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Peer Support: Coming of Age of and/or Miles to Go before We Sleep? An Introduction

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At the time of this writing, the Veterans Administration has succeeded in hiring over 1,000 peer support staff (200 more than its target of 800) and 31 states have come to agreements with the Centers for Medicare and Medicaid Services (CMS) to include peer support on the panel of behavioral health services that are reimbursable. In anticipation of a rapid and significant expansion of the peer workforce as a result of implementation of the next phase of the Affordable Care Act, peer leaders from around the country recently came together, at the invitation of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), to develop and adopt a set of national practice guidelines for peer support services in behavioral health.¹ Additional work is currently underway to develop a complimentary set of practitioner competencies and a national code of ethics, all of which are building blocks for the instantiation of peer support as its own profession. Clearly, we have come a long way since persons with histories of serious mental illnesses first began to volunteer, and then later were paid, to function as “case manager assistants” in the late 1980s.

Among the peer support and broader recovery communities, these developments are a cause for celebration and a sense of gratification for all the hard work that is now beginning to pay off. In my own case, for example, it took five years to get my first manuscript on peer support accepted in an academic journal,² having been dismissed by many reviewers for being what one particularly irritable authority described as “unsubstantiated rot.” But as may all too often be the case, this celebration is also a cause for reflection and for a redoubling of certain efforts related to the development and delivery of peer support. While we certainly have come a long way in some respects, many people nonetheless remain under the impression that the best peer staff can do is to function as case manager assistants. What precisely peer staff do—beyond disclosing their own history of disability and recovery—and what short and long-term outcomes we can expect peer support staff to generate for the persons they support largely remain to be determined and disseminated. The evidence base for peer support has not kept pace with its broad proliferation, and the profession that is just now forming itself is at risk of having its fate decided, and severely circumscribed, by other parties. The following two articles by Chinman and colleagues embody both the achievements of, and significant challenges that still face, this movement.

First, we should note that these two reports are part of a larger, longer initiative that first appeared in print in 2006³ and was then described in more detail by Chinman and colleagues in 2010.⁴ In these early papers, this research group presented the organizational

change strategy that they employed in introducing peer staff into the VA system; a strategy that included involving existing (non-peer) staff in the process from the very beginning in discussions about what peer staff might do, how they might do it, what their roles might be, how they might be supervised, etc. The research team used these opportunities to elicit and address stigmatizing and discriminatory beliefs and attitudes on the part of staff, as well as to provide information about the nature of peer support and discuss some of the concerns staff raised. As has been common to settings in which peer staff have been deployed, existing (non-peer) staff had questions about peer staff access to medical records, confidentiality, boundaries, self-disclosure, and potential for relapse. In addition to approaching this initiative in a thoughtful way, Chinman and colleagues have done organizations newer to the issue of hiring peer staff a favor by documenting this collaborative process, discussing the nature of some of the more common issues raised, and offering one approach for developing consensus and moving ahead into what is now no longer uncharted territory.

The implementation science framework described in these two earlier papers sets the stage for the results presented in the two papers in this issue. In these papers, the authors present both qualitative and quantitative data that were collected as part of their PEER initiative within the VA, and in doing so shed light on both the promises and potential pitfalls of peer support. Because of their use of an inclusive approach focused on culture change as well as implementation of a new service, policy makers, system administrators, agency leaders, and practitioners will all find useful information in these papers that will help them to anticipate and identify obstacles to the effective deployment of peer staff. What may not yet be quite as clear is how to overcome these obstacles in a way that more fully optimizes the unique contributions that peer staff can make to the organizations in which they work.

First to the issue of effectiveness. In the article by Chinman, Oberman, Hanusa, et al.⁵ in this issue of the *Journal of Behavioral Health Services & Research* (JBHS&R), we read about a cluster randomized, controlled trial that compared outcomes among veterans with serious mental illnesses who had substantial histories of inpatient care who were served either by intensive case management teams that deployed peer staff or by similar teams that had not yet hired peer staff. An innovative feature of this study was that it compared outcomes of all persons served by these teams rather than just those persons who were assigned peer staff, as has been done in most previous studies. The authors justify using such an “intent to treat” approach based on the fact that peer staff typically “float” on intensive case management teams, as opposed to being assigned their own caseload, and on the hypothesis that having peer staff on such teams also enhances the recovery orientation of the team as a whole. The apparent advantages of this approach have to be balanced, though, with the fact that 43% of the participants had no documented contact with a peer staff member and another 21% had only between one and four contacts, resulting in the majority of participants (roughly two-thirds) not receiving an adequate “dose” of the experimental intervention. Nonetheless, the authors found a significant increase in activation for those participants on the teams that had hired peer staff; activation being defined as the degree to which people have the knowledge, skill, and confidence needed to manage their own health.

