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Research Report

Interim Report: Review of Recent Literature on Peer Support Providers

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Abstract / Overview

This report updates a literature review on peer support providers prepared in 2015. Peer support workers fulfill a broad range of tasks and job titles, in a broad range of mental health and substance use disorders recovery settings, and in various service models, although there is a lack of consensus on the core competencies and duties of this role. Despite a growing body of literature on the effectiveness of peer support, there is still little literature on peer support in forensic and inpatient settings.

Purpose

The purpose of this report is to update literature on peer support providers building upon a 2015 landscape analysis conducted by UCSF for the Substance Abuse and Mental Health Services Administration (SAMHSA).[1] This report will examine peer-reviewed literature and non-peer reviewed reports on roles, responsibilities, education and certification, and payment models for peer support providers and services, with a specific emphasis on literature focused on peer support providers in transitional models including forensic and inpatient settings.

Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a peer provider as "*a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience*."[2] Peer-delivered services and employment have grown in the past few decades, and are becoming a more integral part of the behavioral health care system nationally.[3,4]

Brief Summary of Previous Literature

The 2015 landscape report (literature review) conducted by UCSF, included over 70 peer-reviewed papers and reports describing peer provider roles, settings, and models of care. Findings from that literature demonstrated that peer providers assume a variety of roles in a wide range of settings. The titles of these workers may

vary depending on the training and licensing structure of the state. In general, for peer providers that specialize in mental health or substance use disorders (SUD), the most prevalent job titles include: peer support specialists, certified peer specialists, peer recovery coaches, or peer recovery support specialists. Peer providers work in a myriad of settings, including peer-run and operated recovery organizations, which are largely non-clinical in nature, traditional care settings such as mental health clinics, substance use disorder treatment centers, psychiatric hospitals, and inpatient substance use disorder recovery services. Findings suggested that peer providers are being increasingly used to support transitions of care from inpatient mental health and substance abuse programs into the community, and from forensic settings (jail and prison) into the community.

Models of care incorporating peer roles included Assertive Community Treatment Teams, crisis stabilization units, and mobile crisis teams. In these models, peers were found to provide services as part of teams or in tandem with traditional mental health and substance use treatment providers.

At the time of the 2015 landscape report, about 40 states had a statewide certification protocol for mental health peer support specialists, and about one-third of states had statewide certification for SUD peer recovery coaches. Training requirements and certification standards for peer support specialists were found to vary widely by state and organization in the number of hours of training required, the amount of work and/or volunteer experience required, and curriculum used for training. Literature pertaining to funding, billing, and reimbursement demonstrated that in addition to Medicaid funding, peer provider employers have depended on state and local funding, and federal block grants.

Many studies concluded that peer-delivered services resulted in measured outcomes equal or better than the same services provided by professionals without lived experience. However meta-analyses called into question the rigor of this research.

Methods

Search Strategy

For this report, literature was identified using targeted keyword searching in Google. Peer-reviewed studies on peer support providers were identified through searches of the following databases: PubMed, CINAHL, PsycINFO, Embase, and Social Services Abstracts. We reviewed the references of promising studies to find studies that may have been missed during searching. The search was limited to studies written in English language, published in the year 2016.

For literature about peer workers in forensic and inpatient settings, no date limits were used since our intent was to focus on these areas for the purposes of this investigation. Search terms included *peer-based*, *peer support specialist*, *peer provider*, *peer*

recovery coach, *peer workforce certification*, *peer group* with additional terms such as *substance abuse*, *inpatient mental health*, *behavioral health*, *forensic*, *jail*, and *prison*.

Search Results

After removing duplicates, 145 peer-reviewed studies were found. Of these, 116 were eliminated because they did not address the peer provider workforce or research questions; 9 were eliminated because they were included in the 2015 report or did not meet the date criteria. Two researchers reviewed the remaining 20 abstracts to categorize papers according to which research questions they addressed. All abstracts of included papers can be found in Appendix I of this report. These coded topics included: peer provider roles, organizational settings, and models of care; training and certification; integration of peer providers; evidence of efficacy of peer support; and billing, reimbursement, and sources of funding for peer support programs. Papers deemed most relevant to these topics were reviewed in depth to inform this analysis.

FINDINGS FROM RECENT LITERATURE

Peer Provider Roles, Settings, and Models of Care

This review of the peer-reviewed literature yielded several studies that discussed roles and/or titles of peer provider employees in behavioral health. The literature suggests that the role is a fast-growing occupational group[5], and is becoming increasingly professionalized[6], especially in agencies such as the Veterans Administration (VA).[7] According to recent literature, peer providers fulfill a broad range of tasks, with titles including, but are not limited to, peer support specialist, peer mentor or counselor, recovery support specialist, recovery coach, client liaison, peer bridger, and family support navigators.[4,8]

Several studies acknowledge a lack of consensus on core components of the role in both mental health and substance use disorder settings [6,8,9] with no national standards defining core competencies of peer support specialists.[8] Some authors suggest that lack of clarity about the role may hinder its widespread adoption.[10] A 2016 study in a jail diversion program for veterans by Clark & Barrett suggest that the designation of peer roles should vary according to population served and incorporate the perceptions of the consumer.[9] A 2016 case study of peer providers in integrated primary and mental health care settings in Los Angeles County, California revealed wide variation in the definition of peer providers, their roles, and extent of their programmatic infrastructure to support their team involvement.[11] Despite these workforce challenges, there is a growing literature base illustrating peer services as an increasingly integral component of behavioral health care systems in many states.[8]

