Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment

13. Peer Delivered Services
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Overview

This module presents a discussion and review of services delivered by consumers who have recovered sufficiently to use their experiences to be of help to others with similar illnesses. There are several different kinds of peer delivered services and these are presented in this module. There are many terms used to refer to services provided by peers and this module attempts to clarify these to the extent possible. Most often individuals who offer services to consumers are referred to as peer providers and that connotation is used in this module except where the person is engaged in the particular service model known as peer support. In this case, the provider is referred to as a peer support worker or as peer support personnel. There are other titles used such as peer specialist, but this can connote a Certified Peer Specialist who has received a certain kind of training and is certified. Not all peer support personnel are certified; thus peer support worker or personnel are used.

Peer delivered services are relatively new in the mental health service delivery arena, although these services have proliferated across the U.S. Consequently, research on the various models is fairly recent and some reviews of the individual studies have been completed recently. Findings from these reviews along with the issues and challenges of implementing peer delivered services are presented.

Learning Objectives

At the end of this module you will be able to:

- Describe at least two of the different models of peer delivered services
- Identify three characteristics of peer support
- State three key research findings related to peer support and peer delivered services; include findings for individuals receiving services from peers, findings related to peer providers, and finding related to service systems
- Describe two issues that must be addressed to implement peer delivered services

Resources

- Lecture Notes
- Required Readings
- Lecture Notes Citations
- Sample Learning Activity
- Sample Evaluation Questions
- Additional Resources
Required Readings


Activities

Complete the following activities:

- Read the lecture notes
- Read the required readings
- Engage in a learning activity related to this module
- Evaluate students’ understanding of this module.
Lecture Notes

People with lived experience of serious mental illness are strongly encouraged to be part of the delivery of the curriculum including being active participants in the delivery of the lecture. Refer to the curriculum Instruction module for additional information.

Introduction

Participation of consumers in the design, delivery, and evaluation of mental health services is one of the hallmarks of a mental health system that truly supports the principles of recovery. In the U.S., programs and services offered to consumers by their peers have surpassed the number of professionally operated programs (Goldstrom, Campbell, Rogers, Lambert, et al., 2006).

Peer providers may be current or former users of the mental health system, who have achieved a level of recovery that allows them to be helpful to others going through the recovery process. People with lived experience of mental illness consistently report that having the support of others who have experienced what they are going through is one of the most important and helpful services. Several studies have confirmed these perceptions of their experiences (Dumont & Jones, 2002; Nelson, Ochocka, Janzen & Trainor, 2006; Piat, Sabetti, Couture, Sylvestre, et al., 2009).

Models of Peer Delivered Services

There are many different types of services that peers offer and there is overlap among the types of services both in the literature and in practice (Chinman, George, Dougherty, Daniels, Ghose & Swift, 2014). While they all involve some level of help or support from a peer, the various services have been differentiated by characteristics such as where they are delivered, how the service is managed, whether or not the service is part of a traditional mental health system, and the role that the person is performing.

This is an emerging area of service delivery and the extant literature often discusses different models in similar ways. Many categorizations of the various services could be offered - one delineation of peer delivered services is as follows:

- Peer led self help interventions that can involve sharing experiences, offering information, e.g., in a mutual support education group, or teaching others how to develop a recovery plan such as a Wellness Recovery Action Plan (WRAP) (Copeland, 2002)
- Telephone services such as a “warm” line
- Peer operated and managed services
- Traditional mental health services such as case management delivered by peer providers within the mental health system
• Peer support programs, offered as an individual or group service most usually within a traditional mental health service, although the service can be provided by an agency outside the mental health system.

The following information clarifies the different models to the greatest extent possible.

Peer Led Self-help Interventions

Peer led self help interventions can include a variety of formats; two that have been discussed in the literature include 1) groups to help others learn about their illness and develop wellness activities and strategies and 2) mutual support education groups.

Peer Led Recovery Education Groups

Anyone who has ever experienced a serious illness recognizes the value of learning about the illness and developing tools to stay healthy and cope with symptoms that may recur. Peer led recovery education groups can be very useful for helping people learn about wellness activities, the importance of good nutrition, stress management techniques, and community resources that are available. Wellness management and recovery groups (sometimes referred to as illness management and recovery) and educational activities such as Pathways to Recovery (Ridgeway, McDiarmid, Davidson, Bayes & Ratzlaff, 2002) are examples.

