

Peer support for people with psychiatric illness: A comprehensive review



Psychotic Disorders: Comprehensive Conceptualization and Treatments

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Chapter:

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“When I was in the psychiatric unit, we, the patients, were the biggest support to each other. We helped each other out as the nurses sat behind the glass bubble.” (Guy, as cited in, Bellamy et al.¹)

Many former patients or individuals with lived experience of mental illness might say that peer support—individuals with lived experience of mental illness providing support to others with similar lived experiences—is nothing new, that it has been happening informally throughout history, as described in the preceding quote by one of the authors of this chapter. Some might say that it is natural for humans to relate to individuals with similar lived experiences and for mutual support to occur because of those shared experiences. In fact, when we introduce peer support in presentations we often share the example of new parents who seek or are

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given support and guidance by more experienced parents to address daily childcare questions or concerns. What is new, since the 1980s, is the hiring of people with lived experiences as peer supporters in the behavioral health field to provide support to people with mental illnesses in formal mental health outpatient and inpatient facilities. Yale's Program for Recovery and Community Health (PRCH) has been at the forefront of the development and evaluation of peer support since the early 1990s, demonstrating that the involvement of those who have "been there" can be effective in engaging people, connecting them to needed services, and decreasing their use of substances and acute care while instilling hope, providing positive role models, and promoting engagement in self-care.^{1, 2, 3, 4, 5, 6, 7, 8} Peers can be instrumental in facilitating positive lifestyle and behavior changes and, by sharing their own "lived experiences," can help with motivation, coping, and illness self-management. While the use of peer support staff is still a relatively recent development, the US Centers for Medicare and Medicaid Services have added peer support to the menu of evidence-based and reimbursable services and peer health navigators are a key part of the person-centered behavioral health home model. Most states in the United States and some internationally, have developed a peer certification process to incorporate this relatively new and promising approach. This chapter provides an overview of peer support in formal roles within the behavioral and health workforce; it first provides an overview on what peer support is, why it is needed, and what it does to effect change; it then reviews the effectiveness research on peer support, specific duties/roles of peer supporters in practice, and ways to more effectively partner with peer supporters in the behavioral health field.

What is peer support?



Peer support generally falls in three broad categories: self-help groups, consumer operated services, and peer support providers.³ In self-help, mutual support groups such as 12-step meetings, peer support is marked by a mutuality where members who share similar mental health problems voluntarily offer and receive support from one another. Consumer-operated organizations offer services that are developed and run for and by people with mental illness; examples include clubhouses and drop-in centers, peer-run centers.^{9, 10} They serve as a forum for shared experiences, foster community, and promote group pride.¹¹ Meanwhile, peer support employees are individuals with lived mental health experience hired by organizations to work directly with individuals who may be seen as harder to engage or those needing more recovery-related supports promoting self-management strategies. In both mutual support groups and consumer-run organizations, relationships are viewed as reciprocal in nature and everyone benefits, providing the opportunities to give back and get something in return from a fellow peer.² However, mutual support and consumer-operated or peer-run groups or services have not been fostered in agencies in the same way.

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Relationships between peer support employees and the agency's clients/patients tend to be more formal and primarily unidirectional in nature, where the support is intended to help the client and not the peer provider specifically⁴ (see Figure 60.1: Davidson graphic from 2010). In these relationships, the peer support provider typically shares less detail about his or her daily life and does not actively seek the client's support and friendship. When peer support providers do share information, they tend to focus on their own recovery stories, pitfalls they experienced, and the active steps they took to achieve their goals.



Figure 60.1
Continuum of helping relationships.

Davidson (2010).⁶

Despite the one-sided direction of these relationships, the peer support providers themselves still benefit from their work, experiencing an increased sense of self-worth and purpose in life.¹² These effects are aligned with Frank Riessman's¹³ helper therapy principle, which contends that when an individual helps another person, the helper benefits as well.

Why is peer support needed?



Unfortunately, many people with psychiatric diagnoses have experienced social isolation, poverty, stigmatization, discrimination, and demoralization, due to a variety of reasons including negative societal views on mental health in the Western world.¹⁴ This stigmatization and discrimination is even more pronounced for people with diagnostic labels of schizophrenia and psychosis.¹⁵ While stigma campaigns have helped a little,¹⁶ for the most part, stigma and discrimination persists toward people with mental illness.¹⁷ In the United States, for instance, there remains an association between mental illness and violence even though research indicates that people with mental illness are at a higher risk of being victims of violence rather than perpetrators.^{15, 16} This is in part due to the public's perceptions of mental illness that often are reinforced

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through how mental illness is portrayed in the media.^{14, 18} Against the backdrop of misinformation, pessimistic prognoses, and destructive stereotypes, peer staff provide invaluable, concrete proof of the reality of recovery. They instill hope and support that recovery is possible and demonstrate to persons with mental health conditions, their loved ones, and mental health practitioners alike that it is decent and caring people who experience psychiatric and substance use conditions and who, with sufficient and appropriate support, recover from them as well. Peer supporters can be beneficial in assisting individuals because of their experiences dealing with similar experiences of stigma, discrimination, and demoralization as former patients of the mental health system and as survivors residing in the community.

