

THE ART OF PEER SUPPORT:

Work, Health, Consumer Participation, and New Forms of Citizenship in Late Twentieth-Century Mental Health Care in British Columbia

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TODAY, PEER SUPPORT IS a formal and expected part of mental health services. The Mental Health Commission of Canada defines peer support as “support provided by peers, for peers; or any organized support provided by and for people with mental health problems and illnesses.”¹ Its history, however, is only beginning to receive scholarly attention from historians.² This article focuses on the history of peer support in British Columbia’s mental health service system and aims to understand current conceptualizations of peer support in their social context.³

¹ Céline Cyr, Heather McKee, Mary O’Hagan, and Robyn Priest, *Making the Case for Peer Support: Report to the Peer Support Project Committee of the Mental Health Commission of Canada* (2010 1st ed. / 2016 2nd ed.), 10, 45, <http://www.mentalhealthcommission.ca>.

² Erika Dyck and Alex Deighton, *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada* (Winnipeg: University of Manitoba Press, 2017), 200–28; Judith Fingard and John Rutherford, *Protect, Befriend and Respect: Nova Scotia’s Mental Health Movement, 1908–2008* (Halifax: Fernwood, 2008).

³ This article draws from two studies: (1) a multisite project on the history of deinstitutionalization in Canada (funded by Canadian Institutes of Health Research), Principal Investigators (PIs) Megan Davies and Erika Dyck (Geertje Boschma was among the co-investigators); and (2) an oral history project on the shift to community mental health in British Columbia (funded by the Vancouver Foundation), PI Geertje Boschma with Margaret Gorrie. Institutional ethical approval from the Behavioural Research Ethics Board of the University of British Columbia and the Fraser Health Research Ethics Board was obtained as well as interviewees’ consent. Interviewees who consented to reveal their names are addressed as such; those who did not are referred to by pseudonyms. The oral histories are with the respective PIs. Parts of this article are drawn from Geertje Boschma, “Community Mental Health Post-1950: Reconsidering Nurses’ and Consumers’ Identity,” in *Routledge Handbook on the Global History of Nursing*, ed. Patricia D’Antonio, Julie Fairman, and Jean Whelan, 237–58 (London: Routledge Taylor and Francis Group, 2013), and are used with permission. Courtney Devane, PhD student at UBC (Nursing) with Geertje Boschma and Emily Jenkins, received a scholarship award from the BC History of Nursing Society to examine the history of peer support in mental health care. We acknowledge the support of the UBC Peter Wall Institute for Advanced Studies for support of a development workshop in the initial phase of the project.

Peer support arose in the 1970s within Canada's postwar welfare state and underwent profound change in the late twentieth century. In this era, attentiveness to patients' rights became an essential factor in health policy. Awareness of patients' rights and citizenship underlay efforts to construct a social context of inclusive citizen participation of people challenged by mental health or illness difficulties.⁴ A rights-based discourse not only advanced a more inclusive notion of social citizenship but also transformed mental health policy.⁵ More important, patients became essential players in creating supportive structures within a new orientation towards a community-based mental health system.⁶ This shift in policy and practice was in part due to deinstitutionalization; that is, the downsizing of provincial mental hospital patient populations that started in British Columbia during the 1960s.⁷ Another formative influence involved the civil rights and anti-psychiatric movements that were emerging internationally.⁸ Despite the ideals of community-based care, the existing service structure was ill-designed to attend to the needs of patients discharged from Riverview, British Columbia's large mental

⁴ Dominique Clément, *Human Rights in Canada: A History* (Waterloo: Wilfrid Laurier University Press, 2016); Dyck and Deighton, *Managing Madness*; Harry Oosterhuis and Frank Huisman, ed., *Health and Citizenship: Political Cultures of Health in Modern Europe*, 1–40 (London: Pickering and Chatto, 2014); Marcia Rioux, "The Right to Health: Human Rights Approaches to Health," in *Staying Alive: Critical Perspectives on Health, Illness and Health Care*, ed. Toba Bryant, Dennis Raphael, and Marcia Rioux, 93–120 (Toronto: Canadian Scholars' Press, 2010); Nancy Tomes, "The Patient as a Policy Factor: A Historical Case Study of the Consumer/Survivor Movement in Mental Health," *Health Affairs*, 25 (2006): 720–29.

⁵ Erika Dyck, "Dismantling the Asylum and Charting New Pathways into the Community: Mental Health Care in Twentieth-Century Canada," *Histoire Sociale/Social History* 44, 88 (2011): 181–96. An important early influence shaping this health policy direction in Canada was Marc Lalonde's 1974 report *A New Perspective on the Health of Canadians* (Ottawa: Government of Canada, 1974). On pages 61 and 62, Lalonde explicitly discusses mental health and the need to combat stigma, to change public views and attitudes towards mental illness, and to promote prevention.

⁶ Lanny Beckman and Megan Davies, "Democracy Is a Very Radical Idea," in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume, 49–63 (Toronto: Canadian Scholars' Press, 2013); Dyck, "Dismantling the Asylum."

⁷ Geertje Boschma, "Deinstitutionalization Reconsidered: Geographic and Demographic Changes in Mental Health Care in British Columbia and Alberta, 1950–1980," *Histoire Sociale/Social History* 44, 88 (2011): 223–56; Despo Kritsotaki, Vicky Long, and Matthew Smith, ed., *Deinstitutionalization and After: Post-War Psychiatry in the Western World* (Basingstoke, UK: Palgrave Macmillan, 2016).

⁸ Jennifer Laws, "Crackpots and Basketcases: A History of Therapeutic Work and Human Occupation," *History of the Human Sciences* 24, 2 (2011): 65–81; Geertje Boschma, "Accommodation and Resistance to the Dominant Cultural Discourse on Psychiatric Mental Health: Accounts of Family Members," *Nursing Inquiry* 14, 4 (2007): 266–78; Geertje Boschma, "Electroconvulsive Therapy (ECT) and Nursing Practice in the Netherlands, 1940–2010," *European Journal for Nursing History and Ethics* 1 (2019): 17–39.

hospital, and there were considerable gaps in care.⁹ In this context, peer support arose as a new form of patient advocacy and activism, its purpose being to secure better help and service. Embracing the civil rights discourse, patients began to identify as consumers and survivors of mental health services and as advocates for its improvement. Patient identities as peer supporters emerged against the interconnected backdrop of a rising national and international consumer/survivor movement, an effort to fill gaps in service created by deinstitutionalization, and new rehabilitative practices in mental health care.¹⁰

British Columbia provides an important case study for examining peer support within the shifting landscape of post-1970s mental health. The province was home to Canada's first peer-run support organization, the Mental Patients Association of Vancouver (MPA), founded in 1971.¹¹ The group was central to the emerging patient liberation movement in Canada and served as a countercultural role model for the evolution of peer-run services and peer support.¹² Peer support was an essential part of MPA's influence in the Vancouver area, including the way it challenged earlier institutional traditions of patient and volunteer work within British Columbia's main provincial mental facility, Riverview Hospital (RH).

During the 1980s, the new social role of peer supporter, as the position was eventually called, became formalized within governmental health policy, both federally and provincially, but it met with contradictory social responses. Neoliberal concerns about health and welfare funding introduced market values into the health care system, stressing individual responsibility for productive citizenship and health. Budget cuts followed, with a new emphasis on efficiency and outcome measurements. The neoliberal focus on "productivity" was in sharp contrast to the earlier

⁹ Boschma, "Deinstitutionalization Reconsidered."

¹⁰ Irit Shimrat, *Call Me Crazy: Stories from the Mad Movement* (Vancouver: Press Gang, 1997); Judi Chamberlain, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (New York: Hawthorn Books, 1978); "The Inmates Are Running the Asylum: Stories from the MPA [Mental Patients Association] – A Documentary," DVD, 36-mins., created by the MPA founders' collective, Megan Davies (producer), Marina Morrow (co-producer), Geertje Boschma (associate co-producer), © History of Madness Productions, 2013, <http://www.oralhistorycentre.ca/inmates-are-running-asylum-stories-mpa-1>; Dyck and Deighton, *Managing Madness*, 200–28; Geertje Boschma, Megan Davies, and Marina Morrow, "Those People Known as Mental Patients: Professional and Patient Engagement in Community Mental Health in Vancouver, BC, in the 1970s," *Oral History Forum/d'histoire orale* 34 (2014), <http://www.oralhistoryforum.ca/index.php/ohf/issue/view/47>; Dyck and Deighton, *Managing Madness*, 200–28.

¹¹ Mental Patients Association, *Head On: Into the Eighties* (Vancouver: Carolina Publications, 1983).

¹² Chamberlain, *On Our Own*; "The Inmates Are Running The Asylum: Stories from the MPA [Mental Patients Association] – A Documentary."

notion of social citizenship, and it interrupted the latter's ideals with the logic of cost containment – arguably framing self-help as cost-effective.¹³ Beginning in the 1980s, peer support became increasingly formalized within the mainstream mental health system in British Columbia as a form of work ranging from volunteer jobs to paid employment. Still, whether peer support should be conceptualized as a source of communal support or as individualized employment opportunities for former patients – who, as experiential experts, were entitled to rightful work – remained unsettled.¹⁴ Ironically, the interruption of the ideal of participatory citizenship and communal peer support envisioned in the patient liberation movement was facilitated by the prominence of self-reliance and self-responsibility – another set of values associated with the patient liberation movement and civil rights discourse.¹⁵ As the BC case illustrates, during the 1990s and early 2000s, peer support consolidated as a recognized role, but it was also marked by contradictory demands. On the one hand, peer support was enthusiastically promoted by peers and professionals alike as an avenue towards autonomy and inclusion, inspired by aspirations for social freedom, justice, community, and mutuality. On the other hand, the neoliberal turn also consolidated demands for the standardization and formalization of peer support as a form of employment, thus enhancing processes of individualization and emphasizing productivity and professionalization.¹⁶

By centring on broader federal and provincial policy developments around peer support, we show how peer support in mental health was not an isolated event but, rather, part of a broader stream of self- and peer-help initiatives and networks emerging in the 1970s countercultural movements in education, health care, and social work, all of which were intimately connected to a civil rights discourse. During the 1980s, however, such grassroots initiatives were bureaucratized and became part of a governmentally supported service structure. Within British Columbia's mental health reforms of the 1990s, for example, peer support

¹³ Janine Brodie, "Reforming Social Justice in Neoliberal Times," *Studies in Social Justice* 2, 1 (2007): 93–107.

