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ADVOCATING AND PLANNING
FOR A BEHAVIORAL HEALTH
PEER SUPPORT PROGRAM

NATIONAL PEER SUPPORT
Collaborative Learning Network
Advocating and Planning for a Behavioral Health Peer Support Program
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This document has been developed by the Behavioral Health Work Group of the NPSCLN. Additionally, suggestions, corrections, or additions are invited at yptang@email.unc.edu.
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What is the purpose of this toolkit?

This guide lays the framework for employing lay persons (also known as peer supporters, peer specialists, community health workers, health coaches, or promotoras) in providing peer support to people with chronic mental and physical health conditions. It is intended for organizations that are interested in learning about, or considering developing, a behavioral health peer support program to help clients with their chronic disease self-management and recovery.

The use of the term behavioral health in place of the older term mental health marks a transition to more modern, collaborative, and whole-person approaches to treatment and recovery. Behavioral health is a pillar of behavioral medicine, which, according to the Society of Behavioral Medicine, is the interdisciplinary field concerned with the development and integration of behavioral, psychosocial, and biomedical science knowledge and techniques relevant to the understanding of health and illness, and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation.

Peer support in behavioral health is part of a broader trend in behavioral medicine toward patient-centered, community-oriented, population-focused care. In the United States, the Affordable Care Act is pushing toward an integrated system of care that connects behavioral health and primary care. Peer support is ideally suited to provide a continuum of care between behavioral health and primary care, and promises to help clients manage a host of co-occurring chronic conditions.

For many behavioral health providers, peer support is already an integral part of their service delivery models. However, for providers that don’t have experience developing and running peer support programs, some advocacy may be needed to build organizational support. This guide combines organizational advocacy and program planning to prepare you to become a champion for peer support within your organization.

Section 1 of this toolkit provides an overview of peer support, including its key functions, delivery approaches, and benefits. Section 2 provides guidelines to obtain organizational buy-in for a peer support initiative. This section will help you enhance the appeal of your program and address common concerns about peer support. Finally, Section 3 contains recommended practices and resources for program development and implementation.

The objectives of this toolkit are to:

- Define peer support and its role in behavioral health
- Define the steps involved in advocating for and developing a peer support program within an organization
- Provide guidelines for advocacy at the local organizational level for a behavioral health peer support program
- Provide information on best practices in developing and managing a behavioral health peer support program
- Inform readers about special considerations and challenges in using peer support in behavioral health
Section 1. Making the Case for Peer Support

Planning for Advocacy

The first step to effective advocacy and planning is to understand the decision-making process within an organization. Knowing how to communicate your proposal and influence key decision-makers will help you make a stronger case of peer support. Identifying and characterizing stakeholders will help you align your objectives and be better prepared to address questions and concerns.

Behavioral health providers will arrive at different solutions based on their particular situations. Section 1 of this toolkit provides recommendations and examples to bolster your advocacy efforts. It covers the rationale for peer support, the definition and functions of peer support, service delivery approaches, benefits of peer support, models of success, and impacts of the Affordable Care Act.

Before you begin, these questions will assist you in developing your advocacy plan.

Understand the decision-making process at your organization

- How are ideas or issues generated for a new policy or program?
- How will the proposed idea be introduced into the formal decision-making process?
- Who and what influences the key decision-makers?
- What is the communication structure in your organization?
- How will the proposal be approved or rejected?

Identify the issue

- What client group is your target population?
- What are characteristics of the target population that will be important for the program – where they are located, how their care is funded, where they receive care, which other organizations provide care to them?
- How many people have the problem?
- What ideas, beliefs, attitudes, values or myths get in the way of the problem?
- Are there successful interventions to help people with the problem or need?
- What is the change you are proposing?
- Why is it necessary?
- What prevailing practices contribute to the issue?
- How would changes in the prevailing practices help to resolve the issue?
Identify the players

- Who can champion the cause?
- Who are the stakeholders or partners associated with the change?
- Who are the opponents?
- What is the reason for their resistance?
- How do you address their concerns?
- Who are the undecided voters?
- What are the financial implications of this proposed change?

References


1.1 What is the rationale for peer support?

Managing chronic conditions is a challenge due to the difficulty of initiating and maintaining behavioral changes. To promote better patient self-management, health providers need to provide care that meets the needs of the whole person. Peer supporters can play a key role in providing this kind of care. Whether they are using their experiential knowledge or their familiarity with the patient’s culture or community, peer supporters can provide services that professional healthcare providers cannot. Patients identify more readily with peers than with healthcare professionals, and patients feel comfortable turning to peers for specific, unmet social and medical needs.

Peer supporters provide assistance in daily management, social and emotional support, and linkages to clinical care and community resources. They provide a range of services that complement and extend formal health care services. Peer support programs for chronic disease self-management have improved health outcomes, quality of life, and adherence to the treatment regimen (Table 2). Additionally, they have the potential to help reduce costs in areas of high utilization, reduce health disparities, increase accessibility to healthcare services, and enhance community support services. Studies have found that peer supporters experience greater self-efficacy in coping with their own illness, as well as a sense of satisfaction from being able to help others. It’s a win-win situation.

Mental health and physical health are inextricably linked. Evidence shows that mental health conditions, especially depression, are strongly associated with serious chronic diseases, including diabetes, hypertension, stroke, heart disease and cancer. In diabetes self-management, the American Association of Diabetes Educators has identified seven fundamental self-care behaviors: healthy eating, being active, monitoring, taking medication, problem solving, healthy coping, and reducing risks. This set of self-care behaviors serves as a good template for managing other chronic diseases and mental health problems as well.