Another example that has become widely utilized is a recovery action planning tool that is considered highly useful because it can facilitate action by the person to identify and notice triggers or symptoms that are becoming more pronounced. It can also facilitate action by the person’s support network when they notice that the person is in need of assistance. A clinician’s treatment planning efforts ought to be directly informed, and can be facilitated by, such personally developed recovery plans. A recovery action plan can include items such as reminders about triggers, activities to stay healthy, a crisis plan, and instructions given by the person about actions to be taken by supporters when certain conditions are met. The most well known recovery action plan is WRAP (Copeland, 2002), and research has shown that people who have developed a WRAP have reported significantly increased awareness of early warning signs, awareness of symptom triggers, increased use of wellness tools, increased likelihood of having a crisis plan in place, and increases in having a social support system (Cook, Copeland, Corey, Buffington, et al., 2010).

Mutual Support Groups

As with other support groups, i.e., disorder specific support groups (cancer, cystic fibrosis, multiple sclerosis, etc.), or mutual support education groups can be a venue for giving and receiving support, gaining new knowledge about a wide array of topics from housing to new services, to tools to remain well, etc. Just as with other support groups, a support group for people with mental health disorders can be face to face or can be internet based. Studies have found that participants report positive outcomes including improved functioning and illness management, increased self esteem and self efficacy, increased
feelings of optimism and social support, and reduction in self reported symptomatology (Christensen & Jacobson, 1994; Fukui, Davidson & Rapp, 2010; Powell, 2001; van Gestel-Timmermans, Brouwers & van Nieuwenhuizen, 2010).

**Telephone Services Such as a Warm Line**

A relatively new service that is available in some locations for people in recovery is called a warm line. A warm line can be used when someone is in crisis, but is more often thought of as a service that people can call to obtain support, alleviate loneliness, and obtain help with symptom management. Often warm lines operate after traditional services have closed, i.e., after normal business hours, and are staffed by trained peer providers who have access to an on-call supervisor for those calls that present an emergency or crisis situation. Although research is limited, one study has found that users reported substantially reduced need for crisis services, increased sense of well-being (defined as increased ability to function well) and increased sense of personal empowerment (Dalgin, Maline & Driscoll, 2011).

**Peer Managed and Operated Services**

Services that are wholly managed and administered by people with lived experience of serious mental illness are another category of peer delivered services. These services are not affiliated with a traditional mental health service and may have people who have not experienced a serious mental illness within the organization. The key point is that decisions are made by peer providers who “own” and operate the service rather than by non-peers who may happen to work in the program (Substance Abuse and Mental Health Services Administration, 1998; Solomon & Draine, 2001). Often these programs are freestanding entities and have both paid staff and volunteer staff. These services can take any form and common examples include drop-in centers, clubhouses, crisis services, educational and employment services, and peer support programs (Solomon, 2004).

**Traditional Mental Health Services Such as Case Management Delivered by Peer Providers**

Increasingly, people with lived experience of serious mental illnesses are working within traditional mental health systems, serving in a variety of staff roles. A common example is case management, but individuals with lived experience are also working in a wide range of other professional positions. In some cases, these individuals have disclosed their mental health history; in other cases, they have not and choose to keep their health information private.

While those individuals who have disclosed their history may be able to provide support to their clients, they are generally not considered to be providing peer services if they are providing traditional mental health services because their primary function is to fulfill their staff role, i.e., as a case manager, social worker, psychologist, psychiatrist, administrator, etc., rather than to provide peer services.
Peer Support Programs

Peer support programs within a traditional mental health service are increasingly recognized as an important component of the service; there are also independent peer support agencies that can be contracted to offer the service outside the formal mental health system. Because of the value attached to the service by consumers, peer support is increasingly available in many countries around the world.

As mentioned, there are many models of service delivery where peers provide services to others with similar mental health conditions, and there is overlap among the models (Chinman, George, Dougherty, Daniels, et al., 2014). One way of distinguishing between these has been proposed by Davidson and his colleagues (Davidson, 2010; Davidson, Chinman, Sells & Rowe, 2006), and involves the issue of reciprocity, or the benefits that accrue to the provider versus the recipient of services. In this conceptualization, the peer support worker is not the beneficiary of service provision, i.e., does not receive reciprocal benefit from helping his or her peer, at least not to the extent that one would benefit from a mutual support group for example. Davidson has characterized this as “involving an asymmetrical—if not one-directional—relationship, with at least 1 designated service/support provider and 1 designated service/support recipient” (Davidson, 2010).