¹⁴ Ibid.

¹⁵ Dyck and Deighton, *Managing Madness*, 200–28. See also next section about the MPA, and note 34 for examples of other provincially based groups exemplifying the movement.

¹⁶ Cosmo Howard, ed., *Contested Individualization: Debates about Contemporary Personhood* (New York: Palgrave Macmillan, 2007); Laws, "Crackpots and Basketcases"; William Anthony, "Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s," *Psychosocial Rehabilitation Journal* 16, 4 (1993), 11–23; Patricia E. Deegan, "Recovery: The Lived Experience of Rehabilitation," *Psychosocial Rehabilitation Journal* 11, 4 (1988): 11–19; Patricia E. Deegan, "Recovering Our Sense of Value after Being Labeled Mentally Ill," *Journal of Psychosocial Nursing* 15 (1993): 3–19.

not only professionalized but also developed a stronger connection to individual responsibility, personal success, and “career-minded” self-help, justified by an orientation towards recovery in mental health policy and programs.¹⁷

New training structures to support the professionalization of peer support sprang up across the province. Within an era of social service cutbacks, however, this effort could also be interpreted as a cost-saving measure promoting a more narrowly conceived notion of productive citizenship, one that emphasizes personal responsibility rather than social inclusion. The ambivalence regarding justification illustrates how peer support was not immune to the wider social conundrum of what Bradbury and Myers framed as the “intermediate spaces” between formal politics and family life. Such “in-between” social sites and relationships, they argued, could be “places of potential freedom, self-expression, and assertion of citizenship claims and concurrently sites of unequal power relations and places of moral and social regulation.”¹⁸ Although formally acknowledged as participants and policy actors in the 1980s and 1990s, peer supporters at work in community-based services also faced new vulnerabilities and social constraints.¹⁹

An important goal of this article is to highlight these contradictions in the evolution of peer support and the role of peer supporter by using developments in British Columbia as a case in point. We start with an analysis of peer support within the MPA in the 1970s and then examine the way peer support became formalized within BC mental health policy in the 1980s and 1990s.²⁰ Our main question is: How did peer support emerge and transform against the backdrop of changing mental health policy in British Columbia? And how was it linked to claims of social citizenship?

¹⁷ Marina Morrow, “Recovery: Progressive Paradigm or Neoliberal Smokescreen?,” in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume, 323–33 (Toronto: Canadian Scholars’ Press, 2013); Brian Brown and Nick Manning, “Genealogies of Recovery: The Framing of Therapeutic Ambitions,” *Nursing Philosophy* 19, 2 (2018), e12195, doi: 10.1111/nup.12195; Dyck and Deighton, *Managing Madness*, 200–28.

¹⁸ Bettina Bradbury and Tamara Myers, ed., *Negotiating Identities in Nineteenth- and Twentieth-Century Montreal* (Vancouver: UBC Press, 2005), 3–21.

¹⁹ Barbara Everett, *A Fragile Revolution: Consumers and Psychiatric Survivors Confront the Power of the Mental Health System* (Waterloo: Wilfrid Laurier University Press, 2000); Tomes, “Patient as a Policy Factor.”

²⁰ We draw on source material from two oral history projects with former patients in Vancouver and New Westminster, BC, as well as archival sources and secondary literature. See also note 3.

PEER SUPPORT AND COMMUNITY MENTAL HEALTH
IN THE 1970S: THE MPA

The downsizing of British Columbia's residential psychiatric institutions in the 1970s prompted a new focus on the organization of support outside the established parameters of provincial mental health services.²¹ In 1971, the MPA started in Vancouver's urban Kitsilano neighbourhood as a radical grassroots self-help organization. It was run by peers who had founded it as an antidote to profound inadequacies in existing mental health services. The MPA's founding story illustrates the point: ex-patient and founder Lanny Beckman was at the Monday-to-Friday day program in the nearby Burnaby mental health clinic around 1970 when two fellow patients both committed suicide on weekends, when no staff were available to attend to their crises. His confidence in organized mental health services shaken, Beckman identified how the group decided to rely on each other for support.²² Starting with a contact phone list, formed as a resource so that people could help each other outside of regular office hours, other self-help initiatives soon emerged. Inspired by ideas and tactics employed by gay rights, civil rights, feminist, and North American student movements, Beckman and his fellow patients broadened their initiative not only into an innovative type of peer support group but also into an activist one.²³ With a background in psychology, acting, and media work, and a keen interest in the emerging counter-culture movement and the advancement of democratic self-organization, Beckman brought substantial talent to the group, as did many of the early MPA members.²⁴ With the help of sympathetic allies, they drew media attention to their cause, formed an association, and soon were offered a house at low-cost rent in Kitsilano to set up a drop-in centre. The MPA drop-in was born and thrived in the midst of a lively scene of youth,

²¹ In Riverview Hospital (RH), for example, the end-of-year patient population peaked at 4,602 patients in 1950. Twenty years later, in 1972, this number had dropped to 2,650. See Annual Report, Provincial Mental Health Services, BC, 1951: 90–1; 1972: 85. See also Boschma, "Deinstitutionalization Reconsidered."

²² MPA, *Head On*.

²³ Boschma, Davies, and Morrow, "Those People Known as Mental Patients."

²⁴ Little is known about the specific demographics of the early MPA membership, but from the available sources it appears to have been made up of former service users who also brought talent either as students or as people who had artistic or professional backgrounds. See also: "After the Asylum, Virtual Exhibit," ed., Megan Davies, Geertje Boschma, and Marina Morrow with the MPA Founders, <http://aftertheasylum.appsof.yorku.ca/en/> (August 2016). For Beckman's biography from this site, see the section "How the MPA Reformed Community Mental Health – Biographical Portraits: Lanny Beckman"; and Boschma, Davies, and Morrow, "Those People Known as Mental Patients."

left, and countercultural activity.²⁵ Indeed, the MPA took shape against the backdrop of Vancouver's 1970s countercultural movements and was closely linked to the civil rights movement and the campaign for patient rights.²⁶ The early founders inverted traditional mental health hierarchies by putting former patients and sympathetic lay supporters in charge of new and innovative peer-led community resources. Creative responses included the MPA drop-in, four communal peer-run residential homes, a hospital-visiting program and a weekly schedule of activities, work opportunities and artistic initiatives, and the production of a monthly newsletter. The latter soon grew into a full-fledged imaginative, peer-run, and self-published newspaper called *In a Nutshell*.²⁷

The MPA model of self-help was simultaneously an alternative to and a critique of a provincial mental health service system that continued to be primarily located in the hospital rather than in the community. Part of the patient liberation movement that emerged in the wake of deinstitutionalization, the MPA and similar groups in other parts of Canada, the United States, and Europe challenged the individual focus of the dominant medical model in mental health and asked for (more) collective solidarity and democratic participation.²⁸ Patients began to refer to themselves as “ex-patients,” “survivors,” and “consumers” or “users” of mental health services, terms used strategically and not necessarily interchangeably but always tapping into a discourse of rights and responsibility and used as a way to assert entitlement to citizenship.²⁹

Convinced their personal experience was political, MPA members freely and critically asserted personal and political perspectives and reported on their activities and actions in *In a Nutshell*, whose readership spread nationally and internationally. *In a Nutshell* became a voice for the Mental Patient Liberation Movement in Canada, astutely advocating for respect, self-expression, and the citizen rights of people living or labelled with mental illness. The MPA thus evolved as a self-help service organization that was run by members and that generated support and

²⁵ Lawrence Aronsen, *City of Love and Revolution: Vancouver in the Sixties* (Vancouver: New Star Books, 2010); Michael Boudreau, “Hippies, Yippies, the Counterculture and the Gastown Riot in Vancouver, 1968–71,” *BC Studies* 197 (Spring 2018): 39–65.

²⁶ Dyck, “Dismantling the Asylum”; Beckman and Davies, “Democracy Is a Very Radical Idea”; Boudreau, “Hippies.”

²⁷ “Inmates are Running the Asylum – A Documentary”; Judi Chamberlain, *On Our Own*.

²⁸ Beckman and Davies, “Democracy.”

²⁹ Boschma, Davies, and Morrow, “Those People Known as Mental Patients.”

paid jobs.³⁰ This soon became a new framework for voluntary and paid employment in peer support.

The hospital visiting program MPA members established is another example of an inventive initiative in peer help and communal support. On a weekly basis, members visited fellow patients who were to be discharged from Riverview Hospital or newly established psychiatric departments in general hospitals to support them in their transition to community living.³¹ In enacting this goal, the members of the MPA not only asserted their influence but also negotiated new identities as service creators, allies, participants, and workers in new mental health work, embodying new forms of help and citizenship based on ideas of friendship and understanding rather than on medical perspectives. They clearly distanced themselves from professional service models, setting new trends.³²

The early 1970s federal employment programs provided the MPA with the opportunity to create jobs. They successfully applied for funding from the federal Company of Young Canadians, Local Initiatives Programs (LIP grants), and the Local Employment Assistance Program (LEAP grants). The funding provided members with ongoing employment (e.g., as residence coordinators).³³ Members were voted into positions during regularly held communal member meetings, which were conducted based on principles of democracy and shared authority.³⁴ Although this relative new freedom was short-lived as the federal government considerably reduced the public funding of provincial local initiatives in the late 1970s, in the early years of that decade it did stimulate initiatives such as those brought forward by the MPA.

One of the MPA's first grants from the Department of Manpower and Immigration, for example, funded a program for winter employment: "The grant will allow us to hire up to twelve people for full-time positions

³⁰ *Ibid.*; *In a Nutshell: MPA Newsletter* was model to other peer-run newspapers, such as *Phoenix Rising* in Toronto established in 1977, and *Our Voice/Notre Voix* (editor Eugence LeBlanc) founded in 1987.

³¹ Dave Beamish, "Hospital Visiting," *In a Nutshell: MPA Newsletter* 2, 1 (1973): 5.

³² In Ontario the MPA example was followed by the Ontario Mental Patients Association, later named On Our Own (1977). Their newsletter was called *Phoenix Rising*. See also Onar Usar, *Psychiatric System Survivor/Consumer Advocacy: A Critical Literature Review* (Toronto: Black Creek Community Health Centre, 2014). A Moncton-based self-help centre, Group de support émotiionnel was founded in 1987 (director Eugence LeBlanc).

³³ *In a Nutshell: MPA Newsletter* 1, 10 and 11 (1971–72); *In a Nutshell: MPA Newsletter* 2, 5 (1973): 12.