Is peer support effective?



Studies on the use of peers in the mental health field have demonstrated that peer staff have an ability to reach people who have been otherwise seen as difficult to engage. In research conducted by PRCH, peer interventions have been associated with fewer hospitalizations, fewer days in the hospital, longer community tenure after hospitalization, increased hope, improvements in self-care, enhanced sense of well-being in patients, decreased drug and alcohol use, and improvements in quality of life.^{1, 2, 3, 4, 5, 6, 7, 8} Similarly, individual studies have shown that program participants interacting with peers experience longer community tenures with fewer hospital stays,^{19, 20, 21, 22} shorter hospital stays,^{19, 22, 23} and fewer emergency department visits²³ than those in treatment as usual. Studies also show no differences in rates of hospital admissions provided by peer supporters than care as usual^{24, 25} demonstrating outcomes that parallel those of professionally trained staff. Some studies also showed improved psychiatric symptomatology²⁶ and social functioning,^{26, 27, 28} improved quality of life,²¹ and increased treatment engagement.⁸ Research studies also indicate that peer support contributes to improvements in empowerment among clients^{29, 30} and an increased sense of independence and empowerment for both the clients and peer supporters.³¹ Furthermore, peer supporters themselves experience increases in self-esteem and self-confidence through their work supporting others^{32, 33, 34} and their non-peer colleagues develop increased empathy and understanding of their clients by working alongside peer providers.³⁵ While several studies demonstrate these positive outcomes, meta-analytic^{36, 37, 38} and systematic reviews;³⁹ describe a more complicated picture.

Pitt and colleagues³⁸ searched various registries and included 11 randomized control studies of consumers of mental health services employed as peer providers in mental healthcare settings from 1979 to 2012. They determined these studies were moderate to low in quality, citing various issues of research bias. They found that quality of life, symptom outcomes, satisfaction with treatment, number of hospital admissions, length of hospital stay, and other service use patterns for

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clients of teams with consumer-providers “were no better or worse” than outcomes achieved by professionals working in similar roles.³⁸ Lloyd-Evans and colleagues⁴⁰ conducted a systematic review and meta-analysis of 18 randomized trials of peer support interventions in nonresidential settings dating from 1982 to 2013. They determined there was little or no evidence that peer support was associated with positive outcomes for hospitalization, overall symptoms, or service satisfaction. Peer support was somewhat associated positively with hope, recovery, and empowerment, but not consistently within or across the different types of peer support. Fuhr and colleagues³⁷ conducted a meta-analysis of 14 randomized control studies from 1995 to 2012. While three of the studies revealed positive results on quality of life and hope, for the majority of the studies no effects were found that indicated peer services enhanced any of the outcomes studied.

Chinman and colleagues³⁶ identified 20 studies conducted from 1995 to 2012 focusing on peer support for adults with serious mental illness. Taking into consideration the range of methodological rigor, the most positive impacts were found among studies with peers added to services and with peers delivering structured curricula. Across studies peer-delivered services brought reduced inpatient stays, increased levels of empowerment, improved engagement with care, and increased hopefulness, among other recovery outcomes with one exception.³⁶ A quasi-experimental study conducted by van Vught and colleagues²⁶ found several positive outcomes with the exception of increased days hospitalized among clients working with peers on an Assertive Community Treatment team. Cabassa and colleagues⁴¹ conducted a systematic review of 18 studies dating from 1990 to 2015 focusing on health interventions for people with severe mental illness (SMI) involving peers. There were positive health outcomes related to self-management, dietary habits and communications with doctors, limited findings for physical activity, smoking, medication adherence, weight-related and cardiometabolic outcomes and mixed findings for quality of life, use of services, and self-related health outcomes. They found several methodological issues limiting the strength of the evidence and preventing the identification of the most beneficial interventions.

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Most recently, Bellamy and colleagues¹ conducted an updated review based on meta-analyses and systematic reviews along with additional studies not included in previous reviews. The authors acknowledge the methodological limitations with a number of the studies. However, with the exception of the van Vugt study noted by Chinman and colleagues,³⁶ they contend that the evidence still supports that peer services results in outcomes “at least equivalent” to traditional care and/or services provided just by non-peer providers.¹ They further maintain that the evidence is strongest for peer support impacting recovery-oriented outcomes such as hope, quality of life, and empowerment than traditional mental health outcomes such as symptom severity and hospitalization rates.¹

How does peer support work? Mechanisms of change



This question turns out to be complicated by a number of issues. Not the least of these complications is the fact that defining someone as a “peer”—which in this case means identifying someone as having a personal history of serious mental illness—tells us little about the person except for this one facet of his or her prior experience. As the idea of peer-provided services has spread, it has become more common for more experienced and established mental health professionals to disclose their own histories of mental illness; histories that in the past would have been kept private. While we have learned that peers can provide some conventional services as effectively as non-peers, what are the actual mechanisms at work?