Findings in the literature continue to reveal that peer specialists work in a broad range

of behavioral health settings.[8] A 2016 national survey of the peer provider workforce in the U.S. conducted by Cronise and colleagues revealed that the most common settings of peer provider workers are in community and/or peer-run program settings.[4] The Department of Veteran's Affairs has implemented a number of peer support programs,[9] and in 2008 announced a requirement for all VA medical centers to offer individual or group services from peer specialists to veterans treated for severe mental illness.[7] In a 2013 press release, the VA announced that they had hired over 800 Veterans as mental health peer specialists and peer apprentices.[12]

Authors Silver & Nemec (2016) acknowledge the broad range of service models, including those that encompass one-on-one services rendered, those that feature an integrated interdisciplinary service team with a dedicated role for a peer support worker, and peer-run programs.[13] The paper by Swarbrick and colleagues (2016) illustrates a range of peer service models employed in Georgia, Michigan, and New Jersey.[14] Silver & Nemec (2016)[13] and Chinman and colleagues (2016)[6] stress the need for further documentation of service models within the framework of peer roles in order to further the outcomes research and facilitate dissemination. The following are examples of models in the current review of the peer-reviewed literature. However, these examples have not been established as standards in the peer workforce, and authors have cited the need to further document models, identify core components, and develop fidelity scales.[6,13]

Therapeutic community model– This model was implemented by the California Men's Colony in San Luis Obispo and published in a peer-reviewed paper in 2008.[15] It is an evidence-based treatment model in which long-term sentenced inmates serve as peer mentors and counselors to lead the program for incarcerated individuals with SUD.

Transitional care model (TCM)–This evidence-based model was initially developed to improve post hospital outcomes for elderly with physical health conditions; a 2014 paper by Hanrahan, Solomon & Hurford studied the model with individuals who have serious mental illness in a randomized controlled trial.[16] Findings indicated the intervention group's general health was improved, but was not statistically significant compared to the control. The authors recommend further study of the transitional care intervention with this population, modifying the model from a single nurse to a multidisciplinary team that includes a peer support specialist. The authors suggest that the peer support specialist would offer an "off-the-grid" kind of expertise about how the patient can best manage health and social complexities.

Peer-Supported Economic Empowerment Intervention Model– represents a framework proposed in a study by Jimenez-Solomon and colleagues (2016) developed with the aims of reducing socioeconomic inequalities that affect people with psychiatric conditions.[17] This model is designed to help these individuals build essential financial capabilities, and

address social determinants of mental health and disability. Further research to pilot-test and refine peer-supported economic empowerment strategies is currently underway.

Training and Certification

According to a recent report by the University of Texas at Austin, as of July 2016, 41 states and the District of Columbia have established programs to train and certify peer specialists and two states are in the process of developing and/or implementing a program.[18] The literature suggests an emerging consensus on the value of training and certifying these workers.[13] In states where peer services have become eligible for reimbursement, a number of organizations offer training and certification to qualify peers to deliver reimbursable services.[6]

Myrick & del Vecchio (2016) describe the state of the peer credentialing environment as a patchwork of state, private, and nonprofit training and certification programs; the authors suggest that the variation in credentialing may be attributed to the Centers for Medicare and Medicaid Services' stipulation that peer providers must complete training and certification as defined by the state.[8] A 2016 national survey by Cronise and colleagues of the peer provider workforce in the U.S. revealed that over half (57.4%) of respondents (N=521) completed between 20 to 80 hours of training to qualify as a peer provider; 80% of the respondents felt the amount of training was sufficient for their work as a peer provider.[4] A mixed methods study conducted in Canada by Rebeiro, LaCarte, and Calixte in 2016 found inconsistent amounts of training in peer support workers working in mental health services, suggesting that internationally, training varies for this workforce.[5]

Efforts to address concerns about recruitment, retention, training, and competence of these workers continue. A 2016 paper by Hoge and colleagues describes the efforts of three agencies in Alaska that developed a set of core competencies and skills needed for these workers in health and social services settings, as a first step to developing a standardized curriculum.[19]

In regards to training strategies, Cronise (2016) discusses the potential gains of incorporating a collaborative learning approach within peer provider training in which peer providers collectively share real life experiences to provide opportunities to explore perspectives and enrich practice of all participants.[20] The author suggests that the advantage of incorporating a collaborative learning approach in peer training is an increased sense of community among peer employees that provides opportunity for safe learning, exploration of new perspectives, and receiving honest feedback toward personal and professional growth. The paper features three examples of programs that have adopted this approach.

Two papers and one non-profit organization report provide examples of peer worker training in transitional settings in California. A 2008 study features a prison-based

therapeutic program in San Luis Obispo, California.[15] Faced with staffing difficulties, the program worked in partnership with a university center that was charged with training peer mentors to recruit and train a new peer mentor workforce. A 2016 case study of peer providers in integrated mental health and primary care settings in Los Angeles County found that most programs with peer providers (10 out of 14 programs evaluated) had a formal infrastructure for training peer providers for their roles.[11] Most trainings occurred in settings external to the agency and included Bridge peer health navigation, Wellness Recovery Action Plan, and occasional peer advocacy trainings through the Department of Mental Health.[15] In addition, the non-profit Transitions Clinic in San Francisco employs community health workers (CHWs) who have a history of incarceration as part of the healthcare team to serve patients recently released from prison and support their re-integration into their communities.[21] All Transitions Clinic CHWs must complete the City College of San Francisco's Post Prison Health Worker (PPHW) Certificate Program in addition to on-the-job training.[22] The program is a 20-unit course of study that includes core courses from the school's CHW certificate program and additional training on the health impacts of incarceration and chronic disease management. California lags behind many other states in standardizing the curriculum and certification protocol for peer services.[23]