³⁴ Beckman and Davies, "Democracy"; Boschma, Davies, and Morrow, "Those People Known as Mental Patients."

from 15 Dec 1971 to 31 May 1972.”³⁵ The newsletter called it “an enormous venture,” and the excitement over the ability to hire members into full-time work was tangible. The hiring of seven coordinators for a second MPA house and a new farm project, a secretary, a cook, a supervisor for the MPA arts and craft program, an activity program coordinator, and an employment coordinator was all part of establishing the MPA as an organization run communally by peers and supportive allies.³⁶ Peers brought both relevant past work experience and experience as former or ex-patients, thus stimulating self-determination. Employment not only boosted their self-esteem, they argued, but it also offered an avenue to equitable citizenship.

Dave Beamish, who joined the MPA in 1972, was one member-organizer. His experience demonstrates the meaning of membership, peer support, work, and creative activity aligned with the broader ideals of social citizenship the MPA had to offer. Beamish recalled: “The informal way you became a member of the place was to go through the front door twice and go to a general meeting and you were a member.”³⁷ Multiple bouts of manic-depression (his terminology in the interview) had made Beamish feel very low. His employment at the MPA not only raised his self-esteem but also strengthened his capacity, politically and culturally: “I gained a lot ... when I was working there. I got more confident in myself and learned what I could, things that I could do that I didn’t know I could do, you know. Like that. Helped me a lot.”³⁸ He also saw his job at the MPA as an integral part of advocacy work and action. One of the first activities he joined was the hospital visiting program mentioned above.³⁹

Inspired by peers, Beamish started to write poetry, and *In a Nutshell* became a medium not only to express himself through poetry but also to regularly publish reports on his managerial work and initiatives: “For me *In a Nutshell* was good because I found out that I could write, you know? Not just poetry but stories, or not stories but information, you know, like that. I could write ... So I got to be pretty good at writing

³⁵ *In a Nutshell: MPA Newsletter* 1, 9 (7 December 1971): 1–2.

³⁶ *Ibid.*; additional funding for an arts and crafts coordinator was obtained from the provincial Department of Rehabilitation and Social Improvement, which supported community initiatives to work with handicapped persons, as reported in the same newsletter issue.

³⁷ Interviews with David Beamish were conducted in June 2010 and May 2011 by Megan Davies and in August 2011 by Boschma and Davies. Quotes are from the interview with Beamish conducted by Davies, June 2010. For more detail on Beamish’s life story, see Boschma, Davies, and Morrow, “Those People Known as Mental Patients.”

³⁸ Interview with Beamish, June 2010.

³⁹ Beamish, “Hospital Visiting.”

and I was grateful for that.⁴⁰ One of the gifts that the MPA gave him, he recalled, was an opportunity to build a sense of self-esteem through working and discovering his talents.⁴¹ The MPA proved a new avenue to social citizenship that was creative and productive, modelled by members like Beamish. Their work became a defining cultural influence, interrupting and reversing the idea and practice of what patients or expatriates could do. Engagement in work, creative activity, and self-control were intertwined concepts in the MPA definition of support and social citizenship.

Beamish's role at the MPA was also remarkable for how he was able to transport the MPA ideal to Riverview Hospital, establishing a permanent MPA presence at the hospital. A closer look at this initiative, however, and Beamish's subsequent participation in the establishment of a hospital-sanctioned organization, the Riverview Hospital Volunteer Association (RHVA), illustrates how the ideal of communal peer help gradually morphed into a more bureaucratized and formalized structure during the political climate of the 1980s. Peer help and patient participation began to be incorporated into formal provincial health policy and, in a sense, became more controlled by it. As a result, peer-run control over initial MPA initiatives and programs diminished as the funding structures supporting it transformed during the late 1970s. Conversely, the cultural acceptance of patients on advisory councils and in patient support networks only seemed to strengthen.

THE MPA AT RIVERVIEW HOSPITAL: THE RHVA AND A CHANGING POLITICAL CLIMATE IN THE 1980S

As a former patient from Riverview Hospital, Beamish was able to strategically expand his connections there during his visits. The MPA took a critical stance regarding how patients should be "prepared" to live independently, and members advocated their idea of self-help at RH.⁴² Astutely, in 1976 Beamish proposed the formation of a permanent MPA presence on the RH grounds. He successfully obtained funding through one of the federal programs to support what he called the MPA

⁴⁰ Interview with Beamish, conducted by Davies, May 2011; Dave Beamish, *King of the World: Poems and Prose* (chapbook), (Vancouver: t.p. verso, 2003).

⁴¹ Interview with Beamish, June 2010.

⁴² In each issue of *In a Nutshell* the Resources Directory page carried the motto: "How to help yourself before they help you." Beamish was an outspoken advocate of self-help and patient-led initiatives.

Riverview Extension Program, of which he also became the manager.⁴³ Although reluctant at first, the RH administration soon accommodated itself to the MPA presence, in all likelihood not indifferent to the help and resources the MPA had to offer.⁴⁴ Modelled after the MPA, the Riverview Extension Program became a drop-in on the hospital grounds once the MPA group obtained space within the existing RH volunteer department.⁴⁵ Although this location might suggest the MPA had been incorporated into existing hospital structures, the group in fact sought to interrupt the voluntary structures of rehabilitation that had sprung up in the 1950s and 1960s. It wanted to move beyond existing, professionally led rehabilitation programs and initiate programs patients would lead themselves.⁴⁶

When the MPA started its hospital visitor program, Riverview Hospital already had a volunteer department. Established in the mid-1950s, it emerged when the provincial mental health services branch began reforms at RH following the Second World War. Whereas wards had always been locked, RH began to develop some “open wards,” where patients could freely walk in and out.⁴⁷ It also discontinued hospital clothing for patients and began to create opportunities for patients to make trips outside the hospital. The national volunteer and advocacy organization, the Canadian Mental Health Association (CMHA), became an important advocate for these reforms, seeking to reduce the stigma of hospitalization and to create better alternatives to institutionalization. A provincial division of the CMHA was established in British Columbia in 1952.⁴⁸ The CMHA recruited citizen volunteers for these activities, in close connection with a volunteer department that the RH adminis-

⁴³ Interviews with Beamish; Dave Beamish, “MPA Riverview Extension Program,” *In a Nutshell* 4, 4 (1976): 5.

⁴⁴ Conference report on the role of Riverview Hospital, 17–18 May 1976. Includes Speaker Jackie Hooper, MPA representative outlining the MPA goals and presence at RH. Internal document, RH, Riverview Hospital Historical Society.

⁴⁵ Interviews with Beamish, 2010 and 2011; interview with RH psychiatric nurse (anonymous), 2010.

⁴⁶ Draft proposal of terms of reference for a patient’s council at Riverview Hospital (July 1979). Internal document, RH, Riverview Hospital Historical Society.

⁴⁷ By 1955 RH counted “five unlocked wards ... serving 537 patients.” Cited in Richard G. Foulkes, “British Columbia Mental Health Services: Historical Perspective to 1961,” *Canadian Medical Association Journal* 85 (9 September 1961): 649–55. According to Foulkes: “In 1953, ... volunteer workers organized by the Canadian Mental Health Association (CMHA) appeared for the first time on the wards, and outpatient services were established for discharged patients” (654). He also noted that the advent of psychotropic medications in the early 1950s generated much hope that patients with long-term mental illness, such as schizophrenia, “could be assisted back to the community after a relatively short period of treatment” (*ibid.*).

⁴⁸ Jack Griffin, *In Search of Sanity: A Chronicle of the Canadian Mental Health Association, 1918–1988* (London, ON: Third Eye Publications, 1989). The CMHA had started decades earlier as the

tration had opened in support of this effort in 1955.⁴⁹ Volunteers started an apparel shop at RH, for example, where patients could “shop” for non-institutional clothes, while simultaneously familiarizing the public with mental hospital care and treatment.⁵⁰ Ten years later, in 1965, the CMHA worked jointly with RH administration to establish sheltered work and activity programs in areas where the hospital had begun to board out long-term hospitalized patients through a provincial boarding home program.⁵¹ To facilitate preparation for sheltered work, vocational training, and job placement, the provincial mental health services had started the Hillside Rehabilitation Unit at RH to help patients regain daily-living and home-making skills after a prolonged stay at RH as well as to offer them pre-vocational assessment and job placement.⁵² These efforts, however, were insufficient to accommodate the large number of discharged patients, particularly when short-term general hospital admission became more common.

Increased public criticism over the long-term institutionalization of people with mental illness and inadequate community resources gained momentum in the late 1960s, and a more radical, countercultural, and anti-psychiatric movement arose in various parts of the country. In Alberta, for example, a journalist, Tori Salter, had herself admitted to Alberta Hospital Edmonton in 1968, faking schizophrenia.⁵³ Her resulting critical report in the newspapers sparked public debate over outdated and overcrowded mental hospitals and was part of the rising social critique of institutional care.⁵⁴

Canadian National Committee for Mental Hygiene. See <https://cmha.ca/about>. In the 1950s it evolved as an influential advocacy organization.

⁴⁹ Annual Report, Provincial Mental Health Services, BC, 1955, M19, 26. It is unclear from these records whether citizen volunteers had family ties to some of the patients. This is an area that needs further research. Provincial divisions of the CMHA may have differed in the way they operated and set goals. In British Columbia, the Clinics of Psychological Medicine Act was proclaimed in 1951, which “made voluntary admissions and certified admissions without loss of civil rights possible for a maximum period of four months” (Foulkes, “British Columbia Mental Health Services,” 654). The act enhanced short-term admissions on a voluntary basis. See also Boschma, “Deinstitutionalization Reconsidered.”

⁵⁰ Annual Report, Provincial Mental Health Services, BC, 1955: M19, 26.

⁵¹ Annual Report, Provincial Mental Health Services, BC, 1967, G45-46.

⁵² Anne E. Coppard, “Rehabilitation Programme,” Staff Publication (1963), Riverview Hospital Historical Society; Karen Speirs and BC Mental Health and Addiction Services, *Riverview Hospital: A Legacy of Care and Compassion* (Vancouver: British Columbia Mental Health and Addiction Services, 2010), 59, http://www.llbc.leg.bc.ca/public/pubdocs/bcdocs2015_2/588823/riverview.pdf; newspaper clipping, 1971, posted on <http://hillside-building.blogspot.ca/2007/09/hillside-building-at-riverview-hospital.html>.