The graphic below depicts this with the varying relationships that can operate within the service delivery system.

A Continuum of Helping Relationships among Adults with Serious Mental Illness

Source: Davidson, L. (2010).

Because of the prevalence of peer support services, principally operating within mental health service delivery systems and the interest in the benefits they have for other consumers, the focus of the remainder of this module is primarily on these services.
There are several definitions of peer support including the following:

...as involving 1 or more persons who have a history of mental illness and who have experienced significant improvements in their psychiatric condition offering services and/or supports to other people with serious mental illness who are considered to be not as far along in their own recovery process (Davidson, Chinman, Sells & Rowe, 2006).

...peer support, understood as a sharing of personal experiences and provision of mutual aid, encouragement of self-determination and personal responsibility (Salzer, Schwenk & Brusilovskiy, 2010).

The following elements are generally considered to be common to peer support services:

- A person with lived experience of severe mental illness works with one or more people with a similar illness and or similar experiences providing hope, support, encouragement, information, education, role modeling, and mentoring;
- The peer support worker is a current or former user of mental health services and is further along in his or her recovery, having overcome many of the barriers of living and working in the community to be able to be of assistance;
- The peer support worker discloses his or her status as a person with lived experience of serious mental illness and shares information about how he or she has learned to cope, make progress in recovery, and deal with various situations as they arise;
- The peer support worker offers “conditional regard”, i.e., acceptance of the person within an empathic framework while helping the person accept responsibility for taking charge of his or her health and life;
- The peer support worker is paid for his or work and is most commonly part of the mental health staff although peer support workers may at times provide services in an independent organization (Davidson, Bellamy, Guy & Miller, 2012; Davidson, Chinman, Sells & Rowe, 2006; Salzer, Schwenk & Brusilovskiy, 2010).

Unfortunately, peer support personnel are not always paid appropriately for the service provided and are sometimes relegated to performance of tasks that are not the purview of peer support workers (Gates, Mandiberg & Akabas, 2010). These issues are discussed further in later sections of this module.

**What Peer Support Workers Do**

Peer support workers assist consumers who are striving to recover from the effects of their illness. Some of these effects are impairment or disability, deterioration in physical health, institutionalization, homelessness, unemployment, poverty and involvement in criminal justice systems. Peer support workers listen, share their own experiences, and offer support, hope, encouragement, education, and practical suggestions. Peer support workers can perform a variety of services from mentoring by offering advice and modeling
approaches to attaining goals, teaching skills and behaviors for managing illness and remaining well, taking personal responsibility and achieving success in the community, and providing practical assistance with housing, medication, entitlements, schooling, employment, etc. (Davidson, Chinman, Sells & Rowe, 2006; Salzer, Schwenk & Brusilovskiy, 2010).

Peer support programs, like other peer delivered services, are provided by individuals who have experienced a serious mental illness and who have recovered sufficiently that they can be helpful to their peers who have similar problems. Peer support workers can work individually or in groups, and can also provide help and supportive services in the community. Peer support workers are employed in a variety of program settings including case management, psychosocial programs, supported education and employment programs, clubhouses, recreation and leisure programs, to name but a few.

**Benefits of Peer Support**

Since the introduction of peer support services in the early 1990s, there has been considerable interest in determining the benefits that consumers might receive from them. A brief summary of what has been learned to date follows.

**Benefits for Recipients of Peer Support**

There have been several reviews of the published literature on peer support and while there is overlap in the models and services studied, there is presently a fair amount of consensus about the beneficial effects of peer support and peers as providers of other services such as self help and educational groups. While individual studies and reviews of those studies have not shown differences in traditional outcomes (employment, housing, etc.), benefits for people receiving peer support have been demonstrated. Additionally, there are benefits for consumers who serve as peer support personnel. As mentioned, there is frequently overlap between the models and services studied or reviewed but some conclusions can be drawn about the benefits of receiving services from a peer. A brief review of some of the more salient findings follows.