Peer supporters help promote self-efficacy or belief in one’s own abilities by sharing experiential knowledge and by modeling recovery and coping strategies.³² Unlike traditional mental health practitioners, peer supporters disclose aspects of their illness and recovery stories and then draw on these experiences when working with their clients. They instill hope that recovery is possible and demonstrate that others, too, can and should assume more control over their lives.^{4, 9, 42} While the intention is to assist the agency’s clients and not themselves, the process of self-disclosure can lead to decreases in self-stigmatization and related improvements in quality of life and setting and achieving goals.⁴³

Peer supporters are role models for recovery; they offer a view of the paths and steps others can take to achieve it themselves.^{4, 9} With role modeling, behaviors are learned through observation. Albert Bandura’s (1977) social learning theory is based on the premise that a person identifies with a role model, and observes and then adopts the role model’s behaviors, values, beliefs, and attitudes. Rosenthal and Bandura (1978) further describe observational learning effects as new patterns that one can learn and adopt after watching a model demonstrate novel responses that are not part of the observer’s repertoire. Leon’s Festinger’s⁴⁴ social comparison theory offers additional insight into the psychological underpinnings of role modeling. It is based on the premise

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that individuals evaluate their beliefs and abilities by comparing themselves to others. Program participants can see themselves in peer supporters, compare themselves to them, and importantly see it is possible for them to achieve similar recovery goals. Anecdotally, peer supporters will often say they began working toward becoming a peer supporter after interacting with a peer supporter themselves.

Beyond being role models, peer supporters can further help service recipients to adopt new behaviors by encouraging them and helping them practice and refine these new skills. They offer real-world advice with managing symptoms, navigating complex service systems, living in poverty, and overcoming discrimination and stigma.^{2, 9} However, this guidance goes beyond practical advice; peer supporters help people get through difficult periods by providing support; relating to them; offering genuine empathy, trust, and acceptance; and communicating hope.^{2, 42, 45} As their connections deepen, they encourage taking personal responsibility for one's actions and reinforce their rights to self-determination.⁴⁶

Supported socialization activities allow individuals with serious mental illness to engage in their communities where they can experience caring, reciprocal relationships in which they themselves have something to offer others.⁵ In their roles in mental health programs, peer supporters are the ideal team members to offer structured opportunities and supports that assist people with psychiatric disabilities to actively participate in community life. Having lived experience, peer supporters can share stories about their own journeys to engage in their communities explaining the steps they took and lessons they learned along the way. They can assist their clients in identifying social goals and then explore community opportunities such as connecting with interest groups or joining a religious congregation, among others. Because they themselves have worked through obstacles, peer supporters can assist individuals in identifying emotional barriers such as anxiety they may experience about being accepted by these groups and structural barriers such as difficulties navigating public transportation. By accompanying them at these early stages and supporting them as they transition into their new roles in the community, peer supporters can help their clients engage in meaningful community life.

In summary, what, then, might be considered the unique contributions, or active ingredients, of peers as providers of peer support? As described in Figure 60.2, these contributions fall into three basic categories. The first is the instillation of *hope* through positive *self-disclosure*, demonstrating to the service recipient that it is possible to go from being controlled by the illness to gaining some control over the illness, from being a victim to being the hero of one's own life journey.^{47, 48} The second expands this *role modeling* function to include self-care of one's illness and exploring new ways of using experiential knowledge, or "*street smarts*," in negotiating day-to-day life, not only with the illness but also with the social and human service systems, with having little to no income, with

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being unstably housed, with overcoming stigma, discrimination, and other trauma, etc.^{48, 49} The third focuses on the nature of the relationship between peer supporter and recipient, which is thought to be essential for the first two components to be effective. This relationship is characterized by trust, acceptance, understanding, and the use of *empathy*; empathy which in this case is paired with “*conditional regard*”—otherwise described as a peer supporter’s ability to “read” a client based on having been in the same shoes he or she is in now. Their ability to empathize directly and immediately with their clients can be used in this particular way by peer supporters because they may have higher expectations and may place more demands on their clients, knowing that it is possible to recover, but also that it takes hard work to do so (e.g., “I know how you feel now, but I also know that you can have a better life”).^{41, 49} This may at times lead to conflict and confrontation, but also is just as likely, if not more so, to lead to encouragement and inspiration.^{3, 41, 49, 50, 51, 52, 53}

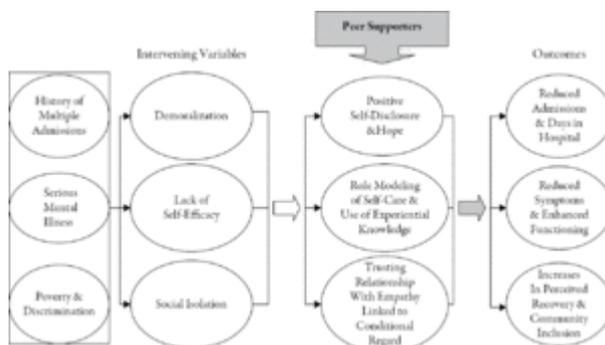


Figure 60.2
How peer supporters assist: mechanisms of change.