⁵³ LaJeunesse, *Political Asylums*, 156.

⁵⁴ Dyck and Deighton, *Managing Madness*, 199; Judith Fingard and John Rutherford, “The Politics of Mental Health Care in Nova Scotia: The Case of the Halifax County Hospital, 1940–1976,” *Acadiensis* 35, 1 (2005): 24–49; Shimrat, *Call Me Crazy*.

The MPA was equally critical of institutional power structures that still tended towards professional control, leaving patients with little say. MPA members rallied for more patient independence and agency as well as for long-term hospitalized patients, seeking to instill them with the notion that they could help themselves and have a life beyond the hospital. The MPA drop-in centre was envisioned as a resource where former patients could find company and engage in meaningful community activities. The MPA sought to bridge connections and to support a smoother transition to community living. It was able to draw public attention to the cause.⁵⁵ Although the MPA's actions initially caused upheaval at RH, soon the hospital administration saw the advantage of having an MPA presence. Spearheaded by Beamish, the MPA obtained an office in the RH Volunteer Department, where it was able to develop a program that mirrored many of the functions of the original MPA drop-in: support, independence, and meaningful activity. In their efforts to creatively reorganize and reorient mental health care towards more independence and patient control, Beamish and MPA ally Fran Phillips also took part in the establishment of a new patient-led council at RH – a council that was in line with the MPA goals of self-help and self-organization.⁵⁶

In the early 1980s, the MPA at RH further expanded its influence and participated in a newly established Riverview Hospital Volunteer Association (RHVA), a collaborative effort that grew out of increased collaboration between MPA members, RH nurses, and existing RH volunteers. Set up as an independent society in 1980, the RHVA's goals were similar to those of the original MPA; that is, to support RH patients upon discharge, to foster optimal functioning and community involvement, and to establish community housing options.⁵⁷ Beamish was the RH ex-patient on the founding board, as stipulated in the RHVA's constitution. Opening in New Westminster in 1982, Pioneer House was the association's first residential facility, providing housing for twenty-

⁵⁵ After the Asylum Exhibit, <https://aftertheasylum.appsof.yorku.ca/how-mpa-re-formed-community-mental-health/>.

⁵⁶ Draft proposal (1979), "Terms of Reference for a Patients' Council at Riverview Hospital," *Draft Proposal of the Task Committee on Proposed Patients' Council, RH*, document collection, Riverview Hospital Historical Society; interview with Beamish, August 2011; interview with Anna Tremere, conducted by Boschma and C. Haney, New Westminster, December 2011.

⁵⁷ The Constitution and Certificate of Incorporation under the Society's Act of the Riverview Hospital Volunteer Association, 6 October 1980. The association updated its constitution in 1993 and then changed its name to Pioneer Community Living Association (PCLA) (copy of the constitution obtained from Colleen Dewar, 2009); interview with Colleen Dewar, conducted by Boschma and Margaret Gorrie, 24 February 2009; interview with Carol Ann Russell conducted by Nerrisa Bonifacio, 14 July 2009; interviews with Beamish; see also Boschma, "Community Mental Health Post-1950."

two people discharged from RH. It later expanded to thirty beds.⁵⁸ To secure a permit under the Community Care Facilities Licensing Act, Beamish again relied on MPA ally Fran Phillips, who had nursing qualifications and agreed to manage the house. As Beamish recalled: “we needed someone with a [professional] certificate.” Phillips then hired Beamish as a worker and they co-led the home during the initial years. Two former RH psychiatric nurses, Colleen Dewar and Carol Ann Russell, were employed to help set up the home.⁵⁹

They encouraged residents to make their own decisions, organize their own regular meetings to manage the home, take initiative, participate in daily household activities, or engage in work (whether in creative arts, cherry picking, or in education), with staff standing on the sideline. In other words, they pretty much followed MPA ideals of self-help and peer support.⁶⁰ Still, the broader understanding of social citizenship and patient self-determination Phillips and Beamish aimed for was soon challenged as provincial mental health services increased control over the management of residential facilities in the mid-1980s, and the ideal of patient self-control melted into the background. In the initial years of Pioneer House, Phillips and Beamish had been able to decide who came to live in the home, but this changed when the province forged stronger connections between hospitals and community mental health centres’ staff to coordinate patients’ placements in residential facilities upon discharge. Mental health centre staff obtained a more prominent role in the regulation of these facilities by means of contracted service. In New Westminster, a placement coordinator appointed at the New Westminster Mental Health Centre (MHC) began to coordinate placement of the residents at Pioneer House and redirected some of the beds to be used in a short-term admission program for youth. By the time the managerial change came about, Beamish had left RHVA following a manic episode. He later continued his advocacy work as the consumer representative on the board of the Canadian Mental Health Association.⁶¹ But Phillips resented the change and was ill-prepared to accept MHC input and contracted service, which, to her, undermined the idea of consumer control.⁶² Dewar and Russell, on the other hand,

⁵⁸ Boschma, “Community Mental Health Post-1950.”

⁵⁹ Interviews with Dewar and Russell, 2009, see note 57.

⁶⁰ Interview with Beamish August 2011; interview with Dewar, 2009.

⁶¹ Interview with Beamish August 2011.

⁶² Interview with Dewar 2009.

accepted the arrangement and took over the management. Phillips resigned.⁶³

The Pioneer House conundrum seemed to reflect wider changes in the governing of self-help organizations nationally and provincially during the 1980s. Over time, the ideal of patient control and independence did not materialize in provincial policy as the early MPA had envisioned. By the end of the 1970s, the political climate had shifted. The federal government decreased its share of public health insurance expenditures, which put more pressure on the provincial health services budget.⁶⁴ Federal employment grants, which had benefitted organizations like the MPA, were reduced or discontinued by the late 1970s.⁶⁵ Meanwhile, demand for community mental health services increased.⁶⁶ In British Columbia, these changes not only triggered policy debate over further downsizing of RH but also influenced community mental health services. Although peer and consumer influence on rehabilitative and residential community care did not disappear, the policy framework that began to guide support for self- and peer-help initiatives did.⁶⁷ These changes affected the way self- and peer-help was understood. For proponents and participants of peer self-organization in mental health, government support for peer help signalled an ideological shift in that the incorporation of peer help into formal policy to some degree diminished the initial critical edge of patient control.⁶⁸ As the RVHA Pioneer House case suggests, informal peer help arrangements became increasingly bureaucratized during the 1980s. On the one hand, the MPA presence boosted patient empowerment at Riverview; on the other hand, the way the RHVA evolved shows how the communal idea of peer help based on

⁶³ See Boschma, "Community Mental Health Post-1950."

⁶⁴ Aleck Ostry "The Foundations of National Public Hospital Insurance," *Canadian Bulletin of Medical History* 26, 2 (2009): 261–82.

⁶⁵ Ian Hector, "Changing Funding Patterns and the Effect on Mental Health Care in Canada," in *Psychiatry in Canada: 50 Years, 1951–2001*, ed. Quentin Rae-Grant, 59–76 (Ottawa: Canadian Psychiatric Association, 2001); Jennifer Keck, "Making Work: Federal Job Creation Policy in the 1970s" (PhD diss., University of Toronto, 1995).

⁶⁶ Annual Report of the Mental Health Services Branch, BC, 1974; F.G. Tucker, "Mental Health Services in British Columbia," *Canada's Mental Health* 19, 6 (1971): 7–12; Boschma, "Deinstitutionalization Reconsidered."

⁶⁷ Interview with Farrel Hannah conducted by Margaret Gorrie, June 2009; BC Ministry of Health, *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital* (Victoria, BC: Ministry of Health, Province of British Columbia, 1987); Charlene Ronquillo, "Deinstitutionalization of Mental Health Care in British Columbia: A Critical Examination of the Role of Riverview Hospital from 1950 to 2000," in *Proceedings of the 18th Annual History of Medicine Days 2009, Faculty of Medicine, University of Calgary*, ed. L. Petermann, K. Sheng-Sun, F. W. Stahnisch, 11–26 (Newcastle upon Tyne: Cambridge Scholars Publishing, 2012).

⁶⁸ Shimrat, *Call Me Crazy*.

friendship and understanding gradually transformed during the 1980s, when neoliberal ideas (and budget cuts) seeped in and undermined or complicated early communal ideals of social citizenship and patient rights. This neoliberal shift transformed the context of self-help, peer support, and consumer initiatives not only within mental health but also within the wider health care system, deeply affecting peer help and mental health policy.

PEERS ENACTING POLICY: NEW IDEOLOGIES OF SELF-HELP AND PEER SUPPORT IN THE 1980S

During the 1980s, national and provincial governments began to adopt policy frameworks encouraging, but also regulating, self- and peer help.⁶⁹ Emphasis was placed on self-responsibility and sustainability of service. Both the 1974 Lalonde Report and the 1984 Canada Health Act stressed preventive health care, using population health perspectives, but they also promoted the idea that individual citizens should carry more responsibility for their own well-being.⁷⁰ Ironically, promotion of citizen independence over their own health (rather than patronizing medical control), rooted in a perception of the universality of human needs, went hand-in-hand with a process of individualization of (self-)responsibility, a tendency that seemed to overlook the fact that neither the potential nor the resources for autonomy were equally distributed over the population. Self- and peer help fit an emerging neoliberal agenda whose purpose was to decrease governmental responsibility and to increase individual self-responsibility in health care. A new bureaucracy was put in place in which peer help held an integral place. Although peer help was acknowledged as a citizenship right and as source of support, it indirectly served the goals of cost containment and promotion of individual responsibility.

This new policy direction was not limited to mental health organizations. Government funding became available to strategically enhance self- and peer help among a range of volunteer citizen groups, organizations, and initiatives. Peer support was also encouraged on university

⁶⁹ Sandra Chatterton, Janet Harris, Shwan Hill, and Lynda Kingsland, *Helping Ourselves: Organizing a Peer Support Centre* (Ottawa: Ministry of Health and Welfare Canada, Community Health Services Division, Health Services and Promotion Branch, 1988); Self-Help Resource Association of British Columbia, *A Basic Guide for Self-Help: Start-Up and Maintenance Information from the SHRA*, 3rd ed. (Vancouver: The Association, ca. 1996).

