Online Supplement to:
Establishing a Research Agenda for Understanding the Role and Impact of Mental Health Peer Specialists

1.

There is much variation in peer specialist role, setting, and theoretical orientation

One thread of research on peer specialists describes their varied roles. These studies describe the roles of peer specialists across multiple or single programs, extract information about job roles from qualitative interviews with peer specialists, co-workers, and supervisors or surveyed peer specialists. For example, Asad et al(1) interviewed peer specialists; Gidugu et al(2) interviewed patients who had received peer specialist services; and Cabral et al(3) conducted interviews and focus groups with both, plus peer specialist supervisors. Several other studies used surveys. Salzer et al(4), Eisen et al(5) and Hebert et al(6) conducted national surveys of peer specialists (Eisen and Hebert were in the VHA mental health system, Salzer was outside it) asking about the setting in which they worked, the types of activities they performed and their frequency. Grant et al(7) conducted a similar survey on a smaller sample of peer specialists who had completed a training program. Another recent effort(8) used a process called "role delineation", in which seven peer specialists and two supervisors completed quantitative ratings and discussions to identify and rate the importance, time needed to acquire proficiency in, and frequency of, various tasks peer specialists perform. This effort found similar roles as the Chinman et al. effort described in the main text (9).

2.

Underlying different orientations of peer specialists are different theories about what makes them effective. Salzer(10) described several theories to explain the impact of peer specialists including social comparison theory(11) (comparing oneself to similar others can improve hope, motivation, affect), social learning theory(12) (behavior change can be enhanced when modeling from similar others), social support theories (peer specialists can provide emotional aid, concrete assistance, information, companionship, and validation), experiential knowledge(13) (peer specialists can share details from their own experience to facilitate recovery), and the helper-therapy principle(14, 15) (peer specialists themselves experience enhanced competence and wellbeing from helping others).

3.

The first review of peer specialist outcome studies began in 1999(16), and several additional reviews have been conducted since then(17-21), including two meta-analyses(22, 23). A recent review of 20 randomized and quasi-experimental peer specialist studies in *Psychiatric Services* found that the use of peer specialists in mental health service delivery is associated with a wide range of improved outcomes including less inpatient use, better treatment engagement, greater satisfaction with life, greater quality of life, greater hopefulness, better social functioning, improved self-reported recovery, fewer days homeless, and fewer problems and needs(24). These results cut across study types that compared patients receiving standard care with or without unstructured peer specialist support and patients receiving a structured curriculum delivered by peer specialists. However, several of these studies suffer from

methodological shortcomings including small sample sizes, untested outcome measures, non-blinded data collectors, self-reported data, and non-randomized research designs. As a result, that review assigned the level of evidence for peer specialists as "moderate" on a three level scale established by the journal (low/moderate/high).

4.

The Vandewalle review of 18 qualitative or mixed methods studies is one of the few to explicitly employ a conceptual framework in their organization of peer specialist ***implementation barriers*** (25). The article uses a 6-level implementation science framework developed by Grol and Wensing to organize barriers and facilitators(26): nature of the innovation (characteristics of peer specialists and their roles); individual professional (peer-professional interactions); service users (interactions with persons seeking mental health services); social context (integration with multi-disciplinary teams, and the extent of recovery-oriented culture); organizational context (training, supervision, structures and processes); and economic and political context (recruiting policies, certification standards, regulations regarding social security benefits). In each of these categories, Vandewalle et al identify two to four barriers, resulting in a total of 18 barrier types. Moran et al(27) put forth a three-category conceptual framework of barriers to peer specialist services: work environment, occupational path, and personal mental health. The combined domains of work environment (accommodations, infrastructure, pay) and occupational path (training, job description, role identity) map roughly to Vandewalle's organizational context domain. Unfortunately there is lack of clarity between authors on how some terms are used. For example, Vandewalle describes negative impacts on peer specialist mental health as one of three sub-categories in the service user domain whereas Moran elevates peer mental health to one of the three main domains(25, 27).

Two of the most commonly cited barriers to successful implementation of peer specialist services are <u>role clarity</u> and <u>organizational context</u> (also described as "work environment"). As one study informant noted, "People at the agency don't know what to do with the peer specialist role. They want to embrace the individual [peer specialist] but don't know how to utilize what he has to offer. The clinician doesn't know when to ask the peer specialist to step in to help a client."(3). For organizational context, the issues have been described by Moran et al.(27) as a, "… lack of clear job descriptions, lack of skills for using one's life story and lived experience, lack of helping skills, and negative aspects of carrying a peer provider label". Vandewalle et al.'s review emphasized that to capitalize on the peer support resource, "…it requires a radical change of culture and practice in mental health organizations." The culture needs to acknowledge a role for peer specialists in the recovery process, include demonstrated leadership support for peer specialists, and involve staff training in how peer specialists contribute to recovery. Other studies expand on aspects of culture and climate that are unfriendly or poorly adapted to the contributions of peer specialists: lack of appropriate supervision; unclear peer role; lack of policies regarding confidentiality of peer specialist and patient information(28); lack of credibility of peer specialist roles; perceptions of discrimination and prejudice from non-peer colleagues; and the need for training (3, 25, 27, 29).

Facilitators of Implementation. Facilitators fall into three main categories– organizational culture change, training of peer specialists, and social support/supervision. Making changes to the <u>organizational culture</u> can make the environment more supportive.

Approaches to organizational change include agency-wide training that specifically addresses existing attitudes (documented by surveys or focus groups) about peer specialists(29-32); fostering a recovery-oriented culture(29); instituting formal orientation programs for peer specialists(33); creating a flexible and accommodating workplace(27, 29); and having more than one peer specialist in the organization to avoid tokenism(34). The second category–training–should include training peer specialists for their role, how and what to disclose with clients, and discussions about self-care.(31) The third category, social support and supervision, may involve peer specialists participating in a number of areas including: agency/organization team meetings, treatment planning and case notes, regular staff development, and informal team lunches and social events. Regular supervision is also seen as vital to the support of peer specialists(28).

References to online supplement

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