Discovering the Fidelity Standards of Peer Support in an Ethnographic Evaluation

Cheryl MacNeil, Ph.D. and Shery Mead, M.S.W.

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Elizabeth (attendee at the peer training): *It was uncomfortable at first. Being in this program and being in this training, it's like it's true these things happened, but gearing it to, 'where do you want to go with this?' and moving beyond it... That's really new and it's very uncomfortable. I think it's probably like a toddler learning to take its first steps. He's unstable. I don't mean like I'm going to fall apart. I don't mean like psychologists would mean unstable, its just a little wobbly. It's new ground.*

Cheryl (evaluator): *What's the new ground?*

Elizabeth: *You get comfortable being the victim after a while. It's familiar. Then all of a sudden, someone's challenging you to move beyond that.*

Cheryl: *So you're moving out of the victim role?*

Elizabeth: *Exactly. I don't want to be a victim any more. I don't like it. I've been beat enough. I just want to go on. It's going out of there and going on and being someone that's respected. That's the word: Respected. I don't ever feel that I was respected. If I had been, how would someone hurt somebody if they respected them? So I want to be a respected person.*

Cheryl: *And that's a whole different role than wanting to be a victim?*

Elizabeth: *Right. Then I became a victim in the system. 'You take care of me. Okay, doctor, I'll agree with you. I'll take this amount of medicine. Okay, if you say so.' I was victimizing myself all over again. I don't want somebody doing that to me. I don't want somebody just shutting me up. So I like what's offered here. Not to do it alone, because if you come in here you don't have to do it alone. Somebody's willing to sit and go through it with you.*

This segment of a transcription was used as evidence in an ethnographic evaluation study of a peer run crisis program for people accessing mental health services. Elizabeth had just completed a week-long training in trauma informed peer support and was becoming more involved in the activities of the peer run program. Like many of the other participants in the study, being involved with peer support was impacting the way Elizabeth defined herself, her thinking about her responsibilities in relationships with others, and her perceptions of recovery. Elizabeth helps us to understand what personal transformation sounds like and begins to shape our understandings about the impacts of trauma informed peer support.

In this article we are going to share findings of an evaluation that was designed to begin to identify the fidelity standards of peer support (MacNeil, 2003). Peer support programs in mental health have been evolving for the last 40 years. These programs have helped

many people decrease their need for traditional services and have been integral in challenging assumptions about mental illness and treatment (Campbell & Schraiber, 1989). However, while building new knowledge, theory and practices that reflect the values of peer support, these nonprofessional ways of interacting and helping have often been evaluated by applying methodologies and assumptions that are incongruent with emerging knowledge. (Kaufmann, Ward-Colasante, Farmer, 1993; Mowbray, Chamberlain, Jennings, Reed, 1988; Mowbray, & Tan, 1992; Segal, Silverman, Temkin, 1995). Studies continue to assess traditional measures of individual growth and functional outcomes in the absence of exploring the evolving cultures and communities of peer support. Research is needed that examines the extent to which peer support programs create new norms, language, relational roles, and clarify the kinds of help and support that people find useful (Anthony 2003).

One process for enhancing understanding of 'what makes for good support' is through the development of fidelity standards. Fidelity standards help to create a portrait of the ideal structures and processes of a model, and provide a mechanism for monitoring adherence to program principles over time. But the development of fidelity criteria for peer support is a difficult task given the current lack of clarity about what peer support is or is not, and the multiple perspectives, values, histories, needs, and preferences of people participating in peer support.

Mowbray, Holter, Teague and Bybee (2003) draw attention to the complexities of establishing fidelity standards in peer models where, "there is little in the way of published literature, and the articles that do exist only describe programs, providing little evidence that the program described is a high quality or an effective one" (p.326). As well, different perspectives exist in peer communities about 'who is the expert' and whose criteria are being illuminated. Mowbray and her colleagues recommend including many perspectives in the development of fidelity standards for peer programs.

In our current study we undertake an ethnographic exploration of a peer support program as a first step in deriving fidelity standards for a peer support program. We set out to identify the program dimensions from the multiple points of view of those involved. The remainder of this paper will provide a brief theoretical overview of peer support (for more extensive information see Mead, Hilton, & Curtis, 2000), describe the specific model of trauma informed peer support we studied, and offer findings related to the development of fidelity standards for peer programs.