What do peer supporters do in practice?



At the root of peer support is the peer supporter’s ability to connect and develop relationships with other individuals in recovery. The connection is often established because of the feeling of commonality—we are in this together—that often comes from having had similar lived experiences. It’s a feeling of, “this person gets me.” Peer supporters are also taught to enhance their relational skills. Intentional peer support (IPS) is one mechanism that is currently being used with a focus on relational skills.^{45, 54} In PRCH’s previous studies on peer support the duties of the peer supporter (or as we defined the role, recovery mentor), were as follows:

Peer support is a combination of the theoretical foundation offered by IPS (focused on the principles and tasks: connection, worldview, mutuality, and moving toward⁵⁴ and the concrete interventions developed by the research team). In PRCH’s earlier work on this model, we suggested that

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peer supporters are guided by the following five principles: (1) The initial focus of care is on the person's own understanding of his or her predicament (i.e., not necessarily the difficulties that brought him or her to the mentor's attention), and on the ways in which the mentor can be helpful in addressing this predicament, regardless of how the person understands it at the time; (2) Regardless of whether or not the person sought help, the mentor recognizes that the mentee had already embarked on his or her own life journey before meeting him or her; (3) Rather than dwelling on the mentee's distant past or worrying about his or her long-term future, mentors focus on the next several steps of the journey; (4) A mentor's credibility and effectiveness are enhanced to the degree that he or she is familiar with, and can anticipate interesting sites, common destinations, and important landmarks along the person's way; and (5) Mentors prepare for their role by acquiring tools that will be effective in addressing or compensating for symptoms and other sequelae of the illness that act as barriers to recovery.⁵⁵ It was within this framework that we developed the interventions of person-centered care planning and community inclusion that were evaluated in the "Culturally-Responsive, Person-Centered Care for Psychosis" project.⁶ We combined these principles with that of Mead's work on IPS, which extends this model in several important ways. IPS is different from traditional service relationships because it does not start with the assumption of "a problem" that has brought the person to care.⁴⁵ Instead, mentors are taught to listen for how and why each person has learned to make sense of their experiences, and then to use the relationship to explore new ways of seeing, thinking, and doing. IPS also is sensitive to the prevalence of trauma in the lives of persons with mental illnesses, avoiding the implication that the person has done something "wrong" to require treatment, and instead asking the person about "what happened?"⁵⁴ and exploring alternative ways of dealing with what has happened. Instead of a focus on what the person needs to stop or avoid doing, mentors also encourage mentees to move toward what and where they would like to be. For one of PRCH's studies, we combined our earlier work with Mead's framework to train recovery mentors in the following three key areas described earlier, here listed in reverse order: (1) cultivating trusting relationships based on shared experiences, and characterized by acceptance, understanding, and empathy linked to conditional regard (incorporating Mead's concept of cultivating connections); (2) role modeling of self-care and use of experiential knowledge to explore new ways for the mentee to manage the mental illness and pursue personal goals (incorporating Mead's concepts of exploring worldviews and moving toward them); and (3) using positive self-disclosure to instill hope and restore the person's sense that he or she can make changes that will improve his or her life (incorporating Mead's concept of mutuality).

What happens at first contact is essential to developing intentional relationships between the peer supporter and the individual they are assisting. At the initial contact, the peer supporter explains his or her role and briefly shares his or her first-hand experience of recovery. This first

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meeting provides an opportunity for participants to connect with a “similar other” about “shared experiences.” During this introduction, participants are also encouraged to talk about their experiences and to identify some of their expectations now that they are or have returned to the community. The peer supporter then offers participants assistance with “moving toward” their goals. This involves discussion of issues related to self-care and managing the person’s illness, and role modeling of different strategies to minimize the disruptions associated with the illness. Just as importantly, though, this also involves assisting the person to identify those interests and goals he or she would like to pursue in the short-term, and providing the in vivo assistance needed for the person to do so. For these two components of the peer supporter’s role, they are trained in person-centered care planning and community inclusion described in detail later. Throughout these activities, peer supporters are careful to avoid portraying themselves as the “experts” or conveying the message that the mentees are novices. Rather, the supporter’s role is to explore with the mentee new ways of dealing with their situations and new ways of pursuing his or her interests and goals, with the mentee deciding on the destinations and selecting among the different pathways with which the mentor may be familiar.