Integration of Peer Provider Roles

Two recent peer-reviewed studies discussed the integration of peer provider roles in transitional settings. A 2016 California case study by Sianz, Henwood & Gilmer recommends developing workplace strategies to promote inclusion of peer providers in integrated mental health and primary care settings and to raise other workforce members' awareness about the importance and effectiveness of peer support services.[11] A 2016 mixed methods study conducted in Canada by Rebeiro, LaCarte & Calixte found that limited integration of peer support workers within mainstream mental health services results from inconsistent training and role functions, which in turn contribute to a lack of understanding of what these workers offer to mental health systems.[5]

In a 2016 national survey of peer provider employees, respondents reported that key aspects of their role were misunderstood, discounted, or even reprimanded by traditionally trained mental health professionals.[4] A literature review of qualitative studies of peer workers' perceptions of barriers by Vandewalle and colleagues (2016) further illustrates the challenges of integrating peer workers in multidisciplinary teams across settings. Their findings indicate that some peer workers report do not feel like equal members in multidisciplinary teams. Neither service user nor professional, the role of the peer worker is not clearly operationalized, leading to reported communication challenges during interdisciplinary team meetings.[24]

Evidence of Efficacy

Four studies discussed the evidence of efficacy of peer services. A 2016 observational study by Vayshenker and colleagues explored the impact of service users' participation at a mental-health drop-in center on recovery-related outcomes over a 6-month period.[25] The authors examined attendance records of participants, and found that moderate and high attenders showed statistically significant improvements over time in measures such as internalized stigma and self-efficacy.

Despite a growing body of knowledge on peer workers, research remains unclear regarding how and to what extent consumers benefit from peer support services.[24,25] Vandewalle et al. (2016) described the evidence of peer workers' effectiveness in promoting improved outcomes for service users as "low to moderate".[24] A 2016 journal article by Chinman and colleagues reported that outcome studies evaluating the effectiveness of peer workers in clinical mental health settings have shown ambiguous results; several reviews have concluded that that adding peer workers to a team can improve health outcomes, yet meta-analyses of randomized trials have found less impact.[6] Moreover, the authors contend that all outcomes studies are limited because none included a measure of the degree to which the peer services were delivered with fidelity. Their article describes the authors' initial development of a fidelity measure for services provided by peer specialists in various mental health settings and implementation factors that impact their employment. Vayshenker and colleagues offer other possible explanations regarding the lack of consistent evidence for peer support, including variation in program content between studies, methodological problems, differences in assessed outcomes, and differences in participant characteristics.[25]

Three studies in the review discussed evidence of peer services specifically in transitional settings. A 2016 randomized controlled trial by Salzer and colleagues examined the effectiveness of peer-delivered services of Centers for Independent Living compared to care as usual for individuals with a schizophrenia-spectrum or affective disorder.[26] No significant differences were found between intervention and control groups. The authors suggest that ability to evaluate the effectiveness of the peer-delivered services may be constrained by the limited amount of engagement with peer services and small sample size, making it difficult to detect small effects. Rogers and colleagues (2016) conducted a randomized control trial to examine the impact of peer support specialist services on individuals with psychiatric disabilities undergoing civil commitment.[27] Intent-to-treat analyses suggested no significant differences between the intervention group, which received intensive support from a peer services, and a control group who, although invited to receive peer support services, did not receive intensive follow-up. However, an as-treated analysis (comparing persons who were exposed to a "high", "low", or no amount of the intervention (control group), measured in minutes of peer support

received) revealed significant differences. There was a significant difference between the low-support group and the control group on quality of life over all; the high-support group reported higher emotional well-being than the control group. Both low- and high-support groups fared better compared to controls on a substance abuse subscale. A 2013 prospective study by Livingston and colleagues conducted in a Canadian forensic mental health hospital evaluated the effectiveness of an intervention that included a peer support program, a patient advisory committee, and a patient-led research team on improving patient outcomes, among other non-clinical outcomes.[28] The peer support program component of the intervention was associated with increases in patient recovery and may have prevented increases in levels of internalized stigma.

Billing, reimbursement, and sources of funding for peer support programs

Congruent with the broadly defined workforce, the literature suggested that funding mechanisms for peer services vary[13], although Medicaid reimbursement is increasingly a major source of funding.[8] Myrick & del Vecchio (2016) report that as of 2014, 36 states bill Medicaid for mental health peer support services and at least 11 states bill for peer support in SUD or co-occurring conditions.[8] According to a 2016 presentation by the California Association of Mental Health Peer-Run Organizations (CAMPHRO), most recent statewide data indicates that only a few California counties allow peer specialists to bill under existing Medi-Cal (Medicaid) codes.[29] The counties that reported billing for peer services have done so under the current state plan that permits billing for rehabilitation, targeted case management and collaterals provided by "Other Qualified Providers", which includes Peer Specialists.[29]

Legislative Updates (California)

Proposed legislation in California, SB 614, would have required the State Department of Health Care Services to establish a statewide certification program for peer support specialists in mental health and substance use disorders, and to recognize peer support specialists as providers in the Medi-Cal program. However, in April of 2015, the bill was "gutted and amended" to a bill that was unrelated to the peer support workforce. Interest from various stakeholder groups in peer support specialist employment and certification remains high in California. According to CAMPHRO, work on the peer certification legislation will continue in preparation for the 2017 legislative session.[30]

Summary

This updated review of the literature on peer professionals reveals findings similar to those in the previous landscape report from 2015. Peer support roles are becoming increasingly professionalized, and workers fulfill a broad range of tasks and job titles, in a broad range of settings, and in various service models. A lack of consensus on core components of the role continues to be a challenge for the workforce. Despite these challenges,

training and certification is proliferating and 41 states and the District of Columbia have established programs to train and certify peer specialists. In California, efforts to create statewide peer certification seem likely to continue in the next legislative session.