Proponents of peer support will likely argue that among the outcomes assessed in this study, activation may be the most relevant both to the hypothesized impact of peer staff and to their current and future role in the behavioral health workforce. Indeed, since the National Association of State Mental Health Program Directors published its 2006 report on the increased morbidity and premature mortality of persons with serious mental illnesses, the health and well-being of this population has become a major concern and focus both of the federal government's efforts (through SAMHSA and the NIMH) and of the peer support community itself (see, for example, the curriculum for Whole Health Action Management developed by Fricks and colleagues and available through the SAMHSA-HRSA Center for Integrated Health Solutions). This direction is fully aligned with the spirit of the Affordable Care Act and the increased focus CMS has been placing on the promotion of self-management in persons with all forms of chronic illness, most recently including behavioral health conditions.⁶

But what about all of the other outcomes assessed in the Chinman et al. study? Why were no significant differences found in other outcomes like recovery, empowerment, community living skills, or quality of life? One answer was suggested above, in the fact that only 36% of the participants had five or more contacts with peer staff. But other answers are also suggested by the companion article, also in this issue of the JBHS&R, by Hamilton, Chinman, Cohen, et al.,⁷ which describes the implementation process of integrating peer staff onto the three intensive case management teams involved in this study. This paper reports on how the researchers used the Simpson Transfer Model, and their own previous experiences with peer support, to guide their efforts in the integration of the peer staff. Once again, Chinman and colleagues are to be complemented on using their own knowledge of the challenges involved in integrating peer staff to anticipate and address proactively the concerns of the VA leadership and staff. It is fair to say that they gave more attention to, and were more adept at, the process of integration than one typically finds in the field. Yet what the report on this implementation process suggests is that the work of full integration is far from completed. While the authors suggest that they overcame most of the "growing pains" they anticipated based on their previous experience hiring peers, they also concluded that "integration of [peer staff] into teams with no prior [peer] experience is a process, not an event, and that roles, responsibilities, and relationships evolve over time." Since the teams involved did not retain their peer positions following completion of this study, they unfortunately did not have an opportunity to see how the roles of peer staff might have continued to evolve beyond the timeframe of the study. But the data, and experience, suggest that additional evolution is sorely needed.

Peer support is still very much in its infancy and such evolution needs to occur, and is occurring presently, in what is a rapidly changing landscape. The comment of one of the VA staff quoted in the Hamilton et al. study eloquently captures the current challenge. When asked what one peer staff's role was, this person replied that she "kind of just did whatever." Although undoubtedly intended as a compliment to the peer's flexibility and willingness to help out in whatever ways she was needed, this phrase unfortunately also describes the lack of role clarity, and substance, that presently plague peer staff across the country. A similarly disturbing comment was made in a recent article by the PEW Charitable Trusts, in which a reporter praised peer support workers for "help[ing] people with mental illness stay on their

medications.”⁸ In settings in which clinical leaders have not given the attention to integration shown by Chinman and colleagues, peer staff frequently complain of being asked to empty garbage cans or file papers, or of having no substantive role at all and being left to languish on their own. Even when significant time has been devoted to preparation, as in the studies described above, it appears that peer staff are still left to “just do whatever.” Clearly, the work on practice standards mentioned at the outset is needed to move the field to recognize that peer staff can be more than case management assistants. Until that is accomplished in practice, however—until peer staff have a unique role against which their performance can be assessed in terms of its fidelity to a well-articulated approach—research on the effectiveness of this new support may continue to show small effects in a few domains. Among those of us who have witnessed the transformative power of peer support, such modest results seem to be more of a reflection of the quality of the services provided than on the potential impact that peer staff may exert once trained, hired, and supervised to make optimal use of their own life experiences, strengths, and accrued wisdom in helping others along their own recovery journeys.

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