement for expenses, workplace accommodations, performance problems, workplace conflict, training)

16. What are the opportunities and barriers for members or ‘clients’ to see the benefits of others you know, compared to the importance of formal or mainstream health service providers?

17. What have been the benefits of being involved in peer support for you, or others you know?
35. What are the opportunities and barriers to consumer/survivor led evaluation of peer run initiatives in your area, province or territory?

Your recommendations

36. What would a strong and equitable peer support presence in the mental health system look like to you?

37. If you have not already said so how would you recommend the following stakeholders show commitment to the development of peer support?

• Provincial or territorial government
• Policy agencies
• Planning & funding agencies
• Mental health service providers
• Other service providers eg family doctors, social services
• Consumer/survivor movement
• Families
• Mental Health Commission of Canada

38. If you have not already said so how would you recommend the following features of peer support initiatives be better defined, changed or developed:

• Sticking to values
• Governance performance
• Staff work conditions
• Organisation structures
• Management performance
• Volunteers work conditions
• Evaluation & promotion of benefits
• Delivery - more option to more people
• Membership diversity & participation

39. Do you have any other recommendations?

Key points

40. To summarise, what are the THREE key points you have made that you would most like to see reflected in the report?

Information

41. Do you have or know of any paper or electronic information on peer support that we may not know about. If so can you provide details of the information and where we can get it from?

To Finish.

Database questionnaire

A reminder for those of you who run peer support initiatives. We also have a database questionnaire asking you for details about your initiative. Download it from http://www.mentalhealthcommission.ca/English/Peers/ServiceSystem.aspx

Copies of the report

Do you want a confidential copy of the draft report to comment on?

Do you want a copy of the final report?

If so please provide us with your email address

Email this questionnaire to Mary O’Hagan mary@maryohagan.com no later than 13 November 2009

Thank you for your participation. We really appreciate it.

APPENDIX 3: INFORMED CONSENT FORM

Mental Health Commission of Canada
Making the Case for Peer Support
Informed Consent Form

I give my consent for my comments to be written and recorded at this focus group or interview.

I understand:

• The consultants and staff at the Mental Health Commission of Canada (MHCC) who see or hear my comments are bound by confidentiality.
• My comments may be used in the upcoming report on peer support in Canada for the MHCC, and the writers will do their best to ensure that all comments are conveyed accurately and are not traceable to me or my organization.
• The notes and recordings taken from this meeting will only be viewed or heard by the consultants on the project in their analysis and writing of the report.
• After the report is completed the notes and recordings will be placed in a locked environment at the MHCC office in Calgary. The data (without any identifying information) may be made available to other researchers if they comply with security and confidentiality requirements.

My name
My signature
Date
Consultant signature
APPENDIX 4: RESPONDENTS

Our respondents: Some demographic information

**Province or Territory**
- PE
- NU
- NT
- NS
- NB
- NL
- YK
- SK
- MB
- AB
- ON
- QC
- BC
- NB
- NT
- NU
- PE
- NS
- MB
- AB
- ON
- QC
- BC
- YK

**Ethnicity**
- Caucasian: 38%
- Other: 8%
- Asian: 6%
- African: 5%
- M. Eastern: 5%
- L. Amer.: 5%
- Other: 5%
- African: 7%
- M. Eastern: 3%
- L. Amer.: 3%
- Asian: 7%
- Caucasian: 58%

**Age**
- 7 or Under: 3%
- 8 - 10: 7%
- 11 - 15: 18%
- 16 - 20: 29%
- 21 - 30: 33%
- 31 - 35: 18%
- 36 - 40: 11%
- 41 - 45: 7%
- 46 - 50: 1%
- 51 - 55: 1%
- 56 - 60: 1%
- 61 - 65: 1%
- 66 - 70: 1%
- 71+: 1%

**Gender**
- Male: 16%
- Female: 84%
## APPENDIX 5: SCHEDULE OF CONSULTATIONS

<table>
<thead>
<tr>
<th>Day &amp; Date</th>
<th>Place</th>
<th>Time</th>
</tr>
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<tbody>
<tr>
<td>Sunday 28th June</td>
<td>Newfoundland &amp; Labrador</td>
<td>6:30 pm – 9:30 pm (teleconference)</td>
</tr>
<tr>
<td>Monday 29th June</td>
<td>Newfoundland &amp; Labrador</td>
<td>8:30 am – 3:30 pm</td>
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<tr>
<td>Tuesday 30th June</td>
<td>Newfoundland &amp; Labrador &amp; English groups</td>
<td>9:00 am – 11:00 am</td>
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<tr>
<td>Thursday 2nd July</td>
<td>Prince Edward Island</td>
<td>8:30 am – 11:00 am</td>
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<tr>
<td>Friday 3rd July</td>
<td>Nova Scotia</td>
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<tr>
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<td>9:00 am – 1:30 pm</td>
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</tbody>
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### English Consultations