⁷⁰ For mental health policy, see Lalonde, *A New Perspective on the Health of Canadians*, 61–62. World Health Organization, *The Ottawa Charter for Health Promotion* (Geneva: World Health Organization, 1986).

campuses, for example, in the form of peer support centres.⁷¹ In 1988, a group of Ontario social workers and peer councillors under the authority of the federal Ministry of Health and Welfare published a guide on how to organize peer support for university women.⁷² The guide clearly summed up the dual goals voluntary peer support was supposed to address. On the one hand, it argued that peer support would help to address stress among students and deal with problems of structural inequity. Women, a growing presence on Canadian campuses since the 1960s, were a specific target group, the guide noted, with a focus on “specific incidents like rape, a high drop-out rate or any unwanted pregnancies.” On the other hand, and somewhat contradictorily, the most important rationale for setting up a peer support centre was presented as “the need [for students] to accept responsibility for their health and social needs and those of their peer group.” The guide laid out a voluntary governance model for peer support based on democratic principles very similar to those found in the model of participatory democracy and peer-run initiatives designed within the MPA. The Ontario guide further pointed out that peer help would be a voluntary complement to professional help and would require careful training and preparation.⁷³ Similar ideals guided the emergence of peer and self-help liberation networks for women that sprang up across Canada.

The Women’s Self Help Network, established in northern Vancouver Island, is an example of such a network. It was established by and for women as a demonstration project funded by Health and Welfare Canada.⁷⁴ Its goal was to encourage women to help themselves within an informal network of support and resources, and it was designed to “address the isolation and low self-esteem of women in the [Northern Vancouver Island] area.”⁷⁵ According to its report, the network’s collective operational structures “were quite different from those of a traditional bureaucratic organization. In a collective, authority does not reside in one individual or individuals but in the whole group.”⁷⁶ Advocacy organizations in mental health, such as the CMHA, also

⁷¹ Patricia Jasen, “Student Activism, Mental Health, and the English-Canadian University in the 1960s,” *Canadian Historical Review* 92, 3 (2011): 455–80.

⁷² Chatterton, Harris, Hill and Kingsland, *Helping Ourselves*. The quotes are from *Helping Ourselves*, .2–3.

⁷³ *Ibid.*, 2–3.

⁷⁴ Janet Currie, *Skills, Sharing and Support: An Evaluation of the Women’s Self-Help Network, Northern Vancouver Island* [Booklet] (n.p., October 1983), copy at UBC Library.

⁷⁵ Janet Currie, *Two Years Later: The Women’s Self-help Networks, Northern Vancouver Island, 1985* (n.p., March 1986), 1, copy at UBC Library. The report does not specify particular groups of women but, rather, emphasizes the need for the empowerment of women generally.

⁷⁶ Currie, *Skills, Sharing and Support*, 23.

expanded peer participation by involving former patients in policy work. Former patients started to call themselves “consumers” or “survivors” to distinguish themselves from traditional patient roles.⁷⁷ In the mid-1980s, the CMHA initiated policy work centring on consumer participation, community reinvestment, and legislative reform to enhance access to health services.⁷⁸ It also started a national project to develop a framework for peer support and consumer rights, which aimed to overturn the inequity and stigmatization of patients seen as incapable of managing their own lives.

The BC government also began to support self-help as a policy directive.⁷⁹ In 1987, after having organized a symposium on self-help a year prior, a group of volunteer organizations in British Columbia concerned with social support and justice obtained a grant from the federal Ministry of Health and Welfare to set up the Self-Help Collaboration Project. In 1990, this morphed into the Self-Help Resource Group.⁸⁰ The group focused on the needs “of the self-help constituency” and developed a resource guide on how to organize a self-help group. By 1993 it became a registered non-profit society, the Self-Help Resource Association (SHRA). With a start-up grant from the BC Office of Health Promotion, a joint initiative of the BC Ministries of Health and the Ministry responsible for Seniors, the SHRA set up a permanent office.⁸¹ “Addiction, health problems and life crises or changes” could be addressed by enhancing and strengthening people’s individual coping skills, a goal argued to be in line with federal and provincial policies for health. “Self-help and mutual aid,” the SHRA stated, “is about people helping people, and in so doing, helping themselves.”⁸² The emphasis, however, was increasingly on psychological and communications skills needed to find resources and to navigate the system rather than on creative arts or employment – giving help itself became an increasingly marketable skill. “More and more health professionals and physicians viewed self-help as a necessary part of the overall health care team,” the SHRA further noted, framing voluntary work as a “vital adjunct” to the health care system. Governmental support for self- and peer help

⁷⁷ In the May 2011 interview, Beamish noted how he and other peers involved with CMHA advocacy work called themselves “consumers” to get away from the patronizing term “patient.”

⁷⁸ Jayne M. Whyte, *Pivot Points: A Fragmented History of Mental Health in Saskatchewan* (Regina: Canadian Mental Health Association, 2012), 87–89.

⁷⁹ Self-Help Resource Association of British Columbia, *A Basic Guide for Self-Help*.

⁸⁰ *Ibid.*, quotes from A2–4.

⁸¹ *Ibid.*

⁸² *Ibid.*, A2. The policies referred to are *Achieving a Healthier Tomorrow*, Health and Welfare Canada, and *New Directions for a Health British Columbia*, BC Ministry of Health, 1993.

stretched to all areas of health, including mental health, and it produced a large network of peer support organizations and self-help resource centres across Canada.⁸³ Financial aid for self-help initiatives from health industries – for example, from pharmaceutical companies – further transformed both the ideological framing and practical embedding of peer support, exposing its vulnerability to being co-opted into a market-driven scheme and economically provided labour.⁸⁴ As peer help became formalized into policy, its structure grew more bureaucratic and its role more professional, with stronger emphasis on peer counselling. This was a noted shift from how peer support had evolved within the MPA, where a communal structure involving a home (drop-in) or group of friends was intertwined with shared activities and work (e.g., arts, music, and community living). As the role of peer support bureaucratized into more organized forms of self-help, its nature also changed, moving towards the profession-building roles of peer counselling, in which help was more aligned with talk or psychosocial groupwork than with material or artisan-type work. The obtaining of the type of skill that had structured older notions of rehabilitation seemed to have less priority and status within the policy discourse.

Within a cost-cutting climate, however, self-help became entangled with governmental strategies to promote individual responsibility in order to reduce costs. Arguably, effective self-help would reduce the cost of publicly funded social services, hence government support for self-help was of a dual nature. The early 1970s ideal of a communally driven collective managed by peers gradually disappeared and more individualized exemplars of peer help arose. Drawing on models of peer counselling, for example, training in peer support competencies came to be seen as a necessary component of effective peer help. It typically became a preparatory requirement in case peer supporters took on semi- or para-professional roles.⁸⁵ Still, peers appreciated the new “market” of

⁸³ Self-Help Resource Association of British Columbia, *Basic Guide*, E19.

⁸⁴ *Ibid.*, A.4. Reference to pharmaceutical companies appears in Section B, *Power Tools*, 8. The Canadian Council on Social Development, which sponsored the publication of *Power Tools*, an eight-page instructional booklet for self-help organization included in the SHRA Guide, stated that it “gratefully acknowledges the financial contribution of the Pharmaceutical Manufacturers Association of Canada ... toward the publication of ‘Power Tools.’” For an analysis of health advocacy and pharmaceutical funding, see: Sharon Batt, *Health Advocacy Inc.: How Pharmaceutical Funding Changed the Breast Cancer Movement* (Vancouver: UBC Press, 2017).

⁸⁵ For an example, see Barbara Davis, Helen Handcock, and Marcia Hills, *Peer Support: Designing Interpersonal Skills Training Plan* (n.p., n.d). The authors represented the Alberta Alcohol and Drug Abuse Commission (AADAC) in Red Deer, the Red Deer Public School District, and the University of Victoria, BC, respectively. The document presents a detailed

peer counselling as offering new opportunities for meaningful work, if not upward mobility, and felt entitled to it. They began to advocate for a more explicit uptake of peers support in health service.⁸⁶ Reflective of wider trends, peer support became a new (job) market within the health care industry, as the history of peer support in the 1990s and early 2000s illustrates. Careful negotiation of the tension between empowerment and co-optation became an important imperative in the development of peer support at the turn of the twenty-first century, and British Columbia was no exception.

RECOVERY AND PEER SUPPORT CENTRAL TO BC MENTAL HEALTH REFORM IN THE 1990S AND 2000S

One of the first governmental initiatives in British Columbia to include consumers as paid peer support workers in community mental health services originated within a planning committee of the Fraser Valley/North Shore Region Mental Health Service in 1991 and 1992.⁸⁷ The Regional Service administration was planning for a new after-hours emergency mental health service in the Fraser Valley and had involved a range of stakeholders in the planning committee, including mental health consumers. The consumers on the planning committee envisioned and advocated for a peer support role. Open to this suggestion, the planning group incorporated provisions to allocate part of the funding the provincial minister of health had made available for new services to support the development of a training program for consumer peer support workers, who would, upon completion of their training, take up positions in the region's services. A contract to develop the peer support training program was given to the Deltassit Community Services Society, which already had extensive experience with training lay counsellors, and the project was launched in 1995. Angela Neuhausler became the coordinator of the society's Peer Support Training Pilot Project, and,

communication skills training guide for peer support (copy from Vancouver Public Library, stamped as a governmental document on 24 May 1988).

⁸⁶ J. Lord, A. Shnarr and P. Hutchison, "The Voice of the People: Qualitative Research and the Needs of Consumers," *Canadian Journal of Community Mental Health* 6, 2 (1987): 25-36; Shimrat, *Call Me Crazy*.

⁸⁷ Angela Neuhausler and Judith Lange, eds., *Peer Support Worker Training Manual for Consumers of Mental Health Services* (New Westminster, n.p., 1995), 5-6, available at Library, Vancouver Coastal Health Authority. Neuhausler's credentials are not listed in the manual. From the introduction it appears she may have had a consumer role with Deltassit and a background in psychology. She is named as the coordinator of the training project. Lange's credentials are given as registered nurse and regional program manager of the Fraser Valley/North Shore Region.

in addition to her coordinating role, she also wrote the curriculum and training manual together with co-editor Judith Lange.⁸⁸ One of the pilot project's first acts was to take in twenty-three consumers in training and place them creatively, "either paid or volunteer, in a variety of settings."⁸⁹ In the Okanagan, a similar project started in 1992 to engage consumers in peer help. The BC Interior Health Authority funded the Consumer Development Project (CDP) administered by the CMHA branch in Kelowna. It aimed to "encourage and support consumer involvement in mental health planning and decision-making throughout the Thompson, Okanagan and Kootenay areas."⁹⁰ The Okanagan initiative also included training programs for consumers.