Thinking about peer support

Peer support is not like clinical support, nor is it just about being friends. Unlike clinical help, peer support helps people to understand each other because they've "been there," shared similar experiences and can model for each other a willingness to learn and grow. In peer support people come together with the intention of changing unhelpful patterns, getting out of "stuck" places, and building relationships that are respectful, mutually responsible, and potentially mutually transforming. In other words people come to a peer support program because it feels safe and accepting. By sharing experiences and building

trust, peers help each other move beyond their perceived limitations, old patterns and ways of thinking about mental health. This allows members of the peer community to try out new behaviors and move beyond the "illness culture" into a culture of health and ability (Copeland and Mead, 2004).

Many people who have used mental health services have been told what they "have," how "it" will be treated and how they must think about arranging their lives around this "thing" ((MacNeil, 2002; MacNeil 2000). They begin to see their lives as a series of problems or "symptoms" and eventually become unconscious to other ways of interpreting their experiences. Because of this, many people have felt different and alone and "other-than" much of their lives, leaving them in relationships that have been less than mutually empowering. People have learned to understand their experiences as signs of illness while burying histories of past violence and abuse (Prescott, 2001; Laird, 1994; Bloom, 1997). They have lost power and choices in many relationships. They have learned to either 'act as if,' or have become dependent on professional interpretation of everyday experiences. When people have been acculturated into this "way of knowing," they find that they are trapped not only in the way they think about their experiences but into a life that is completely bound to the mental health system (rights, housing, finances, support, etc.).

While peer communities have come to relate to and feel safe with each other because of these shared experiences, they sometimes get stuck replicating power dynamics they experienced in the mental health system. This has led to conflict, chaos, and role confusion, which is then understood through evaluation as failure (McLean, 1995). However, when programs have been able to work their way through the tensions created during a critical learning experience they have been better positioned to understand help and support as a mutually transformative process (Campbell, 1997; Campbell, 1996). Understanding and facilitating this process requires new cultural patterns that promote reflective practice and value critical thinking. It is possible that if this kind of analysis is provided while reconsidering the popular definition of "recovery", people may begin to challenge beliefs that have traditionally driven mental health. This process has the potential to lead to meaningful systems and social change (Campbell, 1989).

The trauma informed model of peer support

Trauma informed peer support offers people new ways of thinking about help and support (Bloom, 1997; Copeland and Mead, 2004). Rather than teaching problem solving skills based on 'illness narratives,' it provides people the opportunity to reflect on 'how they have come to know what they know.' It enables people to take a step back from their 'illness narrative,' and understand that everyone learns to tell 'their story,' based on the context they are telling it in (e.g. telling a crisis story in order to access more services). It opens up a new interpretive framework for understanding crisis and problems, and then identifies what makes for useful help. In other words, people begin to understand change and learning not as an individual process but rather one where they continuously construct knowledge from actions and reactions, conversations and the on-going building of consensus. Rather than thinking about personal symptom reduction they are talking

about social change. This new version of "help" offers people the possibility for establishing true mutual empowerment.

In a trauma informed system, issues of power are constantly explored and evaluated therefore helping people who have seen themselves as victims begin to challenge that role in a safe setting (Prescott, 2001, Mead & Hilton, 2003). With this new ability to challenge a passive, "illness" role, many people find they are now able to confront other areas of their lives in which they have felt powerless.

One of the more significant and dramatic additions to trauma informed peer support has been peer-run crisis respite programs, such as the one in our study. These programs emerged as an alternative to traditional psychiatric hospitalization (Mead & Hilton, 2002) and have been at the cutting edge of developing new practices for responding to crisis. They are essentially grounded in the knowledge that crisis can be transformative, that mutually supportive relationships provide necessary connection, and that new contexts offer new ways of thinking about one's experience. Rather than objectifying and naming the crisis experience in relation to the construct of illness (e.g. "You're getting sick again") people proactively and dialogically create a plan that serves as a guideline and as a reminder to what kinds of interactions and activities will support a positive outcome for everyone. Out of this shared dynamic a sense of trust is built and the crisis can emerge as an opportunity to create new meaning around the experience while offering people mutually respectful relationships. As trust builds in the relationships and people feel valued, new ways of thinking and doing become possible. The situation is shared rather than "handled," and it offers an opportunity for tremendous community growth.