Integration of peer provider employees on the clinical team continues to be a challenge, and traditionally trained mental health professionals struggle to accept the role. Funding mechanisms for peer services in general continue to vary, although Medicaid reimbursement is increasingly a major source of funding for peer services. There is a growing body of literature on the effectiveness of services provided by peer workers, but there is still little literature on the effectiveness of peer workers specifically in transitional settings.

Acknowledgements

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APPENDIX I – Paper Abstracts (listed alphabetically by first author)

Chang B-H, Mueller L, Resnick SG, Osatuke K, Eisen SV. Job satisfaction of Department of Veterans Affairs peer mental health providers. *Psychiatric rehabilitation journal.* 2016;39(1):47-54.
OBJECTIVES: Department of Veterans Affairs (VA) peer specialists and vocational rehabilitation specialists are Veterans employed in mental health services to help other Veterans with similar histories and experiences. Study objectives were to (a) examine job satisfaction among these employees, (b) compare them to other VA mental health workers, and (c) identify factors associated with job satisfaction across the three cohorts. METHODS: The study sample included 152 VA-employed peer specialists and 222 vocational rehabilitation specialists. A comparison group included 460 VA employees from the same job categories. All participants completed the Job Satisfaction Index (11 aspects and overall satisfaction ratings). Linear regression was used to compare job satisfaction and identify its predictors among the three cohorts. RESULTS: Job satisfaction was fairly high, averaging “somewhat satisfied” to “very satisfied” in six (peer specialists) and nine (vocational rehabilitation specialists) of the 11 aspects and overall job ratings. Adjusting for length of employment, age and gender resulted in no significant group differences with two exceptions: White peer specialists were less satisfied with pay and promotion opportunities than vocational rehabilitation specialists and comparison-group employees. Across all cohorts, shorter length of time employed in the job was associated with higher job satisfaction. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: The high job satisfaction levels among the two peer cohorts suggest support for the policy of hiring peer specialists in the VA. Furthermore, the results are consistent with those of the nonveteran samples, indicating that integrating peer providers into mental health care is possible in VA and non-VA settings.

Chinman, M., S. McCarthy, C. Mitchell-Miland, K. Daniels, A. Youk and M. Edelen (2016). "Early Stages of Development of a Peer Specialist Fidelity Measure." *Psychiatric rehabilitation journal*. 2016;39(3):256-265.
OBJECTIVE: Research on peer specialists (individuals with serious mental illness supporting others with serious mental illness in clinical and other settings) has not yet included the measurement of fidelity. Without measuring fidelity, it is unclear whether the absence of impact in some studies is attributable to ineffective peer specialist services or because the services were not true to the intended role. This article describes the initial development of a peer specialist fidelity measure for two content areas: services provided by peer specialists and factors that either support or hamper the performance of those services. METHOD: A literature search identified 40 domains; an expert panel narrowed the

number of domains and helped generate and then review survey items to operationalize those domains. Twelve peer specialists, individuals with whom they work, and their supervisors participated in a pilot test and cognitive interviews regarding item content. RESULTS: Peer specialists tended to rate themselves as having engaged in various peer service activities more than did the supervisors and individuals with whom they work. A subset of items tapping peer specialist services "core" to the role regardless of setting had higher ratings. Participants stated the measure was clear, appropriate, and could be useful in improving performance. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Although preliminary, findings were consistent with organizational research on performance ratings of supervisors and employees made in the workplace. Several changes in survey content and administration were identified. With continued work, the measure could crystalize the role of peer specialists and aid in research and clinical administration.

Clark, C., B. Barrett, A. Frei and A. Christy (2016). "What makes a peer a peer?" *Psychiatric rehabilitation journal.* 2016;39(1):74-76.

OBJECTIVE: The purpose of this study was to learn more about which characteristics are considered important for consumers to feel that a person is their peer. METHODS: Forty-one participants in a jail diversion program for veterans were asked to rate characteristics in terms of importance for acting in a peer support role. Differences by gender, combat exposure, trauma history, and mental health and substance abuse treatment were analyzed using t tests and Pearson correlations. RESULTS: Having served in the military had the highest average rating; trauma experience second. Participants with combat experience were significantly more likely than those without to indicate this as an important characteristic. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Increasingly behavioral health programs are recognizing the importance of peer involvement. This study offers guidance on who should be designated a “peer,” suggesting that this should vary according to the population served and be based on the perceptions of the consumers.

Cook, J., S. McClure, I. Koutsenok and S. Lord (2008). "The implementation of inmate mentor programs in the correctional treatment system as an innovative approach." *Journal of Teaching in the Addictions.* 2008;7(2):123-132.