Facilitation of person-centered planning involves organizing and conducting a series of planning meetings in collaboration with a participant and his or her primary clinician, that bring together the person with his or her network of professional and natural supports. The goal of these meetings is to discover a vision for a desirable future and to help the person develop an action plan to achieve that vision. Core principles of person-centered planning include: (1) primary direction in the planning process coming from the individual; (2) involvement of significant others and reliance on personal relationships as the primary source of support; (3) focus on capacities and assets rather than on limitations and deficits; and (4) an acceptance of uncertainty and setbacks as natural elements in the path to enhanced self-determination.⁵⁶

Facilitation of community inclusion is based on the principle of person-centered planning, with emphasis on identifying, and promoting access to, integrated community settings rather than segregated settings designed for people with disabilities. To facilitate community inclusion, mentors help clients develop and use resource maps of their local communities based on their goals and interests.⁵⁷ Developing resource maps involves discovering existing, but untapped, resources and other potentially hospitable places and organizations in which the contributions of people with serious mental illnesses are welcomed and valued. Once identified, participants then receive in vivo, interactive training in joining community activities and organizations of their choice. In addition, participants are encouraged to and assisted in keeping a journal of their community outing experiences with entries such as words and stories,

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drawings, souvenirs, and photographs to use as a mechanism for remembering and celebrating their efforts and successes.

Training peer supporters



Earlier we shared work being done to clarify the role of peer supporters. New York was one of the first states to train, certify, and hire peer support specialists.⁵⁸ In 2001, Georgia became the first state to fund peer support as a Medicaid-fundable service,⁵⁹ and on December 1, 2001, 35 mental health consumers had an opportunity to participate in a training and exam to become Georgia's first class of "Certified Peer Specialists," which allowed them to bill for Medicaid services.^{60, 61} Since 2001, Georgia's program has trained over 1,600 CPSs.⁶⁰

As peer support became Medicaid fundable in many states, there has been a proliferation of state peer certification training programs (Connecticut and a few other US states do not directly receive Medicaid funding). Through data compiled by the Texas Institute for Excellence in Mental Health at the University of Texas at Austin as of July 2016, 41 states and the District of Columbia had established peer certification training programs and 2 states were in the process of developing certification programs.⁶² Training programs vary in length and content with most occurring over 4 to 10 days. Topics taught generally include concepts of hope and recovery, interpersonal communication, telling your recovery story, identification and treatment of mental health disorders, wellness management, legal issues in mental health, stigma/discrimination issues in mental health, boundary issues, ethics/confidentiality/HIPAA, cultural competence and linguistic issues, overview of evidence-based practices, and workplace considerations. Modalities used to train peer supporters range but generally include didactics, discussions, role plays, and group exercises. Following training, most states administer an examination (written and/or oral) before certifying individuals. Criteria for eligibility varies across states. Most states require that applicants first and foremost identify as a person with a psychiatric and/or addiction history and then vary when it comes to other requirements. Some have a minimum age requirement, others expect applicants be out of the hospital for a defined period of time (we do not advocate for this requirement), while others want applicants to have a high school diploma among other criteria. In addition, most states do not offer the training to agencies or supervisors of peer supporters, which poses a challenge if the supervisors do not have lived experience of mental illness and recovery.⁶²

Partnering with peer supporters in the workplace



The hiring and retention of peer supporters has been met with a few challenges, such as lack of role clarity—what is it that peer supporters will do; organizational culture—readiness to promote recovery-oriented care within the organization; and lack of preparation for supervisors of those in peer support roles. Part of the challenges in

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recognizing and including peer supporters in the behavioral health field, stems from beliefs about recovery. It has only been a short time since people received messages that recovery from mental illness was not possible. To go from a system that believed this to one that now embraces people with lived experiences working in behavioral health is still a far leap for some providers who have yet to embrace that people with lived experiences have a unique set of skills to add to the work of others on clinical teams.

PRCH is currently working on an approach to develop learning collaboratives for agencies that are interested in partnering with peer supporters in the workforce. The goal of this initiative is to help agencies establish the organizational culture and administrative infrastructure as well as to provide education on role clarity and supervision of peer supporters. Some of the challenges that peer supporters have faced in the workforce include: lack of role clarity, transition into employment in the behavioral health field, lack of a career ladder as a peer supporter, equitable pay for services provided, lack of effective supervision (educational, supportive, and administrative), microaggressions in the workplace by non-peer staff, and co-optation (staying a peer supporter versus taking on duties of case managers, etc.). Based on our experiences, we recommend that agencies plan for these challenges rather than simply hiring peer supporters. We provide an example below of how peer support came about in the US Department of Veterans Affairs and include workforce challenges and lessons learned.