It is no small feat for peer programs to develop this level of critical self-awareness. People are being asked to act in ways that are not instinctual and they are operating on a level of discomfort that shakes their very realities. It is here however, in community, that narrative becomes transformed (Fay, 1987; White, 1995).

As examples:

> Jack was a young man who told us a story that included a long history of hospitalizations around what he had been told were psychotic experiences. He had recently wanted to get through these times without ending up in the hospital and without increasing his medication. He was also studying eco-psychology and wanted to use the peer respite program as a structure for thinking about psychosis as a systemic phenomenon. At one point he asked to use the peer respite program to move through this experience rather than over-medicate it. His doctor had advised him that taking the risk of not increasing his medications might lead to involuntary treatment and that further, he was much too vulnerable to be going through this with his "peers." In spite of this advice, Jack did use the respite program. He stayed up for 4 days straight. He spent the whole time talking to his peer respite workers, each person sharing their own similar experiences and unique perspectives. No one was afraid of Jack's "bizarre behaviors" or strange ways of thinking at the time. And no one tried to tell him what these things

> meant. After a short stay (with several days just catching up on sleep) he left respite…without increasing his medications and without forced treatment. In fact, Jack went back to school and wrote about his experience. (Mead and Hilton, 2003).

Another person had specifically written about her experience with peer respite:

> I'd come to peer respite after a full week of hearing what I believed was my neighbor's voice as he beat his girlfriend. I could not call the police. I knew and feared that they would come for me rather than my neighbors. I continued to hear the voices during the first day at respite. Rather than medicating my experience, I was able to share my distress with the various workers and began to piece together my story from 20 years before when I'd been the victim of horrific physical and emotional abuse. Up to this point I hadn't considered the "voices" I was hearing as anything other than the symptoms of schizophrenia. Here in the peer respite program I was able to share these experiences with people who really seemed to understand and could relate. I slept soundly for the first time in weeks and as my week there progressed, I felt increasingly more a part of a remarkable community that had learned to collectively re-think the experience of psychosis. Though my psychiatrist had recommended a medication increase prior to my respite stay, when I returned home my distress had abated, as had the need for more medication. In the understanding community of peer support and respite I had begun to find meaning in my life beyond the DSM and I've not experienced painful "delusional" states since then (Blinn, 2001).

These kinds of stories illustrate what happens in trauma informed peer support when people share and explore multiple ways of understanding. In shifting the paradigm of what is to be known and how people should go about knowing it, fundamental assumptions are questioned and new paths of exploration emerge. "Great narrative is an invitation to problem finding, not a lesson in problem-solving. It is deeply about plight, about the road rather than the inn to which it leads" (Bruner, 2002, p.20). What would be different if people described certain behaviors as reactions to past violence rather than simply labeling them as symptoms? How would treatment change if people named their experience as oppression rather than depression (Laird, 1994)? In trauma informed peer support, people can begin to build a larger analysis of the ways in which context is made invisible while those affected are seen as the problem (Foucault, 1988). These are the kinds of narratives that can contribute to the ever-growing "knowledge," and become part of the landscape of how people are "measured."

Uncovering fidelity standards

In our current evaluation, we examined a new peer center operating within a very large traditional mental health system. The center offered a variety of groups, creative activities and a peer-run crisis respite. People accessing the center were as young as 19 and as old as 75. Ninety-five percent of them were women, many of whom disclosed that they had trauma experiences in their histories. All of the people who came to the center for peer crisis supports reported multiple and lengthy past hospitalizations.

Since opening, the peer center workers had extensive training in trauma informed peer support. Both the training and evaluation of the program were grounded in narrative (Russell 2002; White 1995) and critical theory (Fay, 1987; Friere,1997).These theoretical perspectives presuppose that when people who have been oppressed have an opportunity to reflect upon their experience, they often are able to re-define that experience. This has been particularly powerful in peer programs where people who have had similar life experiences are able to share their personal reflections, thereby exposing oppressive constructions without further labeling anyone else. One of the clear tasks for our evaluation of this program was to understand how this particular training and theory was integrated into day to day practice, and to seek out and articulate the quality indicators for peer support as defined through the conversations and activities of the groups.