In October 2006, the California Men's Colony (CMC) in San Luis Obispo, faced with staff recruitment and retention difficulties, took an innovative step to utilize long-term sentenced inmates as peer mentors and primary counselors to lead their prison-based therapeutic community (TC) program. The program was designed, developed, and implemented through the collaborative efforts of CMC's Our House program, the California Department of Corrections and Rehabilitation (CDCR), the University of California, San Diego (UCSD), Center for Criminality and Addiction Research, Training and Application (CCARTA), and the Orange County Department of Education (OCDE). The program is designed to be a peer mentor-driven 24-hour TC built to uphold the fundamental TC principles that have been lost in many treatment programs. UCSD CCARTA was instrumental in training the long-term

residents who served as peer mentors in substance abuse treatment principles and strategies, equivalent to the training received by state-funded providers for the nationally accredited Forensic Addictions Corrections Treatment certification program, and the OCDE joined the program to support the community's structural and educational needs. Since the implementation of the peer-driven Our House program, the peer mentors have demonstrated exceptional command of a TC environment and have yielded a postrelease aftercare attendance of approximately 81%, a number much higher than that of most treatment programs in CDCR. Thus, the peer-mentor-driven treatment model may be a much needed solution for the improvement of program quality and effectiveness, especially in rural and other hard-to-hire regions with constant staff retention problems.

Crane, D. A., T. Lepicki and K. Knudsen (2016). "Unique and common elements of the role of peer support in the context of traditional mental health services." *Psychiatric rehabilitation journal.* 2016;39(3):282-288.
OBJECTIVE: The goal of this report is to clarify the unique role of peer support providers (PSPs) and define peer support as a distinct occupation in the context of traditional mental health services. METHOD: A systematic methodology was used to compare roles of PSPs with those of similarly situated case managers (CMs). Key informants including 12 incumbent CMs and 11 incumbent PSPs participated in focus groups and responded to a set of prompts based on the Discovering a Curriculum (DACUM) methodology (Norton & Moser, 2014), an innovative approach to identifying and comparing duties and tasks associated with distinct occupations. Task analyses were validated through a survey of 71 CM and 29 PSP subject matter experts, including workers, supervisors, trainers, and consumers. RESULTS: The results revealed a variety of duties and tasks specific to the PSP occupation, particularly within the domains of empowering consumers, promoting consumers' educational growth, and supporting personal development. The results also reveal areas of overlapping responsibility between PSPs and CMs, including aspects of each role that promote consumers' development, wellness and recovery, administrative tasks, and care coordination activities. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: These findings may address the role ambiguity that currently challenges efforts to establish peer support as a legitimate service in the field of behavioral health. In addition, the findings demonstrate how the roles of PSPs and CMs could be synergistic in complex organizational settings.

Cronise, R. (2016). "Collaborative learning: A next step in the training of peer support providers." *Psychiatric rehabilitation journal.* 2016;39(3):211-221.
BACKGROUND: This column explores how peer support provider training is enhanced through collaborative learning. PURPOSE: Collaborative learning is an approach that draws upon the "real life" experiences of individual learners and encompasses opportunities to explore varying perspectives and collectively construct solutions that enrich the practice of all participants. SOURCES USED: This description draws upon published articles and

examples of collaborative learning in training and communities of practice of peer support providers. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Similar to person-centered practices that enhance the recovery experience of individuals receiving services, collaborative learning enhances the experience of peer support providers as they explore relevant "real world" issues, offer unique contributions, and work together toward improving practice. Three examples of collaborative learning approaches are provided that have resulted in successful collaborative learning opportunities for peer support providers.

Cronise, R., C. Teixeira, E. S. Rogers and S. Harrington (2016). "The peer support workforce: Results of a national survey." ***Psychiatric rehabilitation journal.*** **2016;39(3):211-221.**

OBJECTIVE: Given the burgeoning role of peer specialists in the mental health workforce, more information is needed about their work roles, tasks, settings, training, compensation, and work satisfaction. METHOD: Using both purposive and snowball sampling, the authors recruited a national sample of individuals employed as peer specialists and a variety of other peer provider positions. They conducted an online survey to query respondents about various aspects of their work life. A total of 608 participants completed the survey, of which 597 responses were usable for these analyses. RESULTS: Results suggest that individuals in the United States identifying themselves as peer specialists (or similar titles) work in a wide variety of settings and spend the majority of their work time providing direct peer support. However, a significant number of individuals also reported performing nondirect peer support tasks such as administrative work, teaching skills, and systems-level advocacy. Average compensation ranged from $10 to $20 per hour. Peer specialists reported a significant amount of satisfaction with their work but still perceive a lack of recognition for their roles. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Results of this survey provide critical information about the job characteristics of peer specialists and data that should be informative for mental health authorities as they address the needs of this workforce. However, our findings also suggest that ambiguity remains regarding the roles, tasks, and training of peer specialists, which could benefit from further study that would help to clarify the unique role of these professionals within the mental health arena.

Hanrahan, N. P., P. Solomon and M. O. Hurford (2014). "A pilot randomized control trial: Testing a transitional care model for acute psychiatric conditions." ***Journal of the American Psychiatric Nurses Association.*** **2014;20(5):315-327.**

OBJECTIVE: People with multiple and persistent mental and physical health problems have high rates of transition failures when transferring from a hospital level of care to home. The transitional care model (TCM) is evidence-based and demonstrated to improve posthospital outcomes for elderly with physical health conditions, but it has not been studied in the population with serious mental illness. METHOD: Using a randomized controlled design, 40 inpatients from two general hospital psychiatric units were recruited and randomly assigned to an intervention group (n = 20) that received the TCM intervention that was

delivered by a psychiatric nurse practitioner for 90 days post hospitalization, or a control group (n = 20) that received usual care. Outcomes were as follows: service utilization, health-related quality of life, and continuity of care. RESULTS: The intervention group showed higher medical and psychiatric re-hospitalization than the control group (p = .054). Emergency room use was lower for intervention group but not statistically significant. Continuity of care with primary care appointments were significantly higher for the intervention group (p = .023). The intervention group's general health improved but was not statistically significant compared with controls. CONCLUSIONS: A transitional care intervention is recommended; however, the model needs to be modified from a single nurse to a multidisciplinary team with expertise from a psychiatric nurse practitioner, a social worker, and a peer support specialist. A team approach can best manage the complex physical/mental health conditions and complicated social needs of the population with serious mental illness.