Case example of peer support in the Veterans Health Administration

“Who then can so softly bind up the wound of another as he who has felt the same wound himself?”—Thomas Jefferson

Beginning in 2005, Veterans Health Administration (VA) medical centers began hiring peer support technicians (PSTs, later changed to peer support specialists) on their mental health clinical teams.⁶³ The 2008 *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics*⁶⁴ was developed in response to the goals of 2003 President’s New Freedom Commission on Mental Health.⁶⁵ The handbook focused on a range of recovery-oriented services and required each VA medical center to offer peer support services to veterans with serious mental illnesses including the hiring of PSTs.⁶⁵ U.S. Public Law 110-387, established the following legislative requirements for peer support specialists working in the VA: a peer support specialist must be a veteran with an other than dishonorable discharge, be in recovery from a mental health condition for at least 1 year; and be trained and certified by a VA approved or State-approved not-for-profit certification organization.⁶⁶

In the initial years of employment of PSTs in the VA, there was much staff resistance and confusion about the roles and responsibilities of PSTs.⁶⁷ As part of a randomized trial evaluating the implementation of PSTs in VA

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Mental Health Intensive Case Management teams, Chinman and colleagues used the Simpson transfer model to assess the teams' needs and preferences to help guide the implementation of PSTs on their teams. The researchers engaged with the teams to seek their input on desired characteristics of candidates, processes of the hiring, establishing roles and responsibilities, onboarding, training, and supervising PSTs.⁶³ Overall, the researchers found that using an organizational change model was useful for formalized planning. "We believe this approach can be helpful to facilities who have decided to deploy PSTs and useful to engage leadership who have not been predisposed to the idea."⁶³

As of August 9, 2017, the Veterans Health Administration has 1,079 peer support specialists working in VA mental health programs across the nation (personal communication with Daniel O'Brien Mazza). In the VA, peer support specialists now work in various programs (intensive case management, homeless outreach and engagement, vocational, and justice outreach) and settings (residential, inpatient, outpatient) across mental health service lines. Peer support specialists experience a range of mental health conditions including psychotic, mood, anxiety, and substance use disorders with many having co-occurring disorders and a number having faced homelessness and/or unemployment at times in their lives. Often a peer support specialist with a particular disorder such as schizophrenia or post-traumatic stress disorder will work on a team that serves veterans with similar conditions and/or who faced similar life challenges. In the VA, peer support specialists are considered full clinical team members attending rounds, conducting individual and group sessions, educating veterans about setting goals, developing skills to manage illness, and documenting in the electronic health record. While they do not conduct formal assessments nor diagnose, the descriptive information that peer support specialists provide about their encounters with veterans is valued by team members. Teams value the perspectives of peer support specialists, see firsthand that recovery is possible, and use language that is more recovery-oriented. Similarly, research conducted outside the VA suggests that having peer support providers on clinical teams reduces stigma by shifting negative attitudes of mental health providers.^{68 , 69}

Conclusion



In conclusion, peer support is the one of the fastest-growing occupations within the behavioral health workforce. Overall, the evidence suggests that peer support has benefits, and while more research is needed, current evidence suggests that adding peer support will more than likely enhance services for people with mental illness. Research in this area is challenging because definitions of peer support and the roles of peer supporters vary across sites and programs, making it difficult to assess what happens in practice. In addition, integrating or partnering effectively with peer supporters in the field is difficult for the same reasons. Much work needs to be done to further advance the practice and research of peer support, but as with any new or enhanced innovation, we

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must work with organizations and clinical providers to plan more effectively how to better partner with peer supporters so they can effectively deliver peer support services.

References

1. Bellamy C, McDonald HE, Hawkins D, Guy K, Herring Y, Davidson L. Input from stakeholders: Hiring and retaining people in recovery in the behavioral health workforce. *Cadernos Brasileiros de Saúde Mental/ Brazilian Journal of Mental Health*. 2017;9(21):66-78.
2. Bellamy CD, Rowe M, Benedict P, Davidson L. Giving back and getting something back: The role of mutual-aid groups for individuals in recovery from incarceration, addiction, and mental illness. *Journal of Groups in Addiction and Recovery*. 2012;7:223-236.
3. Davidson L, Chinman M, Kloos B, Weingarten R, Stayner D, Tebes JK. Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*. 1999;6:165-187.
4. Davidson L, Chinman M, Sells D, Rowe M. Peer support among adults with serious mental illness: a report from the field. *Schizophrenia Bulletin*. 2006;2005;32:443-450.
5. Davidson L, Shahar G, Stayner DA, Chinman MJ, Rakfeldt J, Tebes JK. Supported socialization for people with psychiatric disabilities: Lessons from a randomized controlled trial. *Journal of Community Psychology*. 2004;32:453-477.
6. Davidson L. *Effectiveness and cost-effectiveness of peer mentors in reducing hospital use*. National Institute of Mental Health application, R01 #MH091453L, L. Davidson, Principal Investigator. 2010.
7. Davidson L, Tondora JS, Staeheli MR, O'Connell MJ, Frey J, Chinman MJ. Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In Lightburn A, Sessions P, eds., *Community based clinical practice*. London: Oxford University Press, 2006, pp. 476-501.
8. Sells D, Black R, Davidson L, Rowe M. Beyond generic support: Incidence and impact of invalidation in peer services for clients with severe mental illness. *Psychiatric Services*. 2008;59(11):1322-1327.
9. Solomon P. Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*. 2004;27(4):392.
10. Stroul B. Rehabilitation in community support systems. In: Flexer R, Solomon P, eds. *Psychiatric rehabilitation in practice*. Boston, MA: Andover Medical, 1993.