- **Sunday 28th June**: Newfoundland & Labrador, 6:30 pm – 9:30 pm (teleconference)
- **Monday 29th June**: Newfoundland & Labrador, 8:30 am – 3:30 pm
- **Tuesday 30th June**: Newfoundland & Labrador, 9:00 am – 11:00 am
- **Thursday 2nd July**: Prince Edward Island, 8:30 am – 11:00 am
- **Friday 3rd July**: Prince Edward Island, 8:30 am – 11:00 am
- **Monday 6th July**: Newfoundland & Labrador, 6:30 pm – 9:30 pm
- **Tuesday 7th July**: Newfoundland & Labrador, 8:30 am – 3:30 pm
- **Wednesday 8th July**: Newfoundland & Labrador, 9:00 am – 1:30 pm
- **Thursday 9th July**: Newfoundland & Labrador, 8:30 am – 11:00 am
- **Friday 10th July**: Newfoundland & Labrador, 6:30 pm – 9:30 pm
- **Monday 13th July**: Newfoundland & Labrador, 8:30 am – 3:30 pm
- **Tuesday 14th July**: Newfoundland & Labrador, 9:00 am – 1:30 pm
- **Wednesday 15th July**: Newfoundland & Labrador, 8:30 am – 11:00 am
- **Thursday 16th July**: Newfoundland & Labrador, 6:30 pm – 9:30 pm
- **Friday 17th July**: Newfoundland & Labrador, 8:30 am – 3:30 pm
- **Monday 20th July**: Newfoundland & Labrador, 9:00 am – 1:30 pm
- **Tuesday 21st July**: Newfoundland & Labrador, 8:30 am – 11:00 am
- **Wednesday 22nd July**: Newfoundland & Labrador, 6:30 pm – 9:30 pm
- **Thursday 23rd July**: Newfoundland & Labrador, 8:30 am – 3:30 pm

### Thank you to the following people who helped organize the focus groups:

- Newfoundland and Labrador: Karan Ann Parsons - CHANNAL
- Prince Edward Island: Eugene LeBlanc
- Nova Scotia: Andy Cox – IWK Health Centre
- Ottawa: Denis Lindsey – PSO
- Smiths Falls: Hatem Almour - Mental Health Support Project
- Lindsay: Paul Orchard – SPAN
- London: Delibea Jones – TEACH
- Toronto: Michelle Solomon – CONNECT
- Toronto: Laura Hill – IBWYAW Counsellors
- Toronto: Tanya Shute – Kristen Centre
- Toronto Business Services: Laura Hutt - IBWYAW Counsellors
- North Bay: Sandra Barber, Gary Fay – NEMHC
- Coghswell: Kelly Fournier - Mental Health Support Project
- Toronto: Greg Kim – CMHA Toronto
- Brandon: Marita Rehuk - Brandon Vocational Training Association
- Milton: Delibea Jones - TEACH
- Winnipeg: Tara Broussard – MOO
- Regina: Dorothy Lloyd & Janie O’Donnell – Eagle Moon
- Edmonton: Komala Pujin – Alberta Health Service
- Calgary: Eva Potential and Henry – Opportunity Works, Debbie Wadie - Peer Options CMHA Calgary
- Kelowna: Clarly Sinclair – CMHA Kelowna
- Penticton: Sharon Grant – Schizophrenia Society, Lisa Ecosleston – South Okanagan Adult Mental Health Services
- Surrey: Peter Andersen – Community, Debbie Sessa Fraser Health
- Victoria: Christopher Babes – Euskal Clubhouse
- Victoria: Wendy McKinnon – BC Schizophrenia Society
- Richmond: Barbara Balew – Richmond Mental Health Consumers & Friends Society
- Vancouver: Ron Carleton - West Coast mental Health Network
- Whistler: Lea Roberts – Second Opinion Society
- Ontario Patients Council: Theresa Dalston – Ontario Patients Council focus group

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APPENDIX 6: DESCRIPTION OF LITERATURE REVIEW

This is a review of academic, grey literature, policy reports and other material on peer support by people with lived experience of mental illness and the mental health system. The review includes materials developed by peer support groups and individual consumers such as newsletters, policy and project reports, personal accounts, annual reports, and other sources.

English-language literature has been collected from Canadian national and provincial, territorial and regional mental health systems. The work of consumer/survivors from as American, British, Scottish, European Union, Australian, New Zealand and other countries has been included. Some materials come from the personal collections of the consulting and project team, based on their personal and professional involvement in the consumer/survivor movements in Canada, New Zealand, Australia, and internationally over the past decades.

Some materials come from the personal collections of the consulting and project team, based on their personal and professional involvement in the consumer/survivor movements in Canada, New Zealand, Australia, and internationally over the past decades.