Hoge, M. A., M. McFaul, L. L. Cauble, K. L. Craft, M. Paris, Jr. and R. M. Calcote (2016). "Building the skills of direct care workers: The Alaskan core competencies initiative." *Journal of Rural Mental Health.* 2016;40(1):31-39.

A large proportion of the health and social service workforce is comprised of direct care workers who have no formal preservice education and receive a limited amount of on-the-job training. These workers are essential in all geographic areas and are especially critical in rural and frontier regions where access to advanced health care professionals is limited. Driven by stakeholder demand, the State of Alaska launched the multiyear Alaskan Core Competencies initiative to strengthen the training of its direct care workforce. This article details the development of a set of cross-sector core competencies relevant to workers in the fields of mental health, addictions, developmental and physical disabilities, and the long-term care of older adults. Also described are the related assessment tools, curriculum, and train-the-trainer learning communities, which were developed to enable the dissemination of the competencies. The authors conclude by discussing the growing interest nationally in competencies for this workforce, the challenges of adapting one set of competencies for varied jobs in diverse health and social service sectors, and the financial barriers to widespread adoption of competency-based worker training.

Jimenez-Solomon, O. G., P. Mendez-Bustos, M. Swarbrick, S. Diaz, S. Silva, M. Kelley, S. Duke and R. Lewis-Fernandez (2016). "Peer-supported economic empowerment: A financial wellness intervention framework for people with psychiatric disabilities." *Psychiatric rehabilitation journal.* 2016;39(3):222-233.

OBJECTIVE: People with psychiatric disabilities experience substantial economic exclusion, which hinders their ability to achieve recovery and wellness. The purpose of this article is to describe a framework for a peer-supported economic empowerment intervention grounded in empirical literature and designed to enhance financial wellness. METHOD: The authors followed a 3-step process, including (a) an environmental scan of

scientific literature, (b) a critical review of relevant conceptual frameworks, and (c) the design of an intervention logic framework based on (a) and (b), the programmatic experience of the authors, and input from peer providers. RESULTS: We identified 6 peer provider functions to support individuals with psychiatric disabilities to overcome economic inclusion barriers, achieve financial wellness goals, and lessen the psychosocial impact of poverty and dependency. These include (a) engaging individuals in culturally meaningful conversations about life dreams and financial goals, (b) inspiring individuals to reframe self-defeating narratives by sharing personal stories, (c) facilitating a financial wellness action plan, (d) coaching to develop essential financial skills, (e) supporting navigation and utilization of financial and asset-building services, and (f) fostering mutual emotional and social support to achieve financial wellness goals. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Financial wellness requires capabilities that depend on gaining access to financial and asset-building supports, and not merely developing financial skills. The proposed framework outlines new roles and competencies for peer providers to help individuals build essential financial capabilities, and address social determinants of mental health and disability. Research is currently underway to pilot-test and refine peer-supported economic empowerment strategies.

Livingston, J. D., A. Nijdam-Jones, S. Lapsley, C. Calderwood and J. Brink (2013). "Supporting Recovery by Improving Patient Engagement in a Forensic Mental Health Hospital: Results From a Demonstration Project." ***Journal of the American Psychiatric Nurses Association.*** **2013;19(3):132-145.**

Mental health services are shifting toward approaches that promote patients' choices and acknowledge the value of their lived experiences. OBJECTIVE: To support patients' recovery and improve their experiences of care in a Canadian forensic mental health hospital, an intervention was launched to increase patient engagement by establishing a peer support program, strengthening a patient advisory committee, and creating a patient-led research team. DESIGN: The effect of the intervention on patient- and system-level outcomes was studied using a naturalistic, prospective, longitudinal approach. Quantitative and qualitative data were gathered from inpatients and service providers twice during the 19-month intervention. RESULTS: Despite succeeding in supporting patients' participation, the intervention had minimal impacts on internalized stigma, personal recovery, personal empowerment, service engagement, therapeutic milieu, and the recovery orientation of services. Peer support demonstrated positive effects on internalized stigma and personal recovery. CONCLUSIONS: Strengthening patient engagement contributes toward improving experiences of care in a forensic hospital, but it may have limited effects on outcomes.

Myrick, K. and P. del Vecchio (2016). "Peer support services in the behavioral healthcare workforce: State of the field." *Psychiatric rehabilitation journal.* 2016;39(3):197-203.
OBJECTIVE: This article examines how the history and philosophy of peer support services has shaped current mental health and substance use service delivery systems. The growth of peer-run and recovery community organizations in the changing health care environment are discussed, including issues related to workforce development, funding, relevant policies, and opportunities for expansion. These initiatives are designed to increase access to recovery-promoting services. METHODS: We conducted an environmental scan and analysis of peer support services within the behavioral health care field in the United States, with particular attention to initiatives of the Substance Abuse and Mental Health Services Administration. Published manuscripts, policy statements, and reports were reviewed. FINDINGS: There is abundant and growing literature illustrating how peer support services have become an integral component of behavioral health care systems in many states. Peer support services have the potential to increase access to recovery-oriented services for people with mental and substance use disorders served by the public behavioral health care system. Numerous initiatives in various states are being undertaken to build this workforce. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Workforce and financing challenges exist, yet opportunities, including among others those made possible by the Affordable Care Act, will continue to strengthen the peer support workforce within behavioral health service delivery systems.