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11. Clay S, ed. *On our own, together: Peer programs for people with mental illness*. Nashville, TN: Vanderbilt University Press, 2005.
12. Mourra S, Sledge W, Sells D, Lawless M, Davidson L. Pushing, patience, and persistence: Peer providers' perspectives on supportive relationships. *American Journal of Psychiatric Rehabilitation*. 2014;17:307-328.
13. Riessman F. The "helper" therapy principle. *Social Work*. 1965:27-32.
14. Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. *World Psychiatry*. 2002;1(1):16-20.
15. Walsh E, Buchanan A, Fahy T. Violence and schizophrenia: Examining the evidence. *British Journal of Psychiatry*. 2002;180:490-495.
16. Evans-Lacko S, Corker E, Williams P, Henderson C, Thornicroft G. Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003-13: an analysis of survey data. *Lancet Psychiatry*. 2014;1:121-128.
17. Pescosolido BA, Medina TR, Martin JK, Long JS. The "backbone" of stigma: Identifying the global core of public prejudice associated with mental illness. *American Journal of Public Health*. 2013;103:853-860.
18. Walsh E, Moran P, Scott C, et al. Prevalence of violent victimisation in severe mental illness. *British Journal of Psychiatry*. 2003;183:233-238.
19. Chinman MJ, Weingarten R, Stayner D, Davidson L. Chronicity reconsidered: Improving person-environment fit through a consumer-run service. *Community Mental Health Journal*. 2001;37:215-229.
20. Sledge WH, Lawless M, Sells D, Wieland M, O'Connell MJ, Davidson L. Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatric Services*. 2011;62:541-544.
21. Klein AR, Cnaan RA, Whitecraft J. Significance of peer social support with dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice*. 1998;8:529-551.
22. Min S, Whitecraft J, Rothbard AB, Salzer MS. Peer support for persons with co-occurring disorders and community tenure: A survival analysis. *Psychiatric Rehabilitation Journal*. 2007;30:207-213.
23. Clarke GN, Herinckx HA, Kinney RF, et al. Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: Findings from a randomized trial of two ACT programs vs. usual care. *Mental Health Services Research*. 2000;2:155-164.

Peer support for people with psychiatric illness: A comprehensive review

-
24. Solomon P, Draine J. One-year outcomes of a randomized trial of consumer case management. *Evaluation and Program Planning*. 1995;18:117-127.
25. O'Donnell M, Parker G, Proberts M, et al. A study of client-focused case management and consumer advocacy: The Community and Consumer Service Project. *Australian and New Zealand Journal of Psychiatry*. 1999;33:684-693.
26. van Vugt MD, Kroon H, Delespaul, Philippe AEG, Mulder CL. Consumer-providers in assertive community treatment programs: Associations with client outcomes. *Psychiatric Services*. 2012;63:477-481.
27. Forchuk C, Martin M-, Chan YL, Jensen E. Therapeutic relationships: From psychiatric hospital to community. *Journal of Psychiatric and Mental Health Nursing*. 2005;12:556-564.
28. Yanos PT, Primavera LH, Knight EL. Consumer-run service participation, recovery of social functioning, and the mediating role of psychological factors. *Psychiatric Services*. 2001;52:493-500.
29. Corrigan PW. Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. *Psychiatric Services*. 2006;57:1493-1496.
30. Dumont J, Jones K. Findings from a consumer/survivor defined alternative to psychiatric hospitalization. *Outlook*. 2002;3(Spring):4-6.
31. Ochocka J, Nelson G, Janzen R, Trainor J. A longitudinal study of mental health consumer/survivor initiatives: Part 3—A qualitative study of impacts of participation on new members. *Journal of Community Psychology*. 2006;34:273-283.
32. Salzer MS, Shear SL. Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal*. 2002;25:281-288.
33. Walker G, Bryant W. Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal*. 2013;36:28-34.
34. Gidugu V, Rogers ES, Harrington S, et al. Individual peer support: A qualitative study of mechanisms of its effectiveness. *Community Mental Health Journal*. 2015;51:445-452.
35. Collins R, Firth L, Shakespeare T. "Very much evolving": A qualitative study of the views of psychiatrists about peer support workers. *Journal of Mental Health*. 2016;25:278-283.
36. Chinman M, George P, Dougherty RH, et al. Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services*. 2014;65:429-441.