*Engagement and Retention in Treatment*

One of the most consistent findings from the reviews of studies done to date is that there are benefits for consumers who receive peer support services as they are likely to become more engaged and more involved in their treatment and their retention in treatment may be more likely; this seems especially true for people who might not normally be likely to engage in treatment (Repper & Carter, 2011; Rogers, Kash & Brucker, 2009). In some studies, effects tend to disappear after a period of time (six to twelve months) (Jewell, Davidson, & Rowe, 2006; Sells, Davidson, Jewell, Falzer, et al., 2006). As stated by Davidson and colleagues:

> In terms of possible active ingredients, these findings appear to support peer providers’ abilities to forge effective and stable working alliances early in the
treatment process with clients typically viewed as among the most disengaged from traditional approaches to care. Consistent with earlier suggestions of Solomon and colleagues (1995), these findings also suggest that differences between relationships with peer specialists and those with regular case managers may tend to surface early in the engagement process and eventually dissolve over time, as non-peer providers “catch up” in forming stronger working alliances with their clients (Davidson, Chinman, Sells & Rowe, 2006).

Peer support workers may be better able to communicate acceptance, understanding, hope and positive regard which helps their clients to be more accepting of treatment and ultimately more motivated to use community services that are peer based (Davidson, Chinman, Sells & Rowe, 2006; Repper & Carter, 2011). For consumers who are alienated from the mental health treatment system, facilitating engagement and retention in services would seem to be important for recovery.

**Longer Community Tenure between Hospitalization and Fewer Days in Hospital**

Another often reported finding is that for individuals with frequent hospitalizations, effects such as reduced time to re-hospitalization and fewer days in hospital when hospitalization did occur have been found, although some of these studies involved using peers as case managers, rather than as peer support workers (Davidson, Bellamy, Guy & Miller, 2012; Repper & Carter, 2011; Simpson & House, 2002; Solomon, 2004). There have also been individual studies that have shown similar effects and a recent study that has found decreased levels of depression and increases in hope, self-care, and sense of well-being (Clarke, Herincks, Kinney, Paulson, et al., 2000; Sledge, Lawless, Sells, Wieland, et al., 2011).

**Symptom Stability, Self-Esteem, Empowerment, Coping Skills, Social Support**

Additionally, findings from reviews of individual studies indicate that for those who regularly engage in peer delivered interventions in a group context such as a mutual support group, benefits are seen in such areas as symptom stability, abstinence from substance abuse, self esteem, self efficacy, empowerment, quality of life, perceived social support, satisfaction with services, coping skills, medication adherence, reduced criminal justice involvement, greater social support and more friends, and greater integration into their community (Repper & Carter, 2011; Rogers, Kash & Brucker, 2009; Salzer & Mental Health Association of Southeastern Pennsylvania Best Practices Team, 2002; Solomon, 2004).

**Cultural Sensitivity and Hope, Illness Management and Satisfaction**

Finally, a recent area of investigation that had been ignored in the literature until recently is the potential benefit of providing peer support services in a culturally sensitive environment. One recent study that investigated the benefits of culturally responsive peer providers found that helping people pursue desired community activities and roles in addition to providing illness management and recovery in a person centered treatment modality led to an increase in hope and engagement in managing their illness, positive
feelings of self and life, satisfaction with family life, social support and sense of community belonging, and decreased psychotic symptomatology (Tondora, O’Connell, Dinzeo, Miller, et al., 2010).

**Facilitation of Community Integration**

Although infrequently mentioned, a benefit of including peer workers in mental health services is that peers can also enhance social networks and facilitate the integration of individuals with serious mental illnesses into all aspects of their community. Salzer and colleagues highlighted several reasons for this, including the following:

- Peers believe in self-determination
- Peers understand environmental barriers (i.e., poverty, transportation, prejudice and discrimination)
- Peers do not have as many pre-conceived notions about what they should be doing and how they should be doing it as traditionally trained practitioners often do (Salzer, Baron, Menkir & Breen, 2013).

Clearly, helping individuals to be connected to friends, family, and their community is facilitative of recovery and using peers to help achieve this goal may be one of their most important potential contributions, not only for those receiving services but for the community as well.