We conducted our evaluation from an ethnographic standpoint attempting to understand peer support from the relational, political, moral, and economic narratives in which it was embedded. We visited the program every six weeks for about a week's time over the course of a year, talking with peer supporters, community providers affiliated to the program, family members, and other visitors. We taped numerous structured and unstructured interviews, recorded groups and meetings, conducted participant observations, collected artifacts, looked at documents, and noted our experiences in our journals. Upon the completion of each visit we would transcribe all of the recordings and compiled them with our field notes. We analyzed all of the data using *HyperRESEARCH* (1999), a qualitative data analysis software program. Throughout the analysis, we used a grounded theory and open-coding approach (Strauss & Corbin, 1988). This allowed us to extract a range of indicators for peer support, or the kinds of things that people directly or indirectly described to be the essence of peer support. We were then able to cluster the indicators into thematic areas that would culminate into the emergent standards of peer support.

As a means of quality monitoring, we engaged in peer debriefing sessions after each series of transcriptions had been completed (Spall, 1998), and periodically throughout the analysis and report writing phases. Evaluation participants who were available at the Peer Center at the time of our visits were asked to review sections of our analysis and writings to see if it represented their experiences. All evaluation participants were given access to a copy of the report for purposes of member checking (Schwandt, 1997) the summaries and conclusions contained within.

Here are the fidelity standards and the related indicators that emerged in our analyses:

Standard 1: Peer support promotes CRITICAL LEARNING and the re-naming of experiences. People involved with peer support eventually tended to think of themselves, the idea of crisis, their rituals of care, and their relationships with others very differently. Because the trauma-based orientation of the peer support culture helped people to better understand how traumas of the past had been viewed through a medical lens, peers began to redefine who they had become, how they had become, the nature of helping relationships, and what they would need to do to heal.

Examples of CRITICAL LEARNING indicators include:

- Realizing you are *not* crazy.
- Understanding that your emotional distress is an appropriate response.
- Redefining your roles.
- Taking power in relationships.
- Developing wellness strategies.

A large part of the critical learning process in this peer support community was developing a proactive crisis plan before a person stayed at the crisis center. The proactive interviewing process between a peer supporter and a potential guest helped the potential guest to understand the program, but also modeled the kinds of interactions that are unique to peer support. It is both a formal and informal process. Here's a story told about the kind of critical learning that can happen during a conversation among peers:

There was this one woman who was in with her partner and we were filling out a crisis plan. I had asked her about trauma and she said: "No, no." She just wasn't sure. And the partner who was there with her pushed and said: "Well, I think being in an accident where somebody died is trauma." So we pushed that around a little and one of her issues is the time she gets most anxious, she feels like she needs to be in Florida. She has gone and bought bus tickets or she really starts bugging her partner, saying: "I really need to go. I really need to go. You need to take me now." She can't sleep and she's very anxious.

So we talked more about this trauma and I asked: "Where was the accident?" "In Florida." "Who died?" "My husband. Well, I guess he was my husband. We'd just gotten married a few hours before." So then her partner said: "Well, someone else died in the accident too." I said, "who? " And it was her two-year old daughter. They're buried there in Florida. She doesn't have any pictures of the baby, because there was a fire and she lost them all. That's information that her doctor didn't have. Her caseworker didn't have. Nobody had. But because we were doing this pre-planning and she was in a good space to do it, we got this information and now we can help her out with it. So we have plans now to try and get some of those pictures -see if other relatives have pictures, if there's something that we can do here creatively in the arts center. We can create a scrapbook for her or something symbolic for that baby.

In this story we hear a different kind of conversation. In being able to sit with the woman and her partner in "a good space", a peer supporter was able to redefine her crisis through the trauma lens. New understandings and responses to her trauma could then be developed.

Another peer offered a reflection that exemplifies many of the participant conversations about how the Peer Center is promoting learning in a helpful way:

"I find this place when I stayed here a place where I could sit down and really take a look at me. I didn't have my mother saying: "You need to do this." I was the one that had to wake up and make sure I take my medicine with nobody telling me. See, in the hospitals, they come in and they give you your medicine. You have no responsibility. So how are you supposed to learn responsibility if you're in a hospital and they're not letting you be responsible? Because when you go back home there isn't anybody saying: "You know what? You need to take your medicine." Or "You need to get up out of bed because you have an appointment." You don't have anybody to do that. Or if you have an animal. You need to get up to take that animal out. Those are responsibilities that you have to learn."

