Establishing a Research Agenda for Understanding the Role and Impact of Mental Health Peer Specialists

Matthew Chinman, Ph.D., D. Keith McInnes, Sc.D., M.Sc., Susan Eisen, Ph.D., Marsha Ellison, Ph.D., Marianne Farkas, Sc.D., Moe Armstrong, M.B.A., M.A., Sandra G. Resnick, Ph.D.

Mental health peer specialists are individuals with serious mental illnesses who receive training to use their lived experiences to help others with serious mental illnesses in clinical settings. This Open Forum discusses the state of the research for mental health peer specialists and suggests a research agenda to advance the field. Studies have suggested that peer specialists vary widely in their roles, settings, and theoretical orientations. Theories of action have been proposed, but none have been tested. Outcome studies have shown benefits of peer specialists; however, many studies have methodological shortcomings. Qualitative descriptions of peer specialists are plentiful but lack grounding in implementation science frameworks. A research agenda advancing the field could include empirically testing theoretical mechanisms of peer specialists, developing a measure of peer specialist fidelity, conducting more rigorous outcomes studies, involving peer specialists in executing the research, and assessing various factors that influence implementing peer specialist services and testing strategies that could address those factors.

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A recovery orientation among systems that care for those with serious mental illnesses involves collaborating with people on personal goals, conveying hopefulness, promoting choice, and focusing on people's strengths (1). A key component of recovery-oriented care is peer support, described by the Substance Abuse and Mental Health Services Administration as "the sharing of experiential knowledge and skills [that] provide important resources to assist people along their journeys of recovery" (2). One type of peer support has been professionalized such that there are now organizations that train and certify individuals for a peer specialist position. We define peer specialists as individuals with serious mental illnesses who are trained by these organizations and who are hired to assist others with these illnesses in their recovery in a variety of service-providing settings. Peer specialists "draw upon their lived experience to share 'been there' empathy, insights, and skills . . . serve as role models, inculcate hope, engage [people] in treatment, and help [them] access support [in the] community" (3).

Increasingly, paid peer specialist services are being delivered within a variety of health care and mental health care systems. For example, as of 2017, the Veterans Health Administration employs approximately 1,100 peer specialists. Other public mental health systems also employ peer specialists, and their services are Medicaid reimbursable in 34 states. As peer specialists have spread, the research has attempted to keep pace. Three predominant types of studies on peer specialists include the following: descriptions of the

role, outcome studies, and qualitative accounts of the factors that hinder or facilitate the implementation of peer specialist services. Although much research has been conducted on peer specialists, key gaps in the literature exist. To begin addressing these gaps, the goal of this article is to take stock of peer specialist research and to offer recommendations for a future research agenda.

Peer Specialists' Roles, Settings, and Theoretical Orientations

Studies describing the roles of peer specialists have been done across multiple or single programs; have extracted information about job roles from qualitative interviews with peer specialists, coworkers, and supervisors; or have surveyed peer specialists about their positions. [A brief description of these studies is available in section 1 of the online supplement to this Open Forum.] Variation in study methods and in job roles of peer specialists has likely contributed to the lack of role clarity often described by those implementing peer specialist services. To address this variation, a recent effort was made to systematically organize the wide range of studies on the peer specialist role. Through a literature review and expert panel process, Chinman et al. (4) developed a list of 16 roles that were used to inform the development of a fidelity measure for the peer specialist position. Four roles addressed peer specialist services (promoting hope, promoting empowerment, reducing social isolation, and increasing people's participation in their own

illness management). Nine roles addressed concrete actions that peer specialists take, including being a role model, sharing their recovery story, doing recovery planning, engaging people into services, linking people to community resources, being a liaison between other staff and people receiving treatment, advocating for recovery to other staff, teaching coping skills, and teaching problem-solving skills. The last three roles described processes used by peer specialists, namely, focusing on people's strengths, providing empathy, and developing a trusting relationship. The benefit of this effort is that it combined various studies that have used different viewpoints (peer specialist, person receiving treatment, coworker, and supervisor) and methods (qualitative, quantitative, and mixed methods). The list, and the measure that was created from it, could be useful as a common nomenclature to characterize peer specialist services in future research.

Besides the varied roles, peer specialists also operate in a diverse number of service settings, including traditional mental health, primary care, or community-based programs. Peer specialists may serve on interdisciplinary teams in which they work primarily with nonpeer clinical providers, with other peer specialists, or independently. Peer specialists may provide different kinds of services depending on the setting and context in which they practice (5).

Peer specialists also vary with regard to the theoretical models or orientation of their services. For example, in the intentional peer support model, relationships are reciprocal, and both persons can take on the role of supporter (6). On the other side of the spectrum are peer specialists within medical systems, who are part of a clinical team, enter notes into medical charts, and support treatment plans that often include psychotropic medication. These peer specialists are not expected to assume the role of the individual needing support. There are also various theories about what makes peer specialists effective [see section 2 of the online supplement]. Some studies, such as Solomon (7), have described mechanisms thought to yield benefits for those who receive peer specialist services (for example, use of experiential learning and natural social support and mutual benefit of peer specialist work). Others, such as Gillard et al. (8), have used qualitative approaches to suggest effective mechanisms (for example, develop trusting relationships, use role modeling to build hope, challenge stigma, build skills, and promote engagement in mental health services and community supports). Although these mechanisms and theories have face validity, studies have not been done to prospectively assess their explanatory power.