**Benefits for Peers Providing Services**

Peers working as peer support workers have reported increased confidence in their abilities, increased ability to cope with their own illness, and increased self esteem, sense of empowerment and hope (Repper & Carter, 2011; Solomon, 2004). These findings are not surprising as the identified benefits are not dissimilar to those experienced by most people who work in an occupation that is perceived as valued and enjoyable.

**Service System Benefits**

Benefits have been reported for service delivery systems as well. Other professionals working along side peer providers see them functioning successfully and have increased respect for their peer workers, and stigma, negative attitudes, values and beliefs that many professionals continue to have about people with serious mental illnesses can be dispelled (Repper & Carter, 2011; Solomon, 2004). Longer lengths of community tenure and shorter hospitalization stays may equate to reduced costs for the system and these monetary benefits of utilizing peer support services may produce overall health care savings and contribute to the overall ability of the service system to meet the needs of the community (Davidson, Bellamy, Guy & Miller, 2012; Solomon, 2004).
Implementation Considerations

The U.S. Department of Health and Human Services’ Centers for Medicare and Medicaid Services now reimburses for peer support services delivered by peer providers. As of 2014, thirty-five states receive Medicaid reimbursement for these services (Insidehealthpolicy.com, 2014). Many other states also provide peer support services within their mental health systems and do so without federal reimbursement.

In order to be eligible for Medicaid reimbursement, states must meet several criteria related to training and supervision requirements. States have flexibility in how they meet these criteria, but competency must be assured (U.S. Department of Health and Human Services, 2007). In order to meet the Medicaid requirements, several states have adopted versions of the Certified Peer Specialist (CPS) training program. These training programs address topics that are important for implementation of peer support services such as communication skills, group facilitation, recovery planning, illness management, confidentiality, dual relationships, and other areas that peer support workers need to perform well. Not all peer support workers are Certified Peer Specialists and those providing peer support services have various titles including peer provider, peer support worker, peer specialist, etc.

Some of the most difficult issues faced by service providers and peer support providers relate to confidentiality, boundaries, and dual relationships. A variety of reasons contribute to the difficulties encountered including the fact that the community of people with serious mental illnesses is usually a small one, even in relatively large cities. Peer providers are usually acquainted with, or are friends of consumers that they also have a professional relationship with, and the peer provider and the consumer may also be in educational or treatment groups together. Another contributing factor is that mental health agencies often do not understand the issues involved and fail to provide suitable training and adequate supervision for peer as well as non-peer provider staff (Gates, Mandiberg & Akabas, 2010).

In addition to the topics noted above, there are also administrative issues that must be addressed such as hiring requirements, adequate pay, training, supervision, creating an accepting environment, gender and cultural issues, etc.

Although not easily differentiated, these topics are divided into two categories for this discussion, personal issues and administrative issues. The topics below are also discussed in several of the required readings. See for example, Davidson, Bellamy, Guy & Miller, 2012; Repper & Carter, 2011; Salzer & Mental Health Association of Southeastern Pennsylvania Best Practices Team, 2002.

Personal Issues

Confidentiality

As mentioned, in small communities, and often in large cities, persons with lived experience of serious mental illness know one another – it is a small community of people
that can be fairly close knit. Thus, when one person becomes a peer support worker working within the mental health system, there can be cause for concern about sharing of information.

Role Identity and Boundaries

One of the essential elements of the peer support relationship is the peer support worker’s disclosure of his or status as a person with lived experience and the sharing of information about how he or she has learned to cope, make progress in recovery, and deal with various situations as they arise. This sharing of one’s self is critical to the relationship and yet creates boundary issues due to the fine line between being someone who discloses information about his or her own illness and struggles, and is at the same time, a helping professional.

For example, peer supporters often find themselves in the same social milieu (e.g., at the same drop in center, or at the same social gathering) as current or former consumers with whom they have worked, or are working, and this presents considerable confidentiality and boundary concerns. In such cases, confidentiality needs to be respected but at the same time, the peer supporter needs to demonstrate friendliness and model good social skills while not disclosing the nature of the professional relationship. This can be especially difficult if the service recipient and peer support worker are known to have been friends for some period of time. As with other mental health professionals, considerable skill and ongoing supervision are important for peer support personnel.