Standard 2: The culture of peer support provides a sense of COMMUNITY. Peers would tell us that peer support is, *"Something you can't buy. You can buy intensive care. You can buy medication. You can even buy diagnoses. But you can't buy community."* The support received in a peer relationship gave people a sense of security and, *"a sense of belonging somewhere."* It was a relationship where people were allowed to have the time they needed to talk to with one and other. Community also implied that healing was a relational process rather than an individual one.

Peer support was not about fixing things. Great value was placed in the power of being seen and heard. Peer supporters encouraged each other to be witnesses of past and present stories, and to validate, not judge, a person's experience. No one was the expert, and no one person defined another's reality.

Examples of COMMMUNITY indicators include:

- You are not told what you *have* to do.
- Validation and witnessing is more important than fixing.
- Acceptance for where a person is at.
- A sense of kindredship in sharing similar experiences.
- An atmosphere of hope and celebration.
- Members are both leaders and followers.
- A place to make friends and to know you are not alone.
- A place to be yourself.

Peers described peer support as a relationship where they were allowed to have the time they needed to talk to people. It was a community space where one could entertain or be entertained. *"We relax. We laugh. There are days that we're quiet. People are just feeling...(sigh sound) quiet. And that's okay," "That was what my idea of what this place was,"* claimed another peer, *"it was a place if you need somebody to talk to or somebody's shoulder to cry on, somebody to just say to, ""This has been the longest fucking day of my life and let me tell you how it sucked." If that's all you need, that's all you need.""*

"Acceptance is something there isn't a whole lot of in our culture," claimed another peer. *"The whole culture is really starved for acceptance. For some reason this is the place where it happens and it's just a wonderful to experience."*

Standard 3: There is great FLEXIBILITY in the kinds of support provided by peers. Peers supported each other around their preferences or needs. The peer community strived to create a range of possibilities to keep people included. This could mean creating roles that would allow a peer to feel included, inviting another peer into one's home as a support option, providing transportation, taking care of a peer's pet if they needed to go on an appointment, making a phone call for someone, and providing a range of other day-to-day supports as needed.

Examples of FLEXIBILITY indicators include:

- Program is experienced as a place to stretch your comfort zone.
- Range of possibilities explored to keep people included.
- Work with people around their unique preferences and needs.
- Conflict or tension is defined as an opportunity.
- Encouragement is given to share talents and expertise.

If you visited the Center on any given day it was likely you would meet someone's pet. Peer support placed great value in the comfort people received from their pets and made accommodations for four-legged comforting as needed. As one guest described:

"During the assessment of my mental health needs it was determined that my dog, Java--this is Java--is very important to me, and that I could have him here with me. Then I came here and one of the staff picked him up and all of his toys--this was last year. She picked me up--us up-- again today (laughing) to bring us back. She picked him up and brought him in. At the time, I had to use a walker to get around, so I was afraid of falling. After the staff person, brought Java over, I became increasingly mobile. I was able to walk better and better. I only had to rely on a cane or like a ski pole for walking outside,"

In another interview we asked a peer volunteer, "What happens to the people that are afraid of leaving their home?"

"Well, we'll try and give them support at home. If we don't have people available to go spend time with them—that was the original grant –it was written for people to go out and be with people in their homes. That part of our program shouldn't end just because we have this center. The hope is that people will still go and give support in folks' homes or by phone. The phone, actually, kind of happened. That wasn't part of the initial thought. The initial thought was that people would go into homes."