The Patient Protection and Affordable Care Act (ACA) is catalyzing one of the largest expansions of coverage for mental health conditions and addictive disorders in a generation. Beginning in 2014, all new small group and individual market places will be required to cover services for mental health conditions and addictive disorders. Insurers will no longer be able to deny coverage because of a pre-existing behavioral health condition.

The U.S. health care system is facing significant challenges from increasing health care costs, an aging demographic, health disparities, and consumer dissatisfaction. Peer support in behavioral health is part of the solution in providing culturally sensitive, cost effective, and consumer-oriented care. The current health care system provides the challenge, and the ACA provides the opportunity to meet these challenges. The principles behind healthcare reform are well-aligned with the strengths...
of peer support. The emerging healthcare system is more focused on consumer needs and interests, more often located in the home or community, more culturally sensitive and aware, more aware of costs, more attuned to chronic care management than acute treatment, and welcoming to non-traditional providers.

References

What is Peer Support?
http://peersforprogress.org/learn-about-peer-support/what-is-peer-support

Community Health Workers Section, American Public Health Association.
www.apha.org/membergroups/primary/aphaspiwebsites.chw

AADE7 Self-Care Behaviors™
http://www.diabeteseducator.org/ProfessionalResources/AADE7


Problem solving in self-management and behavioral health


1.2 What is peer support and what are the key functions of peer support?

Peer support is a specific type of social support provided by a person who has knowledge from their own lived experience with a chronic condition. Peer supporters are different from other health care service providers. They do not provide clinical care. They do not hold a professional license. They relate to the community members as peers rather than as clients. They are effective, in part, because they rely on relationships and trust rather than clinical expertise. Their expertise stems from their shared ties and culture with the communities that they serve.

Peer support is frequent, accessible, flexible, and ongoing. It can take many forms: phone calls, text messaging, group meetings, home visits, going for walks together, and grocery shopping. It enhances the quality of health care services by providing the necessary emotional, social, and practical assistance to manage chronic diseases and stay healthy. The specific job duties of the peer supporter will vary depending on the needs of the particular organization and on the skills of the peer supporter.

Peer support complements and extends formal health care services but does not replace the roles of professional health care providers. While peer supporters should be officially acknowledged as a part of a patient’s disease management, their role is to provide support, not to make recommendations that only a professional can make. A peer supporter is not a licensed psychologist or mental health professional, a certified educator, a registered dietitian, or a licensed health care professional.

There are many ways to meet the needs of people with chronic diseases, which has generated countless peer support models, each of which has unique protocols, modalities (in-person, phone, internet), and services (navigation, coaching, crisis support). Due to this diversity, it is often easier to conceptualize peer support programs by function instead of content (see Table 1).
Peer supporters in behavioral health serve in many roles: as role models to consumers; as a voice of the needs of consumers, as an important source of information, as a powerful source of motivation, and as mentors helping people to better understand the road to recovery. In recovery services, peer supporters are expected to be proficient in outreach, engagement, case management, strategies to establish a social and physical environment supportive of recovery, and assisting people in gaining the skills and resources needed to initiate and maintain recovery.

Recovery services seek to:

- Enhance the person’s recovery capital (by assisting people in addressing their basic needs, gaining employment, going back to school, forming sober social relationships, etc.)
- Remove personal and environmental obstacles to recovery (e.g., through the provision of child care or transportation)
- Enhance identification of and participation in the recovery community (e.g., through connecting people to treatment and to 12-step and other mutual support/recovery-oriented groups)

<table>
<thead>
<tr>
<th>Key functions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance in daily management</td>
<td>Peer supporters help people figure out how to carry out in their daily lives the self-management and healthy coping plans they have developed with their doctors and nurses. They use their own experiences with diet, physical activity, medication adherence, and coping with day-to-day challenges and stressors. They can also help in identifying key resources, such as where to buy healthy foods or to do physical activity.</td>
</tr>
<tr>
<td>Social and emotional support</td>
<td>Through empathetic listening and encouragement, peer supporters are an integral part of helping patients to cope with social or emotional barriers and to stay motivated to reach their goals. The more we learn about the fundamental value of social support, the more we realize that simply “being there” can be of enormous help to people in managing disease and coping with mental health problems.</td>
</tr>
<tr>
<td>Linkages to clinical care and community resources</td>
<td>Peer supporters can help bridge the gap between the patients and health professionals and encourage individuals to seek out clinical and community resources when it is appropriate. Especially if a program is part of a provider organization, the peer supporters can also help people find and arrange the care they need.</td>
</tr>
<tr>
<td>Ongoing support, extended over time</td>
<td>Peer supporters successfully keep patients engaged by providing proactive, flexible, and continual long-term follow-up. They don’t need to be talking to people every day, but they can be available when needed — a feature of tremendous value in our current health care systems.</td>
</tr>
</tbody>
</table>
References

What is Peer Support?
http://peersforprogress.org/learn-about-peer-support/what-is-peer-support

Community Health Workers Section, American Public Health Association
www.apha.org/membergroups/primary/aphaspigwebsites.chw

Peer Support in Health and Health Care: A Guide to Program Development and Management


1.3 What are the benefits of peer support?

Evidence indicates that peer support is an effective strategy for health, health care, and prevention. Its benefits extend from the peer supporter, to the recipient, to the provider, to the healthcare system itself.