Ideally, supervision of peer support personnel would be provided by trained and experienced peer support personnel. Presently, there are not national standards for training or supervision and this can limit the availability and suitability of supervision possibilities. Where trained, experienced peer support supervisors are available, they should be utilized to provide on-going supervision.

Dual Relationships

Relatedly, the issues of sexual partnerships and developing friendships, can be very difficult, again because of the closeness that develops when two people share very personal and sometimes intimate details of their lives. There are some very difficult questions that should be discussed openly including the following:

- How should existing friendships be handled? Should they be maintained when working in an agency that provides services to the friends of peer workers?
- How can peers succeed in being “friendly” toward their clients without actually becoming friends with them? Regardless of its importance to the agency, is this a distinction that even makes sense to the clients?
- Can peer staff accept reciprocal support offered to them by the people they serve? If not, then does this not move them closer to behaving and functioning like non-peer staff?
Like all mental health staff, peer support personnel work in a position of trust with vulnerable people. Although friendships can sometimes develop this is often discouraged but may have an impact on a consumer who wants to develop or maintain a friendship with the peer support worker and does not understand the professional role and boundary issues of the peer support worker. As with all other mental health staff, sexual relationships between peer supporters and consumer clients are unethical and are not permitted. As with all mental health staff, supervision is critical to assisting peer support staff to navigate through these and other difficult situations.

**Administrative Issues**

*Hiring Requirements*

Although training in communication skills, confidentiality, dual relationships, etc., is unquestionably necessary, there are currently no federal standards regarding what is required and there are no standard education or previous experience requirements or recommendations that are recognized nationally. The InterNational Association of Peer Supporters (iNAPS) has developed a training curriculum for peer specialists as part of the U.S. Substance Abuse and Mental Health Services Administration’s (SAMHSA) Recovery to Practice initiative (the initiative that funded development of this APA curriculum). Additional information can be obtained from the iNAPS website at [www.inaops.org](http://www.inaops.org).

While there are no national standards at this time, most agree that peer support personnel should receive training in communication, confidentiality, issues around dual relationships, working with trauma survivors, disclosure, provision of education and support, etc. Mental health managers and administrators also need training to understand the difficult situations that arise for peer support workers. As mentioned, on-going supervision is essential for all mental health staff, regardless of their professional training or experience.

*ADEQUATE COMPENSATION*

Other administrative issues revolve around the tasks that some peer support staff are asked to perform and compensation received for work as a peer support worker. In many mental health systems where peers are employed, peer support workers receive minimum wage or just slightly more than minimum wage. Partly this is because many peer support workers do not have formal education beyond the high school level and partly it is because of the sub-professional tasks that they are often asked to perform in addition to their peer support duties. Peer support personnel are frequently asked to carry out tasks that support other staff and that are usually thought of as secretarial or support tasks, such as transporting clients, arranging meetings, etc. This is demeaning and these duties detract from the essential role of a peer support worker. The practice of treating peer support workers as sub-professional workers should not be acceptable or tolerated. As might have been observed from the discussion of the personal issues noted above, peer support work can be very difficult: emotionally draining, clinically challenging, and personally difficult. Peer support personnel need to be adequately compensated based on the difficult nature of the
work they perform rather than on the education and experience qualifications they bring to the position. Mental health managers and administrators need to be informed and receive training about the difficult nature of peer support work so they can appropriately address these issues (Gates, Mandiberg & Akabas, 2010).

Cultural Competence, Gender Considerations, and Trauma

The issue of matching clients with peer support workers based on gender and or racial or ethnic background is one that requires an open discussion with each client, the peer support worker, and the supervisor. There are times when such matching may be desirable but there can also be times when it would be better for the client and the peer support worker to experience a broader range of cultural and gender backgrounds. There is no generally accepted practice at present and each situation will require a discussion about the potential benefits and challenges of each scenario.

The issue of trauma is considerably different, and extremely important and complex. Due to the essence of peer support work, i.e., sharing of one’s personal experiences, an important consideration is matching peer supporters with consumer clients by gender, especially where either the client or the peer support worker has been abused and suffered trauma. Good supervision by a well-trained clinician who can be of help to both the client and potentially the peer support worker is essential.

