



ISSUE SPOTLIGHT

PEER WORKFORCE & CAPACITY BUILDING

Common Needs for a Fragmented Workforce



Promotores undergo training at Alivio Medical Center

As the peer workforce in the United States grows in size and complexity, pressure is mounting to address the training and career advancement needs of peer supporters. In addition, healthcare providers and community organizations frequently need technical assistance to build the necessary organizational capacity to manage and sustain peer support programs. In this issue spotlight, we'll explore some emerging issues in peer workforce and capacity building.

When discussing these issues, we have grouped the peer workforce in three main categories: volunteer/part-time peer supporters who often work in primary care and community organizations, mental health peer specialists, and community health workers (CHW). Although many training approaches, competencies, and management strategies are shared, these groups have developed largely in parallel, forming unique identities and operating within different organizational structures.

In contrast to volunteer peer supporters often seen in the primary care and community settings, mental health peer specialists and community health workers are officially recognized as occupations. Workforce studies conducted on mental health peer specialists and CHWs have identified similar needs for these workforces.

However, the impermanent nature of volunteer peer support programs in primary care has impeded workforce studies on this group. Here we would like to highlight several key findings about CHWs and peer specialists.

The Community Health Worker Workforce: On-The-Job Training and Opportunities for Personal and Professional Development

Among the three groups, CHWs have the widest range of possible roles, including many that are beyond the scope of peer supporters. In some cases, the primary role of CHWs may be something other than peer support. The Community Health Worker National Workforce Study estimated that there were 120,000 active CHWs in 2005 ([HRSA 2007](#)).

In a comparison of 3 national studies on CHWs in the US over 15 years ([Rosenthal 2011](#)), several trends emerged that could have implications for the CHW workforce. With respect to demographics, the age of CHWs may be increasing and more men may be entering the workforce. The majority of respondents worked in programs that employed 10 or fewer CHWs. Training experiences have remained remarkably similar over time. On-the-job training remains the most common type of training though more and more CHWs are taking advantage of courses offered in community colleges. There is evidence to suggest that on-the-job training is linked to improved retention rates ([Kash 2007](#)).

In a study of 5 workforce development programs for CHWs, common worker-related barriers to workforce development were lack of time and lack of educational readiness ([Farrar 2011](#)). Problems with foundational skills in language and math increased trainee anxiety and lowered confidence in their ability to succeed.

One study advocates increasing CHW networking and opportunities for leadership development. In a national survey, respondents were found to participate in networks at the local (40%), regional (18%), state (20%), and national (8%) levels. [Koskan and colleagues](#) (2013) recommend that fostering individual career and personal development should be made a core element of CHW programs. Individualized attention and mentorship could improve retention and serve as an incentive to boost recruitment. Furthermore, investing in personal and professional development could be a strategy to expand the capacity and cultural competence of local healthcare workforces. (Read more in [this blog](#)).

For more coverage on the CHW workforce, check out this blog series: [CHW Licensing and Training](#), [CHW Roles](#).

The Peer Specialist Workforce: “Grow Your Own” and Leadership Development

As one of the pioneering groups in the field of peer support, mental health peer specialists have a long history of advocating for themselves and have formed a strong sense of shared identity.

The state mental health systems with the largest number of peer specialists are Pennsylvania (500), Michigan (400), Georgia (320), Arizona (300), New Jersey (280), and Connecticut (240) ([Daniels 2010](#)). A major driving force in the advancement of the peer specialist workforce has been the nationwide, systematic commitment of the Department of Veterans Affairs. Peer specialists in VA Mental Health Services are required to be veterans, be individuals who self-identify as being in recovery from a mental health condition, and obtain certification training.

For 2014, President Obama has committed a 7.2% increase above the 2013 level to expand and transform the VA’s delivery of mental health services for veterans. The VA is set to hire an additional 800 peer specialists by the end of the year. (Read more in [this blog](#)). A recent study concluded that the VA has made substantial progress in employing peer specialists, increasing by more than 2.5 times the number employed since 2007 ([Chinman 2012](#)).

A National Action Plan for Workforce Development in Behavioral Health, funded by SAMHSA, laid out a core set of strategic goals and the specific actions needed to advance the behavioral health workforce ([Hoge 2009](#)).

One of the primary goals is to significantly expand peer and family support services, as well as increase the employment of persons in recovery in the healthcare system. Another goal is to address the high rates of turnover in the field through an evaluation of factors such as wages and benefits, nonfinancial rewards, job characteristics, and the characteristics of the work environment. The plan recommends the increased use of “grow your own” strategies that involve hiring workers from the community and ensuring a viable career ladder for professional growth. Leadership development is especially critical to prepare new leaders to fill the void as the current leadership approaches retirement.

Building Organizational Capacity to Enable Peer Support Program Uptake

In resource-limited settings, healthcare organizations often lack the capacity to implement peer support programs due to the initial investment of staff time and resources. The lack of formal, systematic, and comprehensive training programs often results in role ambiguity and tension between CHWs and supervisors. Furthermore, when leadership neglects to set aside time for training, the staff is forced to conduct trainings during their downtime, raising their work stress and resentment toward the program ([Farrar 2011](#)).

As our senior program manager describes in [her blog](#), capacity building centered on knowledge and technical skills is insufficient. Both individual and organizational transformation is required, which can include leadership commitment to staff time, financial resources and re-prioritization, providers’ personal experience of the benefits of peer support, internal advocacy among providers and patients, and workflow tracking mechanisms to allow better integration and team communication.

Recommended systems level changes include updating human resource policies and practices (paid educational release time, hosting classes onsite, extending tuition assistance policies), changing the process of work (integrating learning opportunities and skill development in day-to-day work activities, job shadowing), and changing organizational culture (creating a work environment in which CHWs are valued and respected, training supervisors on supportive supervision, providing educational and career coaching) ([Farrar 2011](#)).

Common Needs

With the increasing professionalization and clinical integration of mental health peer specialists and CHWs, these peer workforces are facing many similar challenges.

The highly professionalized nature of healthcare means that peer specialists and CHWs have fewer opportunities for career advancement. Given that they often enter the workforce with less formal education or background in healthcare, they experience difficulty negotiating professional boundaries and are prone to rapid burnout ([Farrar 2011](#)). With greater networking opportunities and leadership training, peer supporters will be better able to advocate for themselves within the healthcare establishment. It is also clear that mentorship and close supervisory support is a key factor for increasing job satisfaction and retention.

Given that many workforce issues arise from insufficient organizational capacity, policy initiatives that include financial incentives are needed to stimulate capacity-building efforts. A variety of incremental systems level changes have been proposed, but strong leadership is needed to ensure implementation. Rosenthal laments that “no unified CHW voice has emerged” in the field. Since the VA embraced the peer recovery model for mental health, the field has gained an influential ally that is helping to drive the standardization of peer support services at the national level.

Although the different groups that make up the peer workforce currently work in relative isolation, greater cooperation will lead to more effective advocacy and better opportunities for workforce development. Focusing on commonalities and shared interests can help to unite a fragmented peer workforce.

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