Flexibility also meant that peer support allowed people to experiment with their comfort zones. We observed this most clearly in relation to people who were considering volunteering at the peer support center or who had become paid staff. There was a lot of

exploration about what it would mean to make a commitment. And as the responsibilities to the peer support center presented themselves, peers continued learning and experimenting. Here a peer shares her thinking around trying to do an overnight, *" I'm going to try it tonight, and if I'm too uncomfortable, I won't ever do it again. But as I've found a healthy alternative as I talked to Andrea, and said I could work days so we have me working daytimes and on the weekends…we'll see how it goes and work from there."*

Standard 4: Peer support activities, meetings and conversations are INSTRUCTIVE. Peer support offered people an opportunity to increase their knowledge and resources. Peers shared all kinds of information, talents, and expertise. Peers valued each other's expertise and recognized how the instructive dimension of peer support is reciprocal. They were both teachers and learners in any given day. If someone came up with an idea they were encouraged to develop it. When conflict or tension surfaced, it was defined as a learning opportunity.

Examples of INSTRUCTIVE indicators include:

- Atmosphere promotes trusting oneself to figure things out.
- Collective-problem solving is encouraged.
- Alternative healing strategies are encouraged.
- Genuine and inclusive feedback provided.
- Conversation is respectful.
- Conflict or tension is defined as an opportunity.
- There is a presence of potent activities.
- Activities and people are interesting.
- Encouragement is given to share talents and expertise.
- People are invited along to participate in a variety of ways.
- Atmosphere promotes trusting oneself to figure things out.
- There is value in experience and common wisdom.
- Every person is a teacher and a learner.

Here is an excerpt from one of the community meetings that demonstrates how peer support can be instructive:

"Has anybody heard of care partners? It's a program that started in June. Care partners pay only ten dollars flat fee per doctor's visit. There is no enrollment fee. Hospital and diagnostic tests are free. Eligibility is determined by income. I just talked to a family down in Portland where I was the other day. The poor guy, he hasn't worked in three weeks, four kids. He just shelled out sixty dollars so his kid could see a doctor. So let's pass the good news around that evidently in the advanced state of Maine some people care enough!"

As one peer claimed, peer support is about, *"teaching others or learning from others or just being there."* People readily shared how interesting they found their peers. *"The people are interesting to talk to. I like to talk to them about my problems."*

The instructive nature of peer support also embraced offering alternative healing strategies. *"We bring a new approach. We bring a new paradigm -a whole complementary way of looking at healing and at growing. I'm not saying anything negative about the pharmaceutical industry or doctors. But there is another way. Peer counseling, peer support...All the wonderful things that have been actually going on for decades never really had a chance to have a place to really hone in here and grow. But now there is a place where people can try to find a new way to have an understanding of themselves, have an understanding about their life situation, and do some re-planning, restructuring of their life in a team atmosphere."*

Standard 5: There is MUTUAL RESPONSIBILITY across peer relationships. There was respect among people involved with peer support regardless of their 'condition.' There was a range of responsibilities embedded in the relationships of the peer community. Examples in our study included the responsibilities of: 'using one's voice'; 'raising expectations'**; '**taking charge of one's circumstances'; and 'moving forward'. Discarding systems' labels that shape thinking and action was also important to being responsibly involved with peer support.

Examples of MUTUAL RESPONSIBILITY indicators include:

- All persons should be considered equal.
- People are present when they are the subject of conversation.
- Everyone has something valuable to share.
- Building of honest relationships that are essential to healing
- Taking charge of your daily routine and affairs.
- You are expected to go forward in your process.
- Fancy language and labeling practices carry little value.
- You are expected to be honest with yourself and other.

The culture of peer support tried to break out of traditional helper-helpee roles by emphasizing the importance of creating mutually responsible relationships between all peers: guests, visitors and volunteers. Here's a short example from one interview:

Cheryl (evaluator): *So what do you tell guests about their responsibilities?*

Gloria (peer supporter): *Well, I'd say, even though you are a guest, because of the conversations that come up, I would ask you to respect other peoples' confidentiality. They're talking to you as a peer and sharing their own experiences. We would ask that you do your own dishes and clean up your own messes. We would also respect that if you tell us that you would like some time alone, we'll leave you to be there. But if we haven't heard from you in a while and we are concerned, we might knock on your door, ask how you're doing, whatever. We don't confine you to here, but we want to know if you might be leaving what time to expect you back - just because we care. We'd like to know what's going on.*