First and foremost, where a client has been abused by a member of the opposite gender, assignment to a peer support worker of the same gender as the abuser would not be appropriate. At the same time, provision of trauma services by an expert clinician is critical and should be part of every mental health service delivery system (a thorough discussion of these issues is provided in the Interventions III module of this curriculum). Similarly, it would be important to ensure that a peer support worker who experienced abuse has worked through those experiences sufficiently to maintain his or her own stability and be of help to a client from the gender of the abuser.

Relatedly, a peer support worker who has experienced severe trauma may not wish to, or be able to support another person when discussions about the trauma experience come up, which will likely happen even though the peer support process is not a clinical treatment process. This is an important issue that should be discussed openly with the peer support worker each time a new assignment of a client is to be made. Where a peer support worker believes it would risk his or her mental health stability if assigned a client with severe trauma, assignment of the new client should be made to a different peer support worker. It cannot be overstated that clinical services to work through trauma, provided by highly trained clinicians, should be available to all who need them.

Given that abuse and trauma have been experienced by many with serious mental illnesses, this is an issue that will likely come up frequently and must be addressed openly and sensitively in order to avoid re-traumatizing those involved. As stated, expert clinical services and supervision are essential.
Creating an Accepting Environment

A question that was raised several years ago when the concept of peer support services was initially introduced, and would still be raised by those resistant to the idea of employing people with lived experience as providers of service, is whether or not such services have a detrimental effect on users of the service. Consistently, studies have found that using peers to provide services, either traditional services such as case management or peer support services, did not have a detrimental effect on the person being served (Davidson, Bellamy, Guy & Miller, 2012; Davidson, Chinman, Sells & Rowe, 2006; Repper & Carter, 2011; Rogers, Kash & Brucker, 2009; Solomon, 2004) and in fact, consumers consistently report that they highly value the service. These findings are robust and should dispel any doubts that might remain about the viability of using peers to provide peer support or traditional mental health services.

Despite these robust findings, considerable resistance remains with regard to hiring people with lived experience into the mainstream of the treatment setting. As Davidson and colleagues (2012) point out, this resistance takes several forms including questions about possible stress related relapse, ability to handle the workload, etc. Existing staff may have many legitimate questions and these should be discussed openly. Clinicians can be worried about losing status or working alongside, and as an equal with, a person they may have treated not so long ago, or may still be treating. However, questions about the possibility of relapse, stress, etc., are discriminatory and are no more acceptable than they would be if an individual with a physical illness were being considered for a staff position and such questions were raised.

Discussing the questions and concerns that existing staff have is an important step toward creating an accepting environment where concerns can be raised by all involved staff, including peer support workers once they join the team. Ensuring open communication and appointing a senior member of the staff who will support and champion both the concept and the peer support workers can also facilitate acceptance by less senior staff.

Adequate Supervision

An important component of the plan for adding peer support personnel is to ensure that provisions for adequate supervision are in place. Considering the very challenging work that peer supporters do and the fact that they themselves have serious mental illnesses, adequate support and supervision may be one of, if not the most important component for success. As mentioned, every effort should be made to have supervision provided by experienced peer support personnel rather than by non-peer clinicians or managers. Where issues related to trauma are concerned, both highly trained clinicians and peer support supervisors may be needed.
Challenges

The challenges associated with provision of peer delivered services, principally peer support services offered within mental health service systems, are twofold: 1) how to conduct research to determine the efficacy of this rapidly expanding service with service/program models that frequently overlap with one another and or combine elements of different models, and 2) how to resolve the many difficult implementation issues that can hinder provision of the service.

With regard to the first challenge, people with lived experience of shared mental health problems consistently report that having the support and help of peers as they move through the recovery process is one of the best and most important components of their treatment experience. For this reason, it is important to determine the impact of peer support on treatment outcomes, but this has been difficult to do, in large part because the models of peer support are rarely “pure”. That is, they tend not to follow any prescribed protocol, making comparison among and between them and other services difficult. Even the term “peer support” is not used consistently in the literature, and does certainly not denote a consistent service model in practice. The practice is further complicated by the lack of standardization in education and training requirements, as differing levels of these background characteristics could influence the delivery of services and impact on service recipients.