Rebeiro Gruhl, K. L., S. LaCarte and S. Calixte (2016). "Authentic peer support work: challenges and opportunities for an evolving occupation." *Journal of mental health (Abingdon, England).* 2016;25(1):78-86.
BACKGROUND: The peer support worker (PSW) belongs to the fastest growing occupation in the mental health sector, yet it is often under-valued and poorly understood. Despite an emerging evidence base, and strong support from mental health service users, the PSW remains on the periphery of mainstream services in northeastern Ontario. AIMS: To examine the role of the PSW, along with the challenges and benefits, and to understand why the PSW is not more integrated within mainstream services. METHODS: A sequential, exploratory, mixed-methods design was used to collect data on 52 survey and 33 focus group participants. Qualitative data were analyzed thematically. RESULTS: Peer support work was described by participants as being authentic when PSWs can draw upon lived experience, engage in mutually beneficial discussions, and be a role model. Authentic peer support was noted to be important to the recovery of mental health service users; yet, participants revealed that many positions continue to reflect more generic duties. Challenges to further integration include acceptance, training and credentialing, self-care, and voluntarism. CONCLUSIONS: Future development and mainstream integration of peer support work must reconcile current tensions between standardization and loss of

authenticity. Training in communicating the lived experience, setting boundaries and self-care are important steps forward.

Rogers, E. S., M. Maru, G. Johnson, J. Cohee, J. Hinkel and L. Hashemi (2016). "A randomized trial of individual peer support for adults with psychiatric disabilities undergoing civil commitment." *Psychiatric rehabilitation journal.* 2016;39(3):193-196. OBJECTIVE: Given the proliferation of peer-delivered services and its growing but insufficient empirical base, we undertook a randomized trial to examine the effects of such services on individuals with severe psychiatric disabilities undergoing a civil commitment. METHOD: We recruited n = 113 individuals who were civilly committed for inpatient treatment. Randomly assigned experimental participants were paired with a trained peer specialist to receive intensive 1-on-1 support to assist them with both their recovery and the conditions of their mandated court-ordered services. Individuals in the control group were invited to receive other supportive, peer-delivered services, such as social and group educational activities, but excluding individual peer support. We assessed a variety of outcomes including social supports, quality of life, recovery, symptoms, and functioning. RESULTS: Mounting a randomized trial in this setting and with participants who were court-ordered for inpatient treatment proved challenging in terms of recruitment, service provision, retention in the intervention, and attrition from the research. Intent-to-treat analyses revealed no significant differences in outcomes by study condition. As-treated analyses comparing high- and low-use peer support groups with control group participants found significant differences favoring peer support recipients in quality of life and functioning but no differences in other study outcomes. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Difficulties with ensuring the quality of the peer support in this study may be in part responsible for our failure to see more-definitive and -positive results. As the peer support specialist profession evolves, an understanding of its effective ingredients and mechanisms must be elucidated to allow for more-rigorous studies.

Salzer, M. S., J. Rogers, N. Salandra, C. O'Callaghan, F. Fulton, A. A. Balletta, K. Pizziketti and E. Brusilovskiy (2016). "Effectiveness of peer-delivered Center for Independent Living supports for individuals with psychiatric disabilities: A randomized, controlled trial." *Psychiatric rehabilitation journal.* 2016;39(3):239-247. OBJECTIVE: The goal of this study was to examine the effectiveness of peer-delivered core services of Centers for Independent Living (CILs), which include advocacy, information and referral, skills training, and peer support. METHOD: Ninety-nine individuals with a schizophrenia-spectrum or affective disorder who identified at least 3 needs were recruited from mental health centers and randomly assigned to be contacted by a certified peer specialist at a local CIL (CIL condition) or services as usual (SAU condition). Data on community participation, recovery, empowerment, quality of life, and needs were obtained at baseline and 6 and 12 months post baseline, along with responses to open-ended questions about supports received. RESULTS: Participation in CIL supports was very

limited. No differences were found in repeated measures analyses (Time x Condition). Post hoc analyses did show some positive results for those in the CIL condition. More than half of CIL participants described obtaining a substantive support in at least 1 area, and almost half of these resulted in some tangible new resource. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Engagement in CIL supports was very limited, as were outcomes. Nonetheless, numerous examples of supports across a broad range of areas were reported along with examples of how needs were met. CIL supports, which are widely available around the United States, may offer a unique philosophy and approach for addressing the needs of individuals with psychiatric disabilities and are deserving of additional study.

Siantz, E., B. Henwood and T. Gilmer (2016). "Implementation of peer providers in integrated mental health and primary care settings." ***Journal of the Society for Social Work and Research.*** **2016;7(2):231-246.**

OBJECTIVE: Peer providers are essential to the delivery of recovery-oriented mental health services, but little is known about their roles in delivering integrated mental health and primary care services. This study examines how peer-based services are implemented in newly integrated behavioral health care settings in Los Angeles County, California. METHODS: During summer 2013, teams of 3 implementation monitors conducted full-day on-site program visits at 24 integrated behavioral health pilot programs. Site visits involved semi structured interviews with program staff members. Case study analysis was used to explore the implementation of peer services in newly integrated care programs. We report findings using the Consolidated Framework for Implementation Research. RESULTS: The integrated behavioral health teams at 14 integrated programs included peer providers. Variation in the definition of peer providers, their roles, and the extent of programmatic infrastructure to support their team involvement is identified across pilot program types. We find that in many programs designed for underserved ethnic communities, a climate of stigma regarding mental illness influences the inclusion of peer providers who have experienced mental illness. CONCLUSION: Enhanced training of peer providers in the intersecting areas of physical and mental health from a cultural perspective is needed to enhance the effectiveness of peer providers and increase community acceptance of their services. Promoting greater awareness of the critical nature of peer support services among other members of the integrated care workforce is also needed.