Enhancement of peer involvement in mental health services became part of the BC government's larger mental health reform initiative during the 1990s. In 1994, results of a public inquiry into conditions at Riverview Hospital were published in a report entitled *Listening*.⁹¹ Concerns over the slow move towards sufficient community services had stirred public debate and drawn media attention to inadequate community support for patients leaving RH. Significantly, among other community stakeholders and families, peers participated in the inquiry process in their role as *former patients*. In response, that same year the RH administration established a charter of patients' rights accompanied by a review of legal guidelines first published in 1997.⁹²

In addition, the government adopted a policy framework for community agencies focused on psychosocial rehabilitation (PSR), sometimes also referred to as psychiatric rehabilitation, to which a new focus on *recovery* was added. Suggesting a critical stance, the ombudsman leading the inquiry described PSR as "a multidisciplinary approach which acknowledges that treatment extends beyond chemical therapy and places emphasis on developing patients' social and vocational skills."⁹³ However, rather than merely emphasizing productivity and protected

⁸⁸ Neuhausler and Lange, *Peer Support Worker Training Manual*.

⁸⁹ *Ibid.*, 5. In 1991–92 the project started with "Demographic Enhancement monies allocated by the Ministry of Health to mental health services." Neuhausler and Lange, *Peer Support Worker Training Manual*, 5.

⁹⁰ Charly Sinclair, *Peer Support Training Manual: Guidelines for Peer Support Training in the Okanagan Health Services Areas* (Vancouver: CMHA BC Division, consumer Development Project, 2005), 1.

⁹¹ BC Office of the Ombudsman, *Listening: A Review of Riverview Hospital* (Victoria: Office of the Ombudsman, 1994), i–ii. See also Ronquillo, "Deinstitutionalization of Mental Health Care in British Columbia."

⁹² Guide to the BC Mental Health Act (first published in 1997, revised in 1999 and 2005), <http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf>.

⁹³ BC Office of the Ombudsman, *Listening*, 6–5 to 6–6.

employment opportunities, drawing on more traditional frameworks of rehabilitation the added focus on recovery created space for consumer and peer support initiatives that went beyond mere skill development, involving, for example, participation in decision-making regarding services and engagement as (peer) service providers. To strengthen the latter view, a policy focused on consumer initiatives was also adopted.⁹⁴ Both policies reflected increased acknowledgment of the role of peers in mental health services.

Including recovery in a guiding framework for community mental health policy was not unique to British Columbia but, rather, reflected an international trend in the 1990s. Scholars in psychiatric rehabilitation as well as consumers with academic degrees were a formative influence on this vision, which was strongly rooted in the patient rights movement.⁹⁵ William Anthony, often cited as one of the architects of the recovery framework, notes: “Recovery from mental illness is a deeply personal, unique process, of changing one’s attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness.”⁹⁶ It seemed a strategy to bridge original, communal ideals of peer involvement and participatory citizenship with a newer, individualized understanding of peer support as part of a personal recovery process. Although the recovery framework created new opportunities for peer initiatives, it did not entirely answer the deeper philosophical question of how to resolve the inherent tension between individual autonomy perceived as a universal need or right and the entitlement to patient rights within a context of unequal distribution of resources (reflected in the quest for paid employment and career opportunities in peer support work and in the inherent dependency and vulnerability brought about by the disabling nature of mental illness).⁹⁷ It could be argued that a striving towards recovery and optimal mental

⁹⁴ BC Ministry of Health and Ministry Responsible for Seniors, *BC’s Mental Health Reform Best Practices: Psychosocial Rehabilitation and Recovery* (Victoria: BC Ministry of Health and Ministry Responsible for Seniors, ca. 1998); BC Ministry of Health and Ministry Responsible for Seniors, *BC’s Mental Health Reform Best Practices: Consumer Involvement and Initiatives* (Victoria: BC Ministry of Health and Ministry Responsible for Seniors, ca. 1998).

⁹⁵ Shimrat, *Call Me Crazy*; Everett, *Fragile Revolution*; Deegan, “Recovery”; Daniel B. Fisher, “A New Vision of Healing as Constructed by People with Psychiatric Disabilities Working as Mental Health Providers,” *Psychosocial Rehabilitation Journal* 17, 3 (1994): 67–81; Nora Jacobson, *In Recovery: The Making of Mental Health Policy* (Nashville, TN: Vanderbilt University Press, 2004).

⁹⁶ Anthony, “Recovery from Mental Illness,” 15. For Anthony’s earlier research and terminology on psychiatric rehabilitation, see William Anthony, *The Principles of Psychiatric Rehabilitation* (Baltimore, MD: University Park Press, 1978).

⁹⁷ Nellie El Enany, Graeme Currie, and Andy Lockett, “A Paradox in Healthcare Service Development/Professionalization of Service Users.” *Social Science and Medicine* 80 (2013): 24–30;

well-being as defined by the individual concealed larger political economic influences such as those presented by the persistent challenges of poverty or inequitable material conditions.⁹⁸ How social citizenship was understood within the claim of recovery reflected a similar tension. Whereas some foregrounded improvement of service and recovery for and as patients, others saw the new (paid) roles of consumers as a way to avoid the stigmatizing label of being patients and to participate in decision-making, and still others wondered whether its individual orientation would not open the door to further neoliberal steps towards cutting costs by encouraging peer help.⁹⁹ Consumers on British Columbia's mental health services' advisory boards typically saw themselves as advocates of the former two positions, advocating for a better way to incorporate peer support into service provision so as to help each other while enacting a rightful role as social citizens.

Peer supporter Charly Sinclair, for example, who engaged with peer support work in the late 1990s within the Kelowna division of the Canadian Mental Health Association, grasped the tension succinctly. She pointed out how recovery “[was] grounded in the idea that people can recover from mental illness when they play an active and empowered role in their journey.” She also noted that active engagement and participation in the community was believed to strengthen communities and to enhance citizens' understanding of the complex issues faced by people with mental illness.¹⁰⁰ Peer support was an integral part of such a journey.¹⁰¹ However, Sinclair also explained how its representation as a *personal* journey, empowering consumers to live well with mental illness, also strengthened (by social means) an individualistic focus on personal success and self-sustainability.¹⁰² Sinclair's interest in peer support had started in 1997 when she was a member of the advisory committee for Kelowna's peer support program Pep Talk. In 2001, she became involved with the Consumer Development Program in Kelowna.

Kevin Borkes's appointment as a so-called SIL (semi-independent living) support worker with the CMHA's supported housing program in New Westminster provides another example of how engagement in

Candace Johnson-Redden, *Health Care Entitlement and Citizenship* (Toronto: University of Toronto Press, 2002), 30–48; Rioux, “Right to Health.”

⁹⁸ Enany, Currie, and Lockett, “Paradox in Healthcare Service Development.”

⁹⁹ Morrow, “Recovery”; Brown and Manning, “Genealogies of Recovery”; Dyck and Deighton, *Managing Madness*, 200–28; Jacobson, *In Recovery*.

¹⁰⁰ Sinclair, *Peer Support Training Manual, Okanagan*, 1.

¹⁰¹ For example, in the New Westminster oral history project interviewees spoke about volunteering in the CMHA thrift store as a way to engage in the community.

¹⁰² Sinclair, *Peer Support Training Manual, Okanagan*, 1.

advisory work as a consumer turned into paid employment as a service provider. Having lived with schizophrenia since 1992, Borkes started to regularly attend a community mental health drop-in in 2000, where he “became more involved in consumer activities and the consumer movement.”¹⁰³ There he met with other consumers doing paid peer support work: “It kind of showed me how differently people can recover and basically you are learning some skills when you are sitting in these committees and working with people.” Here we can see how the self-learning Beamish had acquired to take up his peer support role within the MPA had gradually given way to the more professionally structured way in which Borkes was achieving that role. While creativity was at the heart of both, in the latter this creativity had become tied to a more formally controlled set of competencies and expectations. In the early 2000s, Borkes was able to take a certificate course in psychosocial rehabilitation at the local college and subsequently obtained a paid position in peer support work at one of the local mental health agencies. While Borkes’s work would continue to focus on helping other consumers, he could now do so in a professional capacity as an employed peer support worker with the necessary credentials. He successfully renegotiated and transformed his identity as consumer into that of a paid and professionalized peer supporter.¹⁰⁴

Peer support roles and programs were increasingly structured as a formal component of mental health service. In 2001, the BC Ministry of Health Services provided one-time funding under the consumer initiative program, and under the direction of the provincial Adult Mental Health Policy Division, to develop provincial guidelines for peer support. These were designed to ensure some consistency in peer support across the province and to give direction to mental health agencies interested in developing peer support programs. Sinclair was among nine committee members representing various fledgling peer support initiatives in the province who developed the resulting *BC Peer Support Resource Manual*

¹⁰³ Interview with Kevin Borkes conducted by Geertje Boschma and Margaret Gorrie, 15 April 2009; Kevin Borkes, “My Recovery: A Long and Winding Road,” *Peace of Mind – Bi-Annual Newsletter of the Canadian Mental Health Association* (Simon Fraser Branch), 7 (2008): 11; Geertje Boschma, Catherine Haney, and Margaret Gorrie, “Gender, Work, and Identity: Consumer Perspectives on Rehabilitation and Recovery in Mental Health Care,” *Bulletin of the UK Association for the History of Nursing* 1, 1 (2012): 8–19, <http://ukahn.org/wp/the-ukahn-bulletin/>.