There was a range of responsibilities attached to peer support. They were embedded in the relational responsibilities to others and to the community. The year of observations

and interviews we conducted produced volumes of comments about what it means to be responsibly involved with the Peer Center. As one peer best summed up, *"Part of what we're trying to encourage people to do here is to speak up about what you need to be well and to get well. I don't think that's something people learn in other hospitals. People aren't encouraged to speak their mind. People need to learn to say: I need this and this and this if I'm going to get on with things here."*

Standard 6: Peer support involves sophisticated levels of SAFETY. Peers in our study talked about safety on a number of complex levels including: emotional safety through validation; the safety one feels in a compassionate interaction; safety in having people advocate for you; safety in the ability to express yourself freely; and safety in being able to disclose. What safety means to each peer and among peers in a peer support relationship has to be mutually negotiated. Safety also means that peers are developing the right tools and seeking education to support one and other, and that they accept the consequences of making others feel unsafe.

Examples of SAFETY indicators include:

- There is compassion.
- Looking out for each other.
- What safety means in a relationship is negotiated.
- Experienced as a safe place to be yourself.
- Provided the 'tools', education, and knowledge to respond.
- There are consequences for making others feel unsafe.
- Policies and procedures pertaining to safety are discussed.
- Emotional safety and validation in being heard.
- Freedom of expression.
- Feeling like you are not being judged.
- Knowing that you don't have to have all the answers.
- An appreciation for 'the long haul' of the healing process.
- Being able to disclose.

"I think safety has to be mutually negotiated. Sometimes it can be a screen for not taking a good look at yourself. When people don't want to talk about stuff that upsets them...that feels disingenuous and it feels assaultive to me. Because it says: I'm not going to be in a relationship with you, because I'm really upset with you. And that hurts. This innuendo that people won't talk to you, but bad things are happening. That's not peer support. Peer support is negotiating what safety means to both of us."

Standard 7: Peer support is being clear about and SETTING LIMITS. In the absence of the strict and permanent boundaries that enclose a person's contact with professionals, the more permeable and personal conduct of peer relating created a need for peers to stay alert to what they said and who they said it to as they worked to honor each others' experiences. Peers had to be clear with themselves and each other about what they could and could not do and why that was so.

Examples of SETTING LIMITS indicators include:

- Respecting the confidentiality of the community.
- Parameters of 'what is tolerable dissonance' within the community are negotiated.
- Composition of the community is taken into consideration when defining limits.
- Expected to reflect upon and articulate personal limits.
- Understanding that limits will change and be redefined as the learning process unfolds.
- Levels of intimacy vary from individual to individual and require acknowledgement.
- Being clear about what you can and cannot do and why this is so.

There were sophisticated limits this community confronted. Peers were learning about their 'professional' responsibilities as peer supporters and discovering their personal limits in upholding these. For example, some people found out what it means to be at the other end of an emergency pager and the demands of carrying of pager. Others had explored their abilities to provide overnight respite. Peers frequently reported that they had struggled in learning about limits, but they were evolving as they learned to reflect upon and articulate their personal limits. Here are some examples provided by four different peers:

"I'm in training right now with something that is just really stressed, and is so important and can be so difficult: To always keep in mind that the relationships always have to work on both sides. Never a one sided relationship so...you're always taking care of your own boundaries. And when that's not working in a relationship, as our instructor says, negotiate it with the other person. That's a very different arrangement."

"I do put limits. I feel very good about putting limits on what I can do, what I can't do. In the past, I've always go go go go go go, get into it into it into it. My husband's saying: yo-yo, you're married. So I do put limits. - on myself and on people from this program. Please don't call me after eight o'clock at night. That's my time for my relationship from eight o'clock on. Setting limits has been important."

"So here's an example in a meeting about this woman who said: Well, this person calls me all the time. She called me at 2:00 AM, and I took her to the emergency room. This person's partner--spouse or husband, whatever-- was right there. But she drove over and took her, and she's thinking like: "I can't do this." So we did some role plays with her setting limits that this person just can't call her 24 hours a day direct. She doesn't use the other pager because she listens to her. I said: Well, what do you think is the ultimate consequence about not having any limits on this is for you? She's like: "I'll stop doing peer support." I challenged her and said: So who's problem is this? I don't think this is this woman's problem. I think it's your problem. If you don't say no then I guess she gets the idea that it's okay to call twenty-four hours a day and talk as long as she wants and not appear to do any work herself."