Peer support for people with psychiatric illness: A comprehensive review

-
37. Fuhr DC, Salisbury TT, De Silva MJ, et al. Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*. 2014;49:1691-1702.
38. Pitt V, Lowe D, Hill S, et al. Consumer-providers of care for adult clients of statutory mental health services. *Cochrane Database of Systematic Reviews*. 2013;3:CD004807.
39. Repper J, Carter T. A review of the literature on peer support in mental health services. *Journal of Mental Health*. 2011;20:362.
40. Lloyd-Evans B, Mayo-Wilson E, Harrison B, Istead H, Brown E, Pilling S, et al. A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry*. 2014;14(1):39.
41. Cabassa LJ, Camacho D, Vélez-Grau CM, Stefancic A. Peer-based health interventions for people with serious mental illness: A systematic literature review. *Journal of Psychiatric Research*. 2017;84:80-89.
42. Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry*. 2012;11(2):123-128.
43. Corrigan PW, Morris S, Larson J, et al. Self-stigma and coming out about one's mental illness. *Journal of Community Psychology*. 2010;38:259-275.
44. Festinger L. A theory of social comparison processes. *Human Relations*. 1954;7(2):117-140.
45. Mead S, MacNeil C. Peer support: What makes it unique. *International Journal of Psychosocial Rehabilitation*. 2006;10(2):29-37.
46. Salzer MS, Brusilovskiy E, Schwenk E. Certified peer specialist roles and activities: Results from a national survey. *Psychiatric Services*. 2010;61:520-523.
47. Croft B, Ísvan N. Impact of the 2nd story peer respite program on use of inpatient and emergency services. *Psychiatric Services*. 2015;66(6):632-637.
48. Pfeiffer PN, Heisler M, Piette JD, Rogers MA, Valenstein M. Efficacy of peer support interventions for depression: A meta-analysis. *Gen Hosp Psychiatry*. 2011;33(1):29-36.
49. Bryan AE, Arkowitz H. Meta-analysis of the effects of peer-administered psychosocial interventions on symptoms of depression. *American Journal of Community Psychology*. 2015;55(3-4):455-471.

Peer support for people with psychiatric illness: A comprehensive review

50. Mowbray CT, Moxley DP, Thrasher S, Bybee D, Harris S. Consumers as community support providers: Issues created by role innovation. *Community Mental Health Journal*. 1996;32(1):47-67.

51. Hibbard JH, Mahoney ER, Stockard J, Tusler M. Development and testing of a short form of the patient activation measure. *Health Serv Res*. 2005;40(6 Pt 1):1918-1930.

52. Hibbard JH, Greene J. What the evidence shows about patient activation: Better health outcomes and care experiences; fewer data on costs. *Health Affairs*. 2013;32(2):207-214.

53. Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Medical Care*. 2011;49(6):599-604.

54. Intentional Peer Support. 2017. <http://www.intentionalpeersupport.org/>

55. Kaplan R, Ganiats T, Rosen P, Sieber W, Anderson J. Development of a self-administered Quality of Well-Being scale (QWB-SA): Initial studies. *Quality of Life Research*. 1995:443-444.

56. Tondora J, Miller R, Slade M, Davidson L. *Partnering for recovery in mental health: A practical guide to person-centered planning*. Hoboken, NJ: John Wiley & Sons; 2014.

57. Bromage B, Kriegel L, Williamson B, Maclean K, Rowe M. Project Connect: A community intervention for individuals with mental illness. *American Journal of Psychiatric Rehabilitation*. 2017;20(3):218-233.

58. Grant EA, Swink N, Reinhart C, Wituk S. The development and implementation of a statewide certified peer specialist program. In: Brown LD, Wituk S, eds. *Mental health self-help*. New York, NY: Springer, 2010: 193-209.

59. Sabin JE, Daniels N. Managed care: Strengthening the consumer voice in managed care: VII. The Georgia peer specialist program. *Psychiatric Services*. 2003;54(4):497-498.

60. Georgia Certified Peer Specialist Project. <http://www.gacps.org/Home.html>

61. Salzer MS. Certified peer specialists in the united states behavioral health system: An emerging workforce. In: Brown L, Wituk S, eds. *Mental health self-help*. New York, NY: Springer, 2010: 169-191.

62. Kaufman L, Kuhn W, Stevens Manser S. *Peer specialist training and certification programs: A national overview*. Texas Institute for Excellence

Peer support for people with psychiatric illness: A comprehensive review

in Mental Health, School of Social Work, University of Texas at Austin. 2016.

63. Chinman M, Shoai R, Cohen A. Using organizational change strategies to guide peer support technician implementation in the Veterans Administration. *Psychiatric Rehabilitation Journal*. 2010;33:269-277.

64. US Department of Veterans Affairs. VHA Handbook 1160.01 Uniform mental health services in VA medical centers and clinics. Washington, DC. 2008.

65. US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration. *Achieving the promise: Transforming mental health care in America: final report, July 2003*. Rockville, MD: Presidents New Freedom Commission on Mental Health.

66. Veterans' Mental Health and Other Care Improvement Act of 2008, Public Law 110-387, Section 405 modifies USC 740. 2008.

67. Gresen R, Chinman M, Davis M, et al. Early experiences of employing consumer-providers in the VA. *Psychiatric Services*. 2008;59:1315-1321.

68. Cook JA, Jonikas JA, Razzano L. A randomized evaluation of consumer versus nonconsumer training of state mental health service providers. *Community Mental Health Journal*. 1995;31:229-238

69. Dixon L, Hackman A, Lehman A. Consumers as staff in assertive community treatment programs. *Administration and Policy in Mental Health*. 1997;25:199-208.