¹⁰⁴ Since 2007 opportunities to obtain credentials in psychosocial rehabilitation have evolved, and today the Mental Health Commission of Canada oversees a network of training opportunities within a full-fledged educational structure. See <https://psrrpscanada.com/memorandum-of-understanding-between-psr-canada-mhcc>.

in 2001.¹⁰⁵ She represented the Consumer Development Program in Kelowna.¹⁰⁶ A focus on profession-building was noticeable in the new manual, although consumer participation as consultants and advisory board members in policy development for peer support also extended the voice and control consumers had gained as rightful participants in service. Once this project was completed, Sinclair co-facilitated the development of a regional peer support training manual for the Okanagan region, eventually published in 2005. It provided a compilation of training materials, directions, and suggestions drawn from over a decade of consumer “on-the-job training in mentoring and community development for staff with first-hand experience with mental illness” at various projects in the region.¹⁰⁷ Emerging peer support programs were diverse, ranging from informal consumer volunteer work, which may or may not involve crafts or artistic expression (such as helping out in a thrift store or a volunteer caregiving job), to various levels of employment in mental health work, typically in roles created in negotiation between agency staff and peer support workers. These roles could include direct service provision, group work, or case management, facilitating client and family support sessions, each with varying mentor or training requirements and methods of payment or volunteer arrangements.¹⁰⁸

The 2001 *BC Peer Support Resource Manual* outlined four classes of peer support to be considered on a continuum of involvement and compensation. Informal positions were identified as voluntary, whereas Class 3 and Class 4 concerned formally structured positions that would involve financial compensation, either for program costs involved (such as training) or, in case of Class 4, a personal remuneration for the peer support worker consisting of an hourly rate based on a maximum number of hours per week. Work could include partaking in the delivery of educational sessions on mental illness, support, and coping to community groups, or one-on-one peer support or group work to help people cope with the isolating effects of mental illness. In the latter case, the peer

¹⁰⁵ British Columbia Ministry of Health, Adult Mental Health Policy Division, *BC Peer Support Resource Manual* (Victoria: Ministry of Health, 2001). The manual was oriented towards BC programs but also took examples from national and international programs. Paul Sherman and Russell Porter, “Mental Health Consumers as Case Management Aides,” *Hospital and Community Psychiatry* 45, 5 (1991): 494–98.

¹⁰⁶ Sinclair, *Peer Support Training Manual, Okanagan*, 1.

¹⁰⁷ *Ibid.*

¹⁰⁸ British Columbia Ministry of Health, Adult Mental Health Policy Division, *BC Peer Support Resource Manual*, 9; Boschma, Haney, and Gorrie, “Gender, Work, and Identity.”

support workers were to be considered adjunct members of a clinical team of service providers.¹⁰⁹

Enabling consumers to speak on their own behalf, to create the parameters of their new professional sphere, all while instilling respectful practice, exchanging information, and providing training and projects designed to help consumers build skills, were all essential goals of peer support within a new para-professional sphere. A flexible amount of either volunteer or paid work often meant a lifeline to participation in social life. It also functioned as a protection from isolation or ongoing challenges of self-esteem, but I brought with it the demands of productive citizenship. These included meeting certain hours, difficulty keeping medical appointments while employed, or the inability to achieve employment after completion of training, the latter of which seemed even more challenging in non-service jobs.¹¹⁰

Interest in consumer involvement in policy and community mental health services became the target of federal governmental policy as well. The Canadian Alliance on Mental Illness and Mental Health (CAMIMH), formed in the late 1990s out of a collaboration of various provincial interest groups advocating for improvement of community services across provinces, urged the federal government to develop a national mental health policy, including improvement of consumer participation.¹¹¹ In response, a Senate review of mental health service took place, led by Michael Kirby, the results of which were published in 2006.¹¹² Many gaps in service were identified. The federal government responded by establishing the Mental Health Commission of Canada (MHCC), which was set up as a non-profit society in 2007, separate from the state. Mandated to develop a national mental health policy and to assert leadership in improving mental health service, the MHCC consolidated the trend towards a recovery-oriented service system focused on (individual) well-being for people living with mental illness. Peer

¹⁰⁹ British Columbia Ministry of Health, Adult Mental Health Policy Division, *Peer Support Resource Manual*, 12–14, 100–8. Hourly rates typically were at minimum wage and the number of hours were kept at a maximum per week so as not to infringe upon employment or disability benefits. See *ibid.*, 49–52.

¹¹⁰ Boschma, Haney, and Gorrie, “Gender, Work, and Identity: Consumer Perspectives.”

¹¹¹ The CAMIMH was a conjoint initiative of the CMHA, the Mood Disorder Association of Canada, the National Network for Mental Health, the Schizophrenia Society of Canada, and the Canadian Psychiatric Association. See Quentin Rae-Grant, *Psychiatry in Canada: 50 Years* (Ottawa: Canadian Psychiatric Association, 2001), 37–48; See also Health Canada, *A Report on Mental Illnesses in Canada* (Ottawa: Health Canada, 2002).

¹¹² Michael Kirby, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Final Report of the Standing Senate Committee on Social Affairs, Science and Technology* (Ottawa: Parliament of Canada, 2006).

support was envisioned as an essential element in recovery-oriented service.¹¹³

The MHCC confirmed the essential role of peer support in mental health care, but it also contributed to further bureaucratization and the levelling of training requirements around peer support certification. In 2010, the MHCC commissioned a workforce advisory committee on peer support in formal mental health services to provide guidance on how to strengthen peer support programs across Canada. This was not unlike the work completed by the consumer committee in British Columbia a decade earlier. The resulting analysis drove further development of peer support in Canada and included a similar levelling of peer support roles that characterized the BC policy.¹¹⁴ Although the analysis identified certain tensions about the prioritization of interests and benefits from the evolving role of peer support, it also recommended the development of peer support as an integral part of mental health service. A formal peer support certification process was also developed.¹¹⁵ National developments mirrored those in British Columbia but took the bureaucratization a step further. The higher levels of peer support work were mostly aligned with counselling roles, attached to which was a newly designed national competency framework within a formal peer support accreditation and certification program. The MHCC Workforce Advisory Committee created Peer Support (Accreditation and Certification) Canada (PSAC), an organization set up to enhance peer support and designed with the view that it could become a self-sustaining endeavour. In 2012, the organization produced *Guidelines for the Practice and Training of Peer Support* in collaboration with peer support organizations and knowledge users across the country. These guidelines were grounded in what became known as the National Peer Support Standards of Practice.¹¹⁶ Peer Support Canada began to endorse the standards of practice by verifying an individual's knowledge, competencies, experience, and code of conduct, and by offering peer supporter, family peer supporter, and peer support mentor certification. Although the certification process was designed to ensure a certain quality of peer

¹¹³ Cyr et al., *Making the Case for Peer Support*. For similar trends in the United States, see Jacobson, *In Recovery*.

¹¹⁴ Cyr et al., *Making the Case for Peer Support*.

¹¹⁵ Peer Support Accreditation and Certification (PSAC) (Canada), *National Certification Handbook* (2016), and *Information for Peer Support Certification Practicum Sites* (2017), <http://peersupportcanada.ca/>.

¹¹⁶ PSAC (Canada), *National Certification Handbook*. In 2018 Peer Support Canada was brought under the wings of the CMHA to further advance peer support across the country. See <https://cmha.ca/news/peer-support-canada-joins-cmha>.

support, the professionalization of peer support also suggested further progress towards individualization and an internal stratification within peer support. For instance, the certification process entailed a relatively expensive training course, an expense that might be hard to achieve for consumers with minimal wages or government benefits.

Autonomy, more so than creativity, seemed to characterize the emphasis on skill building, career development, and self-sufficiency, reiterating an ideal of individual responsibility; for example, in the ability to advance in a (consumer) career, whether as a professional or a voluntary peer supporter. Whether intentionally or not, the program entrenched an individualistic focus on peer support in ways that older models of communal and creative peer support had not. It could be argued that the disappearance of large, long-stay institutions influenced this change as it resulted in more experience with individual and independent living, whereas the earlier generation of ex-patients in the 1970s had identified more readily with the idea of communal living circumstances, whether as an outgrowth of mental institutions or inspired by the 1960s and 1970s counterculture. Within the upsurge of neoliberalist politics affecting the organization and funding of mental health care, however, the recovery orientation generated a new individualistic focus, which generated its own vulnerabilities even though it also created new opportunities for social engagement in peer support.¹¹⁷ Despite these continued tensions, peer support had found its cultural niche within Canadian mental health services. Negotiation of its many cultural forms, however, requires not only continued creative imagination regarding new roles but also critical (and public) commitment to care, whether as a source of communal support, an acknowledged (paid) social role of healing work, or a personal entitlement to social participation.

CONCLUSION

From the 1970s onwards, patients asserted themselves more actively and, as activists, in a new, creatively imagined and enacted discourse of community care. Taking on roles in volunteer and paid peer support work as ex-patients, community-members, consumers, advocates, and

¹¹⁷ An example of role expansion is the uptake of peer support within communication technologies such as tele-health support lines and the internet. Online peer support has developed with opportunities for anonymous, real-time chat, often led by a trained moderator. It provides access to mental health support in areas across Canada with fewer resources for mental health services. See C. Susana Cajax, "A Review of Mental Health Approaches for Rural Communities: Complexities and Opportunities in the Canadian Context," *Canadian Journal of Community Mental Health* 35, 1 (2016): 29–45.

community mental health workers, they transformed the meaning of work as a healing practice within mental health care. Their labour provided a social context to express new forms of social citizenship. Peer support gained cultural power as a form of psychosocial or psychiatric rehabilitation that diverged from the (hegemonic) medical discourse of mental illness, diagnosis, and treatment, foregrounding well-being, community living, and basic human rights.¹¹⁸

In the 1980s, self- and peer help obtained a more formalized form in mental health policy, and former patients who identified as consumers asserted political influence on advisory councils. The role of peer counsellor provided a model for the inclusion of former patients in service provision. During the 1990s, the formalization of peer support in mental health policy also raised a number of structural tensions about what overtly appeared to be the inclusion of consumers in the wider work force. Ensuring basic social support and a certain level of income was complex and imbued with contradictions. The way peer support began to be taken up as an individual, personal journey towards empowerment and recovery reflected a process of individualization that, to some extent, obscured the more structural inequities still affecting the new roles of peer supporters.¹¹⁹ Some such inequities were more immediate, related to the context of workforce issues well outlined in the 2001 *BC Peer Support Resource Manual* and in emerging research evidence from studies of peer support and recovery-based care.

The 2001 BC policy guideline on peer support offered explicit discussion of the potential conflict peer supporters on income assistance or disability benefits might experience if they took on employment commitments that would cross the imaginary line between “rehabilitation and recovery” and “employment.” If individuals living with mental illness who received government benefits exceeded their financial boundary with income from their paid peer support work, they could lose their benefits. The detailed description of this “risk” suggested a new measure of control that seemed to be at odds with the promise of freedom, creativity, and recovery implied in the original idea of peer support.¹²⁰

¹¹⁸ Simon Davis, *Community Mental Health in Canada: Theory, Policy and Practice* (Vancouver: UBC Press, 2014); William Anthony, *The Principles of Psychiatric Rehabilitation* (Baltimore, MD: University Park Press, 1979), 1–5 and 213–36; Dyck and Deighton, *Managing Madness*, 200–28; Tomes, “The Patient as a Policy Factor.”