"I think about what I say to people and I don't think that what I have to say is very helpful right now, because I really need to take care of myself. And I'm afraid that I will get involved with somebody here, and I wouldn't have the energy to take care of me too. Cuz if I'm not taking care of me, how am I supposed to help somebody else? If I'm not meeting my own needs, how am I supposed to meet somebody else's needs? So that's why I'm not here right now. "

Conclusion

"When consumers/survivors/patients talk about what helps them, they generally credit some person who believed in them, who respected them; someone who made a genuine person-to-person connection with them" (Bassman, 2001, p. 22). These are the kinds of interactions we found people talking about as they got involved in peer support. Because peer support is quickly gaining credibility and peer support programs are popping up everywhere and in every form, it is a critical time for fidelity standards to be established that define "What is Good Peer Support" across many different initiatives. Our study brings us to the beginning of this process in describing the dimensions of one community.

The seven standards discovered in our study and their related indicators help us to understand the important ingredients in this trauma informed model of peer support. Standard one, critical learning, demonstrated a shift in a way of thinking about and describing one's experience. The proactive crisis interviewing process used by this community demonstrated a shared power, shared responsibility approach to help. Over and over, as peers collaboratively explored how they had come to understand their experiences, they helped each other challenge what previously felt like "out of control" behavior. This new analysis then provided peers with a way of reframing what support might look like.

The standard of community was a critical component in this developing trauma informed program. In contrast to an individual symptom management approach to recovery, a sense of community helped people to see the living implications of their healing as well as their influence on others. The community offered a comfortable setting in which people could explore relational dynamics that had previously kept them isolated and alone.

The standard of flexibility was also embedded in this peer program. It was assumed that most situations called for an individual approach. Flexibility offered the peer group a chance to work through difficult situations leading to more critical learning and a stronger community. In that, trauma dynamics (e.g. reenacting old roles) could be noticed and dealt with. Related, the focus on education and a standard of instructiveness offered people the opportunity to create a new way of thinking about their experiences and assumed that no one body of knowledge was privileged. Expertise came not only from each individual, but from different reference points. In this trauma informed system, this then led to mutual empowerment.

Mutual responsibility was perhaps the core of this peer support community. When the expectation was that everyone was equally responsible for individual and community relationships, the roles of victim and rescuer were no longer viable. A sense of mutual responsibility allowed people to transcend their illness narrative and offered them a chance to be both "helper" and "helped;" student and teacher, leading to a stronger sense of value and worth.

When the notion of safety was described outside the framework of liability, new ways of defining safety emerged. For many people, the language of safety had traditionally contributed to their sense of fragility and the assumption of their fragility by others. When safety became self-defined and then continuously redefined for community, people could create an environment where trying new things and exploring new ways of thinking became desirable instead of "dangerous risks." Finally, setting limits had not always been easy for many peers who had consequently then found themselves responding with symptoms, withdrawal, aggression, or burnout. As each person was able to push their capacity for learning while at the same time defining their own limits, the peer community built trust and allowed itself to evolve.

Anthony (2003) has argued that "In this decade the evidence based practice initiative has designated certain practices as evidence based (e.g. supported employment, intensive case management) due to their ability to generate positive outcomes in randomized trials. These evidence based practices are described mostly by their program structures (staffing, case load size, etc.). Unfortunately the evidence based practice initiative has overlooked in these program descriptions the ingredients of the helping process that occur within each practice and which behavioral sciences research has shown to be related to how people change and grow (relational variables, skill teaching strategies, hope engendering techniques**)…**the evidence based practice initiative must be broadened to incorporate these empirically derived helping processes that are fundamental to people's growth and change, and which may underlie most evidence based structures" (pp.1-2).

We agree with Anthony's position and recommend the process of identifying fidelity criteria is critical to launching peer support into the arena of evidence base practices. Investigating the standards of peer support will require continuing a discovery process across many different kinds of peer communities exploring different experiences, people's relationships in systems, and the kinds of things they've experienced as "helpful". We offer our study as one contribution to a growing body of knowledge that will help peer support initiatives articulate what it is that makes this model of care distinct. Future studies are needed that continue to identify standards across different peer communities and develop measurement strategies that are coherent with the values and collective standards of peer support.

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