**Benefits to the peer supporter**

- Improves self confidence in dealing with their own condition
- Provides a sense of satisfaction from helping others
- Increases self-esteem
- Improves education and employment status

**Benefits to the recipient of peer support care**

- Improves self-efficacy, self-esteem, quality of life
- Reduces depression and provides hope through role modeling
- Improves health status and self-care skills, including medication adherence
- Improves coping and taking charge of your own health
- Increases knowledge of a disease and potential for better self-management

**Benefits to the provider**

- Improves provider’s understanding of their patient
- Helps providers to develop better prepared care plans
- Frees up time for the provider

**Benefits to the healthcare system**

- Reduces emergency services and hospitalizations
- Provides cost savings
- Decreases morbidity
- Increases access to care
- Reduces health disparities
- Promotes links between primary care and community based prevention of chronic disease

**Peer supporters in behavioral health provide the following benefits at the individual level**

- Reduce distress and both symptoms and incidence of mental health conditions
- Serve as role models to consumers
- Voice and broker the needs of consumers
- Provide an important source of information
- Serve as a powerful source of motivation
- Help others while helping themselves
- Serve as mentors to others, helping them to better understand paths to recovery
Peer supporters offer the following benefits at the system level

- Assist clients in navigating often fragmented service systems
- Perform needed client support activities, such as transportation and life skills development
- Serve as an unofficial liaison with the non-consumer staff, interpreting and in some cases mediating between staff and clients
- Challenge unacknowledged stigma and bias toward clients
- Augment the services of overburdened behavioral health systems, thereby increasing access to services

### Table 2: Benefits of Peer Support at the Individual Level

<table>
<thead>
<tr>
<th>Benefits of Peer Support</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased depression</td>
<td>Chapin et al., 2013; Dennis et al., 2009; Preyde and Arda, 2003; Proudfoot et al., 2012; Rahman 2008; Thomson et al., 2013; Travis et al., 2010; Weber et al., 2007; Van Voorhees et al., 2012; Vijayakumar and Kumar, 2008</td>
</tr>
<tr>
<td>Improved quality of life</td>
<td>Chapin et al., 2013; Hibbard et al., 2002; Thomson et al., 2013</td>
</tr>
<tr>
<td>Improved functioning</td>
<td>Chapin et al., 2013; Chien and Thompson, 2013; Rahman 2008</td>
</tr>
<tr>
<td>Decreased anxiety</td>
<td>Dennis et al., 2009; Preyde and Ardal, 2003; Proudfoot et al., 2012</td>
</tr>
<tr>
<td>Decreased post-traumatic stress disorder</td>
<td>Van Voorhees et al., 2012; Vijayakumar and Kumar, 2008</td>
</tr>
<tr>
<td>Reduction in re-admissions or hospitalizations</td>
<td>Chien and Thompson, 2013; Landers et al., 2011</td>
</tr>
</tbody>
</table>

### References

What is Peer Support?
http://peersforprogress.org/learn-about-peer-support/what-is-peer-support

Science Behind Peer Support
http://peersforprogress/learn-about-peer-support/Science-behind-peer-support


Table References


1.4 What are the delivery approaches of peer support?

Peer support can take many forms and include a wide range of services. Within the diversity of service delivery models, there are some common elements: a focus on recovery and empowerment; opportunities for members to tell their stories to other peers and to wider audiences; belief that recovery is possible; and the support of peers who believe in recovery.

The following tables show some of the models that are used in chronic disease and behavioral health.

<table>
<thead>
<tr>
<th>Models</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional-led group visits with peer exchange</td>
<td>Patients who share the same condition are brought together with a health care provider or team of providers to address their self-management challenges.</td>
</tr>
<tr>
<td>Peer-led face-to-face self-management programs</td>
<td>A person who shares the same condition as the participants leads in-person sessions to exchange encouragement for better self-management.</td>
</tr>
<tr>
<td>Peer coaches</td>
<td>Also known as peer mentors, peer coaches are individuals who have coped with the same condition and meet one-on-one with patients to listen, discuss concerns and provide support.</td>
</tr>
<tr>
<td>Community health workers</td>
<td>Also known as “promotoras,” community health workers are community members who work to bridge the gap between their respective communities and health care providers. They do not necessarily have a chronic condition, but they often share language, culture and community with the patients. Oftentimes, the roles of community health worker and peer coach are merged.</td>
</tr>
<tr>
<td>Support groups</td>
<td>Support groups are gatherings of people who share common experiences, situations, problems or conditions. In these gatherings, people are able to mutually offer emotional and practical support.</td>
</tr>
<tr>
<td>Telephone-based peer support</td>
<td>This type of peer support is provided through regular phone calls that are either the sole form of an intervention or used to complement other modes of intervention.</td>
</tr>
<tr>
<td>Web- and email-based programs</td>
<td>These programs use the internet to mobilize peer support, including internet-based support groups and e-mail reminders. In addition to increasing reach and convenience, they may overcome problems some patients have with face-to-face contact.</td>
</tr>
<tr>
<td>Models</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Drop-in programs               | ▪ Provide informal one-on-one support  
▪ Role model recovery  
▪ Help member find resources in the community  
▪ Provide opportunities for socialization in the community                                                                                                                                 |
| Recovery education programs    | ▪ Teach classes in evidence based practices, such as Wellness Recovery Action Plan (WRAP) and Illness Management Recovery (IMR) plus Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES)  
▪ Lead recovery education activities in topics such as stress management, Declaration for Mental Health Treatment, etc.  
▪ Facilitate support groups  
▪ Role model recovery                                                                                                                                 |
| Peer wellness coaches          | ▪ Provide group and one-on-one peer wellness coaching sessions, focusing on individual health and wellness strengths and needs  
▪ Lead health and wellness educational groups  
▪ Teach classes in the evidence based practice of the Chronic Disease Self-Management Program  
▪ Teach basic nutrition and how to make healthy snacks and meals  
▪ Coordinate intentional physical activities, including dancing, kickball, walking, etc.  
▪ Administer recovery and health and wellness assessments                                                                                                                                 |
| Housing services               | ▪ Serve as resident counselors in Supportive Living Facilities and provide informal one-on-one peer support in that role                                                                                                                                               |
| Psychosocial rehabilitation    | ▪ Teach classes (WRAP, IMR, BRIDGES)  
▪ Work with clients to develop and implement a person-centered individual service plan to reach goals  
▪ Provide one-on-one support  
▪ Teach topics such as anger management  
▪ Provide supported employment, job readiness  
▪ Provide whole health classes  
▪ Provide GED prep                                                                                                                                 |
| Outreach specialists           | ▪ Provide outreach to people who have frequent inpatient hospitalizations or to people who have failed to engage with the mental health system, or who are noncompliant                                                                                                                                 |
| Intensive community treatment teams | ▪ Perform the same duties as other members of the team including working with clients to develop and implement a person-centered individual treatment plan  
▪ Work with clients to develop a psychiatric advanced directive, if desired  
▪ Provide peer support services that address symptom management, coping skills, finding resources |
### Table 4 cont.: Peer Support Delivery Approaches in Behavioral Health