¹¹⁹ Morrow, “Recovery”; Brown and Manning, “Genealogies of Recovery.”

¹²⁰ British Columbia Ministry of Health, Adult Mental Health Policy Division, *Peer Support Resource Manual*, 51–3, 55. The Vancouver Coastal Health Authority has adjusted its guidelines and now provides peer support employment with exemption for people on benefits. See “Peer Framework For Health-Focused Peer Positions,” Vancouver Coastal Health, 2015,

Constraints on employment, opportunity, and ability to work affected consumers' community living.¹²¹ Tension could arise if a peer supporter worked at an agency where they had received care as a patient, and such employment raised complexities about access to records, confidentiality in smaller communities, and/or future access to the agency as a patient.¹²² Despite peer support being a resource in recovery, the requirement to have lived experience with a mental illness as a prerequisite in peer support employment could also deepen a person's vulnerability in terms of work conditions or employment opportunities.¹²³

As peer supporters obtained positions on professional teams, power inequities around enactment of team membership, their acceptance as a team member, and work conditions also arose. When peer supporters joined a workers' union, another layer of complexity was added: trying to delineate between staff and peer support roles. Critical voices have pointed out the challenges careers in peer support might entail, such as unequal pay, a justification for lowering health care costs (e.g., staffing), and cultural inequities playing themselves out in competition for jobs, in internal hierarchies pertaining to talent and background within consumer groups, and in the move towards professionalization.¹²⁴ Although destigmatizing on the one hand, the emphasis on personal well-being in the new recovery model tended to conceal these more structural challenges and seemed to narrow issues of citizenship to issues of employment conditions and training, as if all other matters were equal.¹²⁵

http://dtes.vch.ca/wp-content/uploads/sites/6/2016/06/VCH_DTES_Peer_Framework_FINAL_DIGITAL.pdf; and *Handbook for Contractors with Lived Experience of Mental Illness/Substance Use and Their Supervisors*, Vancouver Coastal Health, 2017, <http://www.spotlightonmentalhealth.com/wp-content/uploads/2017/06/VMHSU-Consumer-and-Peer-Contractor-Guidelines-January-2017.pdf>

¹²¹ British Columbia Ministry of Health, Adult Mental Health Policy Division, *Peer Support Resource Manual*, 45–53; Morrow, “Recovery.”

¹²² British Columbia Ministry of Health, Adult Mental Health Policy Division, *Peer Support Resource Manual*, 55.

¹²³ J. Vandewalle, B. Debyser, D. Beeckman, T. Vandecasteele, A. Van Hecke, and S. Verhaeghe, “Peer Worker’s Perceptions and Experiences of Barriers to Implementation of Peer Worker Roles in Mental Health Services: A Literature Review,” *International Journal of Nursing Studies* 60 (2016): 234–50.

¹²⁴ Enany, Currie, and Lockett, “Paradox in Healthcare Service Development”; Erick Fabris, “Mad Success: What Could Go Wrong When Psychiatry Employs Us as ‘Peers’?,” in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume, 130–39 (Toronto: Canadian Scholars’ Press, 2013).

¹²⁵ C. Forchuk, M. Martin, Y. Chan, and E. Jensen, “Therapeutic Relationships: From Psychiatric Hospital to Community,” *Journal of Psychiatric and Mental Health Nursing* 12 (2005): 556–64; Jacobson, *In recovery*; Howard, *Contested Individualization*. See also British Columbia Ministry of Health, Adult Mental Health Policy Division *Peer Support Resource Manual*; and Morrow, “Recovery.”

International studies on the adoption of peer support in acute care show that some of these challenges seem to intensify within the more formalized and hierarchical structures of an acute care institution.¹²⁶ For example, in acute care settings, bureaucratic barriers and outspoken hierarchical structures that privilege the agency of the biomedical model made it challenging for peer supporters to feel accepted on inpatient wards.¹²⁷ For some, the incorporation of peer support in acute care settings was empty rhetoric, demonstrating peer tokenism and causing the peer to feel isolated.¹²⁸ As “adjunct clinical team members” or “para-professionals,” it appeared peer supporters were not considered equal to other interdisciplinary team members.¹²⁹ When peer supporters joined acute care teams conflicts over role demarcation also seemed to intensify. Delineating peer support from (professional) clinical interventions as a way to draw boundaries between peer and professional ways of therapeutic work generated a sense of rivalry. Although peer support roles within in-patient settings typically centred on supporting clients, considered to be distinct from clinical interventions offered by health professionals, comparisons between the peer supporters and mental health nurses in community settings, for example, showed that distinctions were not always clear.¹³⁰ Others reported that work of formally trained peer supporters blurred the boundaries between professional responsibilities, and this was seen by some as interrupting team work, whereas still others argued that such work complemented the work of

¹²⁶ Bouchard, Montreuil, and Gros, “Peer Support among Inpatients”; J. Repper and T. Carter, “A Review of the Literature on Peer Support in Mental Health Services,” *Journal of Mental Health* 20, 4 (2011): 292–411; P. Solomon, “Peer Support/Peer Provided Services Underlying Processes, Benefits and Critical Ingredients,” *Psychiatric Rehabilitation Journal* 27, 4 (2004): 392–401. Reported benefits included psychological as well as material improvements, such as pay. Workplace challenges included exposure to triggers of mental illness and pressure to work in a team.

¹²⁷ A. Faulkner, and T. Basset, “A Helping Hand: Taking Peer Support into the 21st Century.” *Mental Health and Social Inclusion* 16 (2012): 41–47.

¹²⁸ Solomon, “Peer Support/Peer Provided Services.”

¹²⁹ Vandewalle et al., “Peer Worker’s Perceptions and Experiences,” quotes from 234.

¹³⁰ V. Pitt, D. Lowe, S. Hill, M. Prictor, S.E. Hetrick, R. Ryan, and L. Berends, “Consumer-Providers of Care for Adult Clients of Statutory Mental Health Services,” *Cochrane Database of Systematic Reviews* 3 (2013), 1–104; J. Rivera, A. Sullivan, and S. Valenti, “Adding Consumer-Providers to Intensive Case Management: Does It Improve Outcome?” *Psychiatric Services* 58, 6 (2007): 802–809; P. Solomon and J. Draine, “Service Delivery Differences between Consumer and Non-Consumer Case Managers in Mental Health,” *Research on Social Work Practice* 6, 2 (1996): 193–207; J.I. Bright, K.D. Baker, and R.A. Neimeyer, “Professional and Paraprofessional Group Treatments for Depression: A Comparison of Cognitive-Behavioral and Mutual Support Interventions,” *Journal of Consulting and Clinical Psychology* 67, 4 (1999): 491–501.

nursing teams.¹³¹ In British Columbia, peer support has been extended to acute care settings. This has allowed new and creative applications of peer support, such as offering one-to-one support, facilitating wellness groups (e.g., yoga groups), or providing pet therapy for a certain number of hours per week. From anecdotal information from some initial examples of peer support in acute care in the Lower Mainland, it appears to be a valuable experience for patients; however, at the same time, it raises the very same questions as those discussed above.¹³²

Other challenges in the reworked notion of peer support over the last few decades relate to the professionalized and research-driven model of peer support that was consolidated at a national level in the policy recommendations of the MHCC. This seemed to reinforce a managerial focus very different from the communal self-help initiatives of earlier consumer groups. Some argue that peer supporters should not be adjunct para-professionals to clinical teams or require a certificate from an accredited training program because this would take away from the egalitarian relationship necessary for effective peer support.¹³³ Concerns and focus on the standardization of peer support practice, congruency of programs, disability benefits, formalized training, and wage regulations implicitly appear to demonstrate a priority for productive citizenship enhanced by processes of individualization. According to some, standardization and formalization of peer support might affect the creative practice of peer support and might erode the reciprocal relationships in peer support initiatives. To some degree, standard workforce training steered peer support into co-option – taking on the language and culture of mainstream mental health services.¹³⁴

On the other hand, peer support also continues to be recognized as empowering and destigmatizing: peer support roles divert from a preoccupation with diagnosis and illness and construct experiential expertise as a resource, albeit careful negotiation of the (work) conditions of peer

¹³¹ L. Bouchard, M. Montreuil, and C. Gros, "Peer Support among Inpatients in an Adult Mental Health Setting," *Issues in Mental Health Nursing* 31, 9 (2010): 589–98; J. Hurley, A. Cashin, J. Mills, M. Hutchinson, and I. Graham, "A Critical Discussion of Peer Workers: Implications for the Mental Health Nursing Workforce," *Journal of Psychiatric and Mental Health Nursing* 23 (2016): 129–35.

¹³² Devane, "Peer Support: The Art of Therapeutic Rapport," paper presented at workshop entitled "Exploring Connections between Art, Craft, Healing and History," Peter Wall Institute for Advances Studies, UBC, 3 March 2017.

¹³³ Michael A. Mancini and Hal A. Lawson, "Facilitating Positive Emotional Labour in Peer-Providers of Mental Health Services," *Administration in Social Work* 33 (2009): 3–22; Jijian Voronka, "The Politics of 'People with Lived Experience': Experiential Authority and the Risks of Strategic Essentialism," *Philosophy, Psychiatry, and Psychology* 23 (2016): 189–201.

¹³⁴ Brown and Manning, "Genealogies of Recovery."

support remains vital.¹³⁵ It would seem at odds with an entitlement to patient rights to constrain opportunities to make a living by means of peer support, and the acknowledgment of peer support as real work can hardly be denied. A basic income not only remains a culturally dominant way to achieve social recognition but is also fundamental to (independent) living and a recognized health determinant. Peer support, like the support provided by art (and technology), has evolved around both productive structures and social structures. Professionalization of peer support has created new avenues for caring work and engagement of consumers, but it has also raised new issues of inclusion. In fact, peer support expansion through prescribed standards exposed the risk of a too narrow conceptualization that would undermine the broader goals of social inclusion. Nevertheless, the creativity by which peer support has been reinvented in the context of the consumer initiatives policy implemented in British Columbia in recent decades, building upon the early, groundbreaking initiatives of the MPA in the 1970s and 1980s, clearly underscores that fact that peer support and participation have become enduring characteristics of mental health services.

¹³⁵ Enany, Currie, and Lockett, "Paradox in Healthcare Service Development"; Courtney Devane, "Peer Support"; Boschma, Haney, and Gorrie, "Gender, Work, and Identity."