Outcome Studies of Peer Specialists

Several studies have been conducted evaluating the impact of services provided by peer specialists on outcomes. [A brief description of a recent review of these studies' outcomes and methodological weaknesses is available in section 3 of the online supplement.] Although randomized and quasi-experimental trials have yielded positive outcomes (9), several of these studies have methodological shortcomings. Also, two recent

meta-analyses (10,11) found very little impact of peer specialists. However, these studies only considered randomized trials and grouped together small numbers of studies of peer specialist interventions that varied from each other, which likely affected the ability to detect outcomes. Thus, although some positive evidence exists for peer specialists, more research is needed to understand when, why, and for whom peer specialists have a positive impact, what types of peer specialists have a positive impact, and how the effect of peer services differs from services delivered from nonpeer specialists.

Studies of Implementation Factors Need to Use Implementation Models

Research is also needed on the factors that hinder and facilitate the implementation of peer specialist services (barriers and facilitators) and the practices that are most effective at introducing and sustaining peer specialists. There have been multiple studies and reviews of literature that have examined and categorized the barriers and facilitators of using peer specialists in mental health. [A brief review of these studies is available in section 4 of the online supplement.] However, these studies have tended to use different organizing principles and terminology, and they have not been grounded in implementation science frameworks, with a few exceptions (12). Other shortcomings in this literature include the following: small sample sizes even for qualitative studies, lack of peer specialist involvement in the research, and the use of only the peer specialist viewpoint. In addition, no studies have empirically evaluated the impact of these implementation factors on peer specialist services. For example, it would be important to understand how barriers and facilitators influence the quality of peer specialist services and outcomes overall and in different settings.

A Peer Specialist Research Agenda

More research is needed in several areas. First, empirically testing how theoretical mechanisms of peer support services work would be an important contribution. Although many theories have been promulgated, none have been empirically tested a priori. Second, the use of a measure of peer specialist fidelity is needed. The one recently developed is in the early stages of development and needs further testing (4). Such a tool would help clinical administrators and supervisors support their peer specialists and improve research. Outcome studies to date have not explicitly measured the quality of the peer services they were evaluating. Thus for studies that have reported no positive outcomes, it has not been possible to determine whether the peer services were of poor quality or were simply ineffective. Using a peer specialist fidelity tool would lead to a better understanding of how various models of peer support may be differentially effective.

Third, more outcome studies are needed that address the identified methodological shortcomings. Outcome studies should be controlled randomized trials that use measures

that are psychometrically sound, assess well-described theoretical mechanisms, assess fidelity, and use blinded data collectors (when possible). Long-term studies on the impact of peer specialists are particularly needed, given that outcomes may take longer to manifest. For example, longitudinal studies tracking the recovery of people with serious mental illnesses revealed high recovery rates that countered the established wisdom describing the course of these illnesses as inevitably deteriorating (13). Cumulative effects of peer specialists could be revealed if studied over time. Furthermore, peer specialist outcome studies need to be better described. Across numerous outcome studies, there is wide variability in the descriptions of peer specialists' approaches to services, training, mental health history, supervision, hours worked, and amount of services provided (such as hours and contacts) (9). Without such details, it will be difficult to understand the specific contexts, roles, conditions, and types of individuals for whom peer specialists can be most effective.

Fourth, studies on the factors that hinder or facilitate implementation of peer specialist services need to be better synthesized. Many studies have shown that peer specialists face implementation challenges (3), but it is not well known empirically what impact those challenges have on peer specialist services and outcomes. Use of implementation science models, such as the consolidated framework for implementation research (14), could better organize these factors to develop specific implementation strategies that could then be tested in implementation trials. Finally, these proposed research efforts could be enriched by including peer specialists as part of the research team. Peer specialists could contribute across all phases of research, but they could be particularly helpful in formulating specific research questions based on their experiences.

While this research agenda is developing, it should be acknowledged that delivering peer specialist services in a traditional mental health system may have certain unintended negative consequences for the promotion of recovery. For example, it has been noted that peer specialists may abandon their role as change agent and advocate when engaging others into traditional mental health services (6). Furthermore, there is some qualitative evidence suggesting that peer specialists may conform to a more traditional mental health provider role when employed within a traditional mental health system (15). Research is needed that can more clearly categorize these various roles and evaluate their impact.

In sum, peer specialist services may add to, or complement, traditional mental health services in a unique way. Addressing the proposed research agenda would help determine whether and under which circumstances these benefits occur.

AUTHOR AND ARTICLE INFORMATION

Dr. Chinman is with the Mental Illness Research, Education and Clinical Center (MIRECC) and the Center for Health Equity Research and Promotion, U.S. Department of Veterans Affairs (VA) Pittsburgh Healthcare System University Drive Division, Pittsburgh. Dr. McInnes is with the Center for Healthcare Organization and Implementation Research, Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts, where Dr. Eisen, an independent consultant, was formerly affiliated. He is also with the Department of Health Law, Policy, and Management, Boston University School of Public Health, Boston, where Dr. Eisen was also affiliated. Dr. Ellison is with the Department of Psychiatry, University of Massachusetts Medical School, Worcester. Dr. Farkas is with the Center for Psychiatric Rehabilitation, Sargent College of Rehabilitation Sciences, Boston University, Boston. Mr. Armstrong is with the Errera Community Care Center, VA Connecticut Healthcare System, West Haven. Dr. Resnick is with the Veterans Integrated Service Network 1, MIRECC, VA Connecticut Healthcare System, West Haven, and the Department of Psychiatry, Yale University School of Medicine, New Haven, Connecticut. Send correspondence to Dr. Chinman (e-mail: chinman@rand.org).

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