<table>
<thead>
<tr>
<th>Models</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance navigators/Benefits specialists</td>
<td>- Help people to enroll in insurance&lt;br&gt;- Teach people how to access care (PCP, specialty care, health home)&lt;br&gt;- Help peers understand their benefits&lt;br&gt;- Help individual who seek SSI/SSDI benefits</td>
</tr>
<tr>
<td>Peer evaluators</td>
<td>- Assist consumers in completing evaluation processes</td>
</tr>
<tr>
<td>In-patient psychiatric setting</td>
<td>- Provide one-on-one peer support&lt;br&gt;- Lead support groups&lt;br&gt;- Teach classes in WRAP, IMR, BRIDGES&lt;br&gt;- Serve as the hospital liaison for grievances&lt;br&gt;- Accompany people through the intake process and discharge</td>
</tr>
<tr>
<td>Employment/Job coach</td>
<td>- Provide evidence based practice supported employment&lt;br&gt;- Coordinate services with vocational rehab</td>
</tr>
<tr>
<td>Crisis services</td>
<td>- Crisis services are required to have at least one Peer Specialist on staff and mobile crises response teams are required to have access to a peer specialist.</td>
</tr>
<tr>
<td>Respite</td>
<td>- Provide transportation as a diversion from inpatient hospitalization&lt;br&gt;- Provide respite services as an alternative to crisis services&lt;br&gt;- Accompany people in police care for involuntary inpatient commitment&lt;br&gt;- Work in emergency rooms</td>
</tr>
</tbody>
</table>

### References


1.5 What are some successful peer support programs?

Peer supporters are increasingly recognized as integral members of the health care system. In 2003, the Institute of Medicine recommended that peer supporters serve as members of health care teams to improve the health of underserved communities. The PEW Health Professions Commission evaluated the use of peer supporters in the United States and concluded that they can make substantial contributions to health care access and improve health status in hard to reach populations. Their contributions to improving access to care and health knowledge, behaviors and outcomes are well documented mostly for asthma, hypertension, diabetes, HIV/AIDS, cancer screening, immunizations, and for maternal and child health in general.

Peer support is a best practice model for supporting people who have mental health conditions. Common elements of successful programs include:

- A focus on recovery and empowerment
- Opportunities for members to tell their stories to other peers and to wider audiences
- Belief that recovery is possible
- The support of peers who believe in recovery

There are many models of successful programs, at the national, state and local level.

The Veterans Administration (VA) has widely employed peer specialists that facilitate support groups, advocate for veteran consumers, provide crisis support, act as liaisons between staff and veterans, work on a variety of clinical teams, provide outreach and educate VA staff and veterans about peer support services. In 2013, the VA expanded its peer specialist workforce by 800 new positions.

Several states have peer led programs for behavioral health and recovery services. In Tennessee, peer specialists operate in peer support centers leading evidence based classes (Wellness Recovery Action Plan), health and wellness classes, and support groups.

Vermont’s Blueprint for Health is a promising model for integrating behavioral health and chronic disease management through the employment of peer supporters. It utilizes community based, interdisciplinary teams that include peer supporters, which provides integrated chronic disease management and mental health services to patients of participating primary care providers.

Amigas Latinas Motivando el Alma (ALMA) is a community partnered research project guided by a collaboration between UNC-Chapel Hill and Duke University. ALMA’s is a lay health advisor intervention whose primary focus is to prevent depression and anxiety among Latinas in three counties in central North Carolina. Lay health advisors share their newly acquired skills with Latina peers in their home communities to reinforce positive coping strategies and facilitate healthy behavior change. Preliminary results show that ALMA reduced sub-clinical anxiety and depressive symptoms for Latinas by increasing knowledge, awareness, and skills through a curriculum that normalizes stress, self-care, and support in a group setting.
Advocating and Planning for a Behavioral Health Peer Support Program

Project Wings Home Visits is a mental health intervention for Latino Families. Latino adolescents have higher rates of mental health conditions than their peers, including depressive symptoms, suicide attempts, and violence. Project Wings Homes Visits is a collaborative school-based, community linked mental health promotion intervention for Latino adolescents and their families in Minneapolis, MN. The intervention was developed using a community-based participatory research approach that involved the cooperation of a community health care system, a public high school, and a university. Core to the intervention is the use of a community health worker model to provide home-based outreach and education to parents of Latino adolescents.