Silver, J. and P. B. Nemec (2016). "The role of the peer specialists: Unanswered questions." ***Psychiatric rehabilitation journal.*** **2016;39(3):289-291.**

TOPIC: This article raises questions regarding defining the role of peer specialists and related employment practices. PURPOSE: The questions raised may be used to guide future research. SOURCES USED: Areas needing further investigation were identified through personal and professional experience, discussions with colleagues, and a review of published literature on peer workers. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Questions are raised regarding the definition of "peerness"; the variety and

contradictions in definitions of the role of the peer specialist; existing and potential avenues for career advancement; credentialing standards; the design, implementation, and evaluation of existing and effective peer support service models, including integration of peer workers in other service models; and best practices for supporting the well-being of peer workers and their non-peer colleagues. More and higher quality research data are needed in order to inform and contribute to the use and support of peer specialists in promoting positive system transformation.

Swarbrick, M., T. P. Tunner, D. W. Miller, P. Werner and W. W. Tiegreen (2016). "Promoting health and wellness through peer-delivered services: Three innovative state examples." *Psychiatric rehabilitation journal.* 2016;39(3):204-210.
OBJECTIVE: This article provides examples of the development, implementation, and funding of peer-delivered health and wellness services in three states. Health and wellness services are critical to addressing the health disparities facing people living with mental health and substance use disorders served by the public behavioral health care system. METHODS: Information was compiled from the authors' experiences as champions in three states (Georgia, Michigan, and New Jersey) and the National Association of State Mental Health Program Directors, as well as documents from and discussions with local state and national sources. RESULTS: Key issues for the implementation and expansion of peer-delivered health and wellness services include defining the model to be disseminated, providing training to prepare the peer workforce, accessing funding for implementation, and establishing clear expectations to sustain the services and maintain quality over time. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Peer-delivered health and wellness services can help address the health disparities facing people who are living with mental health and substance use disorders through a variety of innovative models tailored to local needs and circumstances.

Vandewalle, J., B. Debyser, D. Beeckman, T. Vandecasteele, A. Van Hecke and S. Verhaeghe (2016). "Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review." *International Journal of Nursing Studies*. 2016;60:234-250.
OBJECTIVES: To identify peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services. DESIGN: Review of qualitative and quantitative studies. DATA SOURCES: A comprehensive electronic database search was conducted between October 2014 and December 2015 in PubMed, CINAHL, Web of Science, The Cochrane Library, and PsycARTICLES. Additional articles were identified through hand search. REVIEW METHODS: All articles were assessed on quality. A thematic analysis informed by a multi-level approach was adopted to identify and discuss the main themes in the individual studies. Reporting was in line with the 'Enhancing transparency in reporting the synthesis of qualitative research' statement. RESULTS: Eighteen articles met the inclusion criteria. All studies adopted qualitative research

methods, of which three studies used additional quantitative methods. Peer workers' perceptions and experiences cover a range of themes including the lack of credibility of peer worker roles, professionals' negative attitudes, tensions with service users, struggles with identity construction, cultural impediments, poor organizational arrangements, and inadequate overarching social and mental health policies. CONCLUSIONS: This review can inform policy, practice and research from the unique perspective of peer workers. Mental health professionals and peer workers should enter into an alliance to address barriers in the integration of peer workers and to enhance quality of service delivery. Longitudinal research is needed to determine how to address barriers in the implementation of peer worker roles.

Vayshenker, B., A. L. Mulay, L. Gonzales, M. L. West, I. Brown and P. T. Yanos (2016). "Participation in peer support services and outcomes related to recovery." ***Psychiatric rehabilitation journal.*** **2016;39(3):274-281.**

OBJECTIVE: This article presents findings from a naturalistic study that explored the impact of peer support participation on recovery-related outcomes over a 6-month period. In particular, this study hoped to fill gaps in the literature regarding the process through which personal change occurs in peer support organizations. METHOD: Fifty people newly involved in services provided by Baltic Street AEH (Advocacy, Employment, Housing), a consumer-operated organization, participated in the study. Participants were interviewed at entry and 3- and 6-month follow-up. Attendance records were reviewed to determine the number of days attended, and the sample was divided into two categories: minimal or non-attenders (n = 25) and moderate or high attenders (n = 21). The relationship between attendance and outcomes related to recovery over time was examined using a mixed effect regression analysis, allowing data to be included for participants with at least 1 follow-up interview (n = 38). RESULTS: Relative to minimal or non-attenders, moderate or high attenders showed statistically significant improvements over time in internalized stigma, self-esteem-self-efficacy, and community activism-autonomy. No statistically significant differences were observed between groups in hopelessness, social functioning, symptom severity, coping with symptoms, or substance use. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: This study demonstrates the potential impact of engagement in peer support services on some subjective aspects of mental health recovery. Namely, change mechanisms could be hypothesized to include identity transformation (from patient to peer). Future directions should continue to investigate potential mechanisms of change with larger samples in randomized studies.