The literature that was collected was reviewed for contribution to key conceptual themes developed by the MHCC Project Committee at the beginning of the process, with additional themes emerging from the literature. These include:

- Definitions, types and frameworks for peer support processes and models
- Values and philosophies of peer support and the consumer/user movement
- Evidence of effectiveness and outcomes
- Involvement of consumers from marginalized and minority communities
- Organizational development, including governance, management, employee, volunteer and member human resources
- Relationships with traditional mental health services and other stakeholders
- Areas for further research

The current literature review builds upon a previous one conducted for the Consumer/Survivor Initiatives Builder Project in 2008/2009. Funded by the Ontario Ministry of Health and Long Term Care, administered by the Ontario Federation of Community Mental Health and Addiction Programs and led by the Builder project was to review current issues of consumer-run agencies in groups and propose recommendations to ensure their continued relevancy in a reformed mental health system. With some unique features, these consumer-run organizations had been funded through provincial government health funding since the early 1990s, and were run on the basis of the principles and processes of peer support (O’Hagan, Mohai, & Priest, 2009).

In contrast to the Ontario project, the current review focuses on peer support and where it takes place in different organizational structures and locations. The Ontario review was limited to a few models of consumer-run organizations, these are models which provide a broad range of services, including but not limited to 'consumer', 'consumer/survivor', 'user', 'person with lived experience', 'people with mental illness' or 'consumer provider', 'peer provider', 'patient', 'user', 'mental disorder', 'mental illness' were used including 'mental patient', 'consumer', 'peer', 'peer specialist', 'self help', 'consumer/user run services', 'alternative businesses', 'involvement', 'participation', 'mutual aid'. Various terms for people with mental illness and mental health problems were used including 'mental patient', 'consumer', 'peer', 'peer specialist', 'consumer provider', 'peer provider', 'patient', 'user', 'mental disorder', 'mental illness' were used including 'mental patient', 'consumer', 'peer', 'peer specialist', 'consumer provider', 'peer provider', 'patient', 'user', 'mental disorder', 'mental illness' were used including 'mental patient', 'consumer', 'peer', 'peer specialist', 'consumersurvivor', 'user', 'person with lived experience', 'people with mental illness' or 'consumer/provider' to review present issues of consumer-run agencies in groups and propose recommendations to ensure their continued relevancy in a reformed mental health system. With some unique features, these consumer-run organizations had been funded through provincial government health funding since the early 1990s, and were run on the basis of the principles and processes of peer support (O’Hagan, Mohai, & Priest, 2009).

As such, it is hoped that this will contribute to the overall goal of the project to increase understanding of the values, philosophy, models, outcomes and future opportunities of peer support and the important role peer groups play in the process of recovery. It provides a context and foundation for a focused systematic review or reviews on any peer support-related specific question.

A note about the terms used in the review

We use a variety of terms to refer to individuals who experience mental illness, experiences of mental illness or mental health problems. We recognize and respect that different terms may have different meaning for readers. The use of specific terms is not meant to indicate a preference for some values or appraisals over others, but to demonstrate respect for peoples right to define and name their own experiences. Also some terms are more commonly used in certain countries and regions (e.g., ‘consumer/provider’ in Ontario, ‘user’ in England).
APPENDIX 7: THE CONSULTANTS

Céline Cyr
Céline Cyr, both a “lived-experience” expert and knowledge expert, has been involved in the service user movement in Quebec for over 15 years. She is well connected to the agencies in her province, and has taught and trained service users and service providers from Abitibi to Outaouais and from Gaspésie to Montréal — her home base. Her “calling” to transfer knowledge has led Céline from Quebec to the rest of Canada. Peer support continues to enrich her life. She is presently completing her master’s thesis in social work.

Heather McKee
Heather has been involved in the consumer/survivor movement at local, provincial and national levels for the past 15 years as a member of self-help groups, a board member and as a staff member of several Consumer/Survivor Initiatives. She managed several projects at the national office of the Canadian Mental Health Association and has worked in knowledge transfer, research, policy and evaluation activities. She has a M.A. in political science.

Mary O’Hagan
Mary O’Hagan was a key initiator of the mental health service user movement in New Zealand in the late 1980s, and was the first chairperson of the World Network of Users and Survivors of Psychiatry between 1991 and 1995. She was one of three full-time Mental Health Commissioners in New Zealand between 2000 and 2007. Mary is now an international consultant. She has written and spoken extensively on user and survivor perspectives in many countries, including on participatory action research. Mary has been an international leader in the development of the recovery approach, including peer run services; she has developed and managed peer run services. Mary has also written a book on peer run initiatives, based on her international Winston Churchill Fellowship. She wrote New Zealand’s first service user workforce development strategy in 2005.

Robyn Priest
Robyn’s Post Graduate Diploma involved majoring in Social Research Methods and Public Policy and Health. She has been involved in the consumer movement within New Zealand and Australia. She also has many connections overseas within the movement. She has worked in peer/consumer dedicated positions for both Government organisations and not for profit organisations, as well as holding senior management positions in both types of organisations. She has recently been the Project Manager for a world first community based acute service alternative encompassing cultural, peer and clinical approaches working together in an equitable way. Robyn has a passion for sustainability and quality management within the sector and is committed to providing high quality reporting with realistic recommendations.