References


1.6 How might the Affordable Care Act impact peer support?

Peer support services have the potential to improve the quality of health care delivery, lower healthcare expenditures and reduce health disparities. The Affordable Care Act (ACA) outlines funding mechanisms for peer support and community health worker (CHW) programs through chronic health homes, community health teams in support of patient-centered medical homes, hospital readmission reduction programs, and as patient navigators. The ACA defines CHWs as a liaison between communities and health care agencies who:

- Provides guidance and social assistance to community residents
- Enhances community residents’ ability to effectively communicate with health care providers
- Provides culturally and linguistically appropriate health and nutrition education
- Advocates for individual and community health
- Provides referral and follow-up services or otherwise coordinate them
- Proactively identifies and enrolls eligible individuals in health and human services programs

The peer support movement has been a positive force in behavioral health recovery. However, people with mental health conditions still face many challenges. More than 49 million people with mental health conditions live in poverty, and more than 80% are unemployed. National health reform provides an opening for new strategies and opportunities for peer supporters as wellness coaches. While peer support services are common in behavioral health, there is an emerging opportunity in primary care in the form of peer-driven health teams working in health education, screening, outreach, care management, patient navigation, community referrals, and other services.

Certified Peer Support Specialists or other peer supporters can serve as recovery coaches and provide a vital function in helping to coordinate and integrate services, and connecting people to clinical care and community resources. These services are usually delivered in non-clinical setting, but there is potential for expansion of services into newly evolving health settings such as patient centered medical homes and accountable care organizations.

The ACA envisions greater integration of primary care and behavioral health. For this to happen, bridges have to be built between these two separate systems. If peer supporters can be trained in health and wellness coaching, as they are in several US states, then they can leverage their unique relationship with the patient to serve as a bridge between primary care and behavioral health.

References


Section 2. Obtaining Buy-In

The next step is to plan an advocacy strategy to enhance buy-in and respond to resistance. Every advocacy effort needs a strategy to coalesce support. This section includes: positioning your program to build support; eliciting local leadership support; addressing issues that doubters may bring up, such as concerns about peer supporters in mental health and challenges facing peer support programs. The checklist below provides the key elements in planning an advocacy strategy.

Elements in planning a strategy

- Establish a working group to develop a strategy and plan activities.
- Identify your audiences (pro, undecided, and against).
- Minimize the opposition or find areas of common interest as often as possible.
- Refine positions to achieve a broader consensus.
- Develop SMART objectives (specific, measurable, appropriate, realistic and time bound).
- Position your issue to offer key decision-makers a unique and compelling benefit or advantage.
- Identify your resources and plan to build coalitions and mobilize support.
- Plan the activities that are the most appropriate for your intended audience.
- Plan for and combine multiple channels of communication.
- Give the proposed change an appealing name that is easily understood and designed to mobilize support.

References


2.1 How will you position the program to enhance appeal?

Organizational leaders may be unfamiliar with peer support programs. Thus, to gain leadership support for your program, you may have to provide information about peer support programs to demystify any concerns and increase buy-in. You can help to build local leadership motivation and buy-in by communicating the efficacy, utility, and cost-effectiveness of peer support programs.

The Peers for Progress website section on promoting peer support provides useful suggestions for program managers looking to promote peer support programs.

What can managers do to promote peer support programs?

- Clarify how your peer support program will be of benefit to your organization and the clients served.
- Clarify any perceived overlap in the roles of peers and professional staff. For example, peer supporters may assist with case management activities, so how will they work with existing case managers? How will specific activities be delegated? It may be that the case manager will locate resources and the peer supporter works with the client to access them (helping to complete the application process, accompanying them, etc.). Reinforce to the staff that peer supporters do not operate as professionals in the organization.
- Consider how your peer support program aligns with the values, mission and goals for your organization.
- Assess barriers and facilitate factors to developing and maintaining a peer support program (community, organizational structure, funding and culture).
- Consider the checklist developed by King (2006) to assess provider practices and see how many of the activities support peer culture/support and leadership. How will a peer support program help providers in your organization?
- Consider how your peer support program will increase outcomes of interest to the population served. Outcomes can include quality of care (access to services, efficiency of care, client satisfaction), quality of life, mental health outcomes, or physical health outcomes.
- Seek buy-in from key stakeholders (community leaders, organizational leaders, health care providers.
- Build the business case for your peer support program (financial and nonfinancial).

References


2.2 How do you elicit local leadership support?

Your advocacy objectives should take into consideration three different groups of people as outlined below (Scribner and O'Hanlon, 2011):

1. **Current supporters**: Maintain and mobilize current supporters of your change. Not everyone who supports your program change will work actively for its implementation.

2. **Resistors**: Minimize active opposition to the change. You may be able to convince your opponents to limit their efforts to obstruct the change, even if you cannot change their opinions.

3. **Fence sitters**: Convert neutral parties to supporters for your change.

For each of these categories, the advocacy objectives should include the following:

- Whose opinion or behavior do you want to change?
- To what should their opinion or behavior be changed?
- What actions or steps do you want them to take?
- What is the timeline?