With regard to the second challenge, the many unresolved administrative issues surrounding this relatively new service need urgent attention if the practice of peer support is to move forward as a respected service. Training needs to be standardized and education and experience requirements need be settled in order for the practice to gain legitimacy as a respected component of the service delivery system. Peer support workers need to be compensated adequately – minimum wage does not seem to be appropriate remuneration for individuals who must face, and resolve successfully, so many tremendously difficult issues. The situations peer support workers find themselves handling are as challenging, and perhaps even more so, than those faced by the average mental health practitioner. Figuring out how to compensate peer support personnel adequately – possibly on par with highly educated professionals – is a significant challenge indeed.

Adequate compensation is but one of the administrative challenges that need to be overcome. Issues around trauma of clients and peer support workers alike are extremely complex, important, and challenging. Clearly stated duties, deliverables, and expectations should be required components of the job description for peer support personnel. Overcoming the resistance from managers, clinicians, and others in the service delivery system will happen over time and possibly only when many of the other issues are resolved. However, given the importance users of the service system attach to the service, this would seem to be an important undertaking that needs to be attended to with some urgency.
Summary

In summary, peer delivered services, and in particular peer support services, are highly valued by people receiving services for serious mental illnesses. Benefits for people receiving the service have been shown, and peers delivering the service have reported that engaging in the provision of peer support is beneficial to them.

There are however, several challenges that must be overcome if peer delivered services, particularly peer support services, are to become a respected component of mainstream mental health service delivery systems. Given the rapidity with which the concept of peer delivered service has grown, the move to implement various forms of the service into service delivery systems, and the lack of standardization of hiring requirements, training, status, etc., fairly urgent attention should be given to resolving the difficult implementation issues that could ultimately hinder the successful integration of peer support services into service delivery systems.
Sample Learning Activity

The leaning activity is a role play situation. If the group is large, it should be divided into two smaller groups of about six or persons each. The consumers in the group will lead the activity.

Each of the participants will play the role of a professional in a mental health center and one participant will play the role of a consumer. There will be a psychologist, social worker, psychiatrist, nurse, occupational therapist, and recreational therapist plus a consumer. If there are not enough participants, one or two of the professional roles should be eliminated.

The situation is as follows. The psychologist has suggested that a peer support program should be initiated. The other disciplines are opposed. Some are afraid they will lose their professional status, some worry that they will not know how to work with individuals who have serious mental illnesses and who are professional co-workers, others believe that peer support workers will be vulnerable to becoming ill and this will create work flow problems. Other beliefs may come out as well.

All are to espouse their viewpoints and argue for their particular point of view, indicating why they feel as they do. The psychologist is to put forward opposing arguments to convince the others that starting a peer support program is the right way to go. The consumer is to state why he or she believes the new program will be beneficial for consumers.

Following the role play, the group is to process the feelings that they had and discuss their true beliefs about peer support programs and the role of peer support personnel within mental health service systems.
# Sample Evaluation Questions

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<tr>
<th>Question</th>
<th>Correct Answer</th>
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<tr>
<td>1. The following are current models of peers working in peer delivered services:</td>
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<td>a) mutual support group leaders</td>
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<td>b) warm line providers</td>
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<td>c) case managers</td>
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<td>d) peer support workers</td>
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<td>e) all of the above</td>
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<td>f) a, b, and d above</td>
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<td>2. Several essential elements of peer support are:</td>
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<td>a) individuals are current or former users of the mental health system with lived experience of serious mental illness</td>
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<td>b) individuals disclose their status as people with serious mental illness</td>
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<td>c) the peer supporter offers “conditional regard” for people he or she works with</td>
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<td>3. True peer support relationships are ones where the peer supporter receives as much support from the person he or she is supporting as the consumer client because the relationship is one of reciprocal support</td>
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<td>4. Research has consistently demonstrated that there are significant differences in outcomes associated with provision of peer support services, including better employment, housing, and recidivism rates for consumers who have received peer support services</td>
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<td>5. Peer support workers face considerable challenges with respect to navigating issues such as dual relationships, friendships and boundaries, etc., but they are compensated appropriately as professional members of the treatment staff and should be respected as full members of the treatment team</td>
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Lecture Notes Citations


**Additional Resources**

American Psychological Association Recovery to Practice Initiative.  

InterNational Association of Peer Supporters. [http://www.inaops.org](http://www.inaops.org)

Citing the Curriculum

Citation for this Module:

Citation for the full Curriculum:

For additional information, contact:
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