The following actions may help in eliciting local leadership support:

**Gain assistance from your supervisor**

- Discuss with your supervisor mechanisms for educating leadership about peer support programs.
- Keep your supervisor informed of, and involved in, your activities.
- Discuss challenges encountered.

**Meet with organizational leaders**

- Schedule a meeting with organizational leaders to provide information on peer support and discuss any concerns.
- Construct an agenda of key topics that you will discuss in time frame allocated.
- Frame your peer support program in a way that is aligned with the mission, values, and goals of your organization.
- Discuss any systems issues and needs for implementing your program.

**Motivate individuals who may be unfamiliar with, ambivalent toward, or initially unsupportive of peer support programs**

- Identify individuals who may be unfamiliar with, ambivalent toward, or initially unsupportive of peer support programs.
- Talk with them about their concerns and provide education about peer support programs.
- Come up with innovative ways to partner with these individuals.
Look for opportunities to spread the word

- Take advantage of opportunities to put in a plug for your program while walking down the hall, riding in an elevator, waiting in a lunch line.
- Have an elevator speech for discussing your peer support program. Consider the most important aspects of peer support implementation that you will need to convey in the time it takes to ride an elevator.
- Empower other supporters of peer support programs to be local ambassadors.

Once buy-in is obtained from the key stakeholders and resources are secured or identified, you are ready to proceed with organizing your stakeholder team to develop program goals and objectives.

References

Peer Support in Health and Health Care: A Guide to Program Development and Management

Promote Peer Support.
www.peersforprogress.org/promote-peer-support

2.3 What are some common concerns about peer support?

Although peer support specialists have become recognized and valued employees, there are still several barriers to their employment. Some of these are misperceptions about peer support specialists, common concerns of staff professionals, and organizational and structural issues.

<table>
<thead>
<tr>
<th>Table 5: Misconceptions and Concerns about Peer Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Misperceptions about peer support specialists</strong></td>
</tr>
<tr>
<td>Peer supporters cannot work full time, either because of disability insurance or because of the responsibility</td>
</tr>
<tr>
<td>Peer supporters cannot fulfill the same roles as providers who are professionals</td>
</tr>
<tr>
<td>Peer supporters will relapse</td>
</tr>
</tbody>
</table>

| **Common concerns of professional staff**             | **Response**                                                                 |
| Peer supporters are too fragile to handle the stress of the job | Relapse is rare, mainly because peer supporters who are hired have already demonstrated that they can handle job stress. |
| Peer supporters cannot handle the administrative demands of the job | This has been shown not to be the case. They are capable of doing the appropriate documentation and paperwork associated with administrative tasks. Appropriate training will ensure that they have competence in this area. |
| Peer supporters will cause harm to the clients that other staff members will have to undo | Harm, like breaches of confidentiality, dual relationships, poor suggestions to clients, are not unique to peer supporters. Safeguards can be put in place to prevent them. Training covers these issues. Adequate supervision addresses these issues. If peer supporters violate any of the policies and standards in place, they should be held accountable like any other employee. |

| **Organizational and structural issue**               | **Response**                                                                 |
| It may require the creation of a new job class       | This may bring up questions regarding how to determine rate of pay, how to code services for billing purposes, etc. More and more states allow peer support services to be billed under Medicaid. |

[http://www.rand.org/content/dam/rand/pubs/technical_reports/2008/RAND_TR584.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2008/RAND_TR584.pdf)
2.4 What are the challenges facing peer support programs?

A variety of barriers hamper the success of peer support programs. These barriers can be understood in the context of organizational, cultural, and intrapersonal issues. The following table summarizes these challenges and potential solutions.

<table>
<thead>
<tr>
<th>Organizational Challenges</th>
<th>Solutions</th>
</tr>
</thead>
</table>
| **Lack of Training:** Many peer support programs lack a formal, systematic, and comprehensive training program, which can result in role ambiguity and tension between peer educators and supervisors (Chinman & Salzer, 2012). | 1) Provide certified training opportunities for peer supporters with topics that include: using your story as a recovery tool, facilitating mutual support groups, effective listening and asking questions, problem-solving with individuals, planning and accomplishing recovery goals, dealing with ethical and workplace issues, and mental illness basics.  
2) Ensure that the organizations allow for ongoing training/supervision to account for future problems. |
| **Hiring Confusion:** In some settings it may be difficult to hire peer supporters who have had mental illness because HR staff may not understand the condition and how it will affect employment (Chinman & Salzer, 2012). | 1) Know the benefits of peer support and how peer supporters with the condition can provide help to peers.  
2) Provide guidance for how HR and organizations can assess for the qualification of lived experience with mental illness during interviews without violating labor laws. |
| **Lack of funding:** Many organizations lack funding to train, implement, incentivize, and supervise peer supporters (Opportunities in the ACA). | 1) Look for opportunities within the Affordable Care Act for new funding sources for Peer Support programs.  
2) Evaluate costs and cost effectiveness of peer support programs compared to usual care. |
| **Staff Resistance:** Peer supporters may receive less supervision and support from staff and exclusion from treatment team meetings (Pogoda et al., 2011; Peer Specialist Toolkit). | 1) Identify a staff champion or a coordinator for peer support to help ensure that the organization recognizes the value of peer supporters in providing care to peers.  
2) Involve peer supporters in team decisions with stakeholders  
3) Ensure that peer supporters are adequately oriented to the organization and discuss role expectations among all staff. |
| **Burn-out:** Many peer supporters may face burn-out in response to their duties and high turnover rates are common (Fisher et al., 2009; Peer Workforce and Capacity Building). | 1) To reduce burn-out and high turnover rates, several strategies can be employed including: recognition, honoraria, opportunities for exchange of case material with other peer supporters, and in-service training to enhance skills.  
2) Anticipate that turnover is common and provide for limited tenure of peer supporters and constant replenishment of their ranks.  
3) Add plans for sustaining peer supporter’s involvement in community education and link peer supporters to leadership and educational development opportunities. |
### Table 6 cont.: Organizational, Cultural, and Intrapersonal Issues

<table>
<thead>
<tr>
<th>Cultural Challenges</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education vs. Encouragement</strong>: Conflicts may arise surrounding the extent to which peer supporters should focus on education of behavioral health issues or provision of emotional support (Fisher et al., 2009).</td>
<td>1) Recognize that peer support is highly dependent on context and may vary depending on the culture of needs of the individual.</td>
</tr>
<tr>
<td></td>
<td>2) Ensure that program models and curricula leave room for variation in the roles of peer support.</td>
</tr>
<tr>
<td><strong>Expectations for Disease Management</strong>: Societal differences for how individuals should cope with disease (i.e., individual autonomy, family support) may introduce challenges to the work of peer supporters (Fisher et al., 2009).</td>
<td>1) Ensure that peer support programs recognize the context in which support is being provided, and understand cultural ideas surrounding the disease and how it should be confronted.</td>
</tr>
<tr>
<td><strong>Attitudes towards Individuals with Mental Health Problems</strong>: Depending on cultural conceptions of mental health, some organizations may believe that those with mental health conditions are incapable of working as a peer supporter (Pogoda et al., 2011).</td>
<td>1) Provide space for discussion of mental health conditions and the role that peer supporters can play in providing treatment for behavioral health concerns for peers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intrapersonal Challenges</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boundaries</strong>: Confusion can arise as to how close peer supporters should become to the peers with whom they work.</td>
<td>1) Boundaries should be flexible and individually governed to avoid perpetuating power structure of traditional, formal, professional relationships.</td>
</tr>
<tr>
<td></td>
<td>2) Adequate supervision can allow peer supporters to discuss these issues with supervisors and receive advice.</td>
</tr>
<tr>
<td><strong>Role Confusion</strong>: There is little consensus in defining the role of peer supporters, varying from context to context especially for behavioral health.</td>
<td>1) Group supervision can be offered to help peer supporters share insights, coping strategies and experiences.</td>
</tr>
<tr>
<td></td>
<td>2) Expectations for peer supporters should be decided on in advance by organization.</td>
</tr>
<tr>
<td><strong>Stress/Emotional Distress</strong>: Peer supporters may be exposed to stress in performing their duties and attempting to help others.</td>
<td>1) Support and training are needed so that peer supporters understand when to ask for help and when to take time out when required.</td>
</tr>
<tr>
<td><strong>Lack of Confidence</strong>: Some peer supporters may feel under qualified to provide support for peers.</td>
<td>1) Ensure adequate training and ongoing supervision so that peer supporters can confront barriers to helping peers.</td>
</tr>
<tr>
<td><strong>Incentives</strong>: Peer supporters can be compensated for their work in a variety of different ways, ranging from volunteering to salaried positions. This can present problems in how peer supporters are supported and/or recognized.</td>
<td>1) Recognize that compensation will need to take into account a variety of concerns including: the task at hand, selection for the job, the expected results, and how the community will view the motivation strategy.</td>
</tr>
<tr>
<td></td>
<td>2) Ensure that peer supporters are adequately compensated, whether that is through recognition/community support/educational opportunities or through money/financial incentives.</td>
</tr>
</tbody>
</table>
References


Section 3. Developing and Implementing a Peer Support Program

The role of peer support in behavioral health services and person-centered recovery has been actively developing and evolving in recent years. Formal training programs for peer support services have been established. At the state level, the role of peer support has changed since Medicaid designated peer support as a billable service for adults.

A popular approach to peer support in behavioral health is the Peer Support Specialist. Many who work in the field of recovery are Certified Peer Support Specialists, whose role is to work with consumers to assist in regaining balance and control of their lives, and to support recovery. They can work in a voluntary capacity or be employed in mental health, addiction, or recovery-oriented services. Thirty-six states have Certified Peer Support Specialists, whose services are billable to Medicaid. A key factor that differentiates the Certified Peer Specialist from other behavioral health positions is that the individual works out of their own lived experience and knowledge of their mental health condition.

Certification is an approach to securing program quality and patient safety in peer support programs. An alternative to certification of individual peer supporters would be to regulate and certify organizations that train and employ peer supporters. Such standards should include regular supervision and available backup to handle emergent or complex situations beyond supporters’ skill levels. Pursuing this approach, the National Standards for Diabetes Self-Management Education and Support specify the responsibilities of peer support programs and the organizations that house them to provide monitoring, supervision, and backup but leave organizations free to recruit supporters according to those programs’ objectives and settings. This approach to quality assurance may have advantages in terms of greater flexibility in hiring and deploying peer supporters and avoiding professionalization that might compromise “peerness”.

This section provides a series of checklists for you to consider in organizational readiness, program development and management. Each topic begins with a checklist of “best practices” for peer support programs. After the checklist, special issues that may arise related to peer supporters in chronic disease, or peer support specialists working in behavioral health are mentioned.
3.1 What are some factors in determining organizational readiness?

The following checklist may be useful in deciding if you have the organizational resources to develop a peer support program which addresses psychosocial and/or mental health problems.

**Key Factors in Organizational Readiness**

- **Objectives**: Do you have clear objectives for the program that are consistent with your overall organizational mission and the interests of the community you serve?

- **Leadership commitment to staff time**: Are you prepared to dedicate staff for program management as part of their regular duties?

- **Champion and staff buy-in**: Do you have someone who is willing to passionately champion the effort, as well as dedicated staff who buy-in to the program?

- **Expertise in planning**: Do you have expertise in program planning and development to guide implementation and evaluation of peer educator programs?

- **Expertise in education, mentoring and supervision**: Do you have the expertise in education and training to provide on-going training and supervision of peer educators as long as you have them?

- **Capacity to handle emergency**: Will you have 24/7 back-up available in your own organization or through collaborators to answer questions and provide guidance to peer educators in handling emergent or urgent problems, including suicide prevention?

- **Network of support services**: Does your organization have referral access to behavioral health and emergency services within the organization, or in the community, beyond what your peer educators can provide?

- **Financial resources and re-prioritization**: Do you have sufficient funding not only for developing a peer support program but for sustaining one?

- **Integration**: Do you have mechanisms and procedures to allow for integration of the peer educator program with other efforts?

- **Communication**: Do you have open, transparent and regular channels of communication between staff and peer educators?
3.2 What are issues in the management of peer support programs?

Program development involves developing additional policies and procedures to integrate the peer support program into the existing structures, accountability procedures, alignment with the agency’s values and ethics, and assurance of adequate resources. The following key factors address these issues.

Policies and Procedures

- Have you decided what additional policies and procedures are needed?
- Have all relevant policies and procedures been documented and understood?
- Are there policies that are consistent with ethical standards, reliably enforced, and locally developed with input from multiple stakeholders?

Finances and Resources

- Have all the regulatory and financial compliance requirements been identified and met?
- Are there adequate resources to enable the program to continue to operate?
- Does the coordinator have sufficient financial resources to manage the program?
- Are you making good use of technology (data control, communication tools) to support your program?

Values and Ethics

- Are the values underpinning your program regularly revisited?
- Are management practices ethical and non-discriminatory?
- Is there a process for managing grievances?

Accountability

- Does the program have an advisory group made up of consumers, professionals and family members to assist with the ongoing development of the program?
- Are the accountability requirements of the staff and peer supporters well defined?
- Is the system of reimbursement of peer supporter expenses working smoothly?
- Is there an effective system to collect and store records?

Program Issues

- Have you developed a program plan?
- Do you have goals and objectives?
- Does your program have a clear statement of purpose?
- Is the program designed for sustainability?
- Have you provided clearly defined roles and responsibilities for the peer supporters?
- Is there a job description, including selection criteria for the coordinator?
Management of Peer Support in Behavioral Health

Special issues may arise in agencies that employ peer supporters to address behavioral health issues.

<table>
<thead>
<tr>
<th>Management Issue</th>
<th>Recommended Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitioning from client to peer supporter</td>
<td>This can be challenging. Supportive supervision and clear job description can help peer supporters make this transition.</td>
</tr>
<tr>
<td>Use of mental health services</td>
<td>It is not advisable for a peer supporter who is still in need of mental health services to receive it from their employer. He or she should receive his or her own mental health services in a different facility if possible.</td>
</tr>
<tr>
<td>Peer support for the peer supporters</td>
<td>Some form of peer support among the peer supporters themselves can be critical to the success of the peer support program, if there are several working in the organization. Ongoing peer support groups can provide a forum for discussion of issues and mutual strength-building.</td>
</tr>
<tr>
<td>Integration into staff culture</td>
<td>Peer supporters have had mixed initial experiences in their new roles. Peer supporters should be allowed to participate in all team events. Having them enter clinical notes into the medical record helps to integrate them within the team; however, supervision as to the type of information accessible is advisable. They should be allowed to drive team vehicles. Having a peer supporter champion with the responsibility of overseeing the incorporation of peer supporters into the workforce is an important principle of recovery-oriented services.</td>
</tr>
<tr>
<td>Peer supporters in management roles</td>
<td>In addition to having peer supporters providing direct services, it is helpful to have them in management roles. They can be role models who embody the possibility that individuals with mental illness can move up in organizations and not just be hired as tokens.</td>
</tr>
<tr>
<td>Addressing staff concerns</td>
<td>Another challenge peer supporters face as they transition into a staff role is the degree of acceptance they feel from other staff on the team. They may face skepticism when they first join the team. This can be minimized by training of existing staff, involving them in the hiring process, and soliciting their input regarding the role of peer supporters. Supervisors should require the same level of accountability from peer supporters as they do from other staff members.</td>
</tr>
</tbody>
</table>

References


3.3 What are issues in recruitment and selection of peer supporters?

Recruitment and selection of peer supporters is crucial to the success of your program. The Sinai Urban Health Institute’s Best Practice Guidelines for CHW Programs in Health Care Settings contains a review of the literature on recruitment and selection methods. This section summarizes and adds to the findings in that report.

**Recruitment**

The recruitment process will vary depending on the duties and responsibilities expected from the peer supporters, the program setting, and the level of compensation provided. According to Gutierrez Kapheim and Campbell (2014), networking and word-of-mouth are the most common recruitment strategies. In volunteer programs, potential peer supporter candidates are commonly recruited from existing or former patients. Individuals can be nominated by clinicians, identified from a patient database, or recruited from patient education programs. Networking with community groups and community leaders can help identify “natural helpers”. More established peer support programs that formally employ peer specialists or community health workers will tend to solicit applications through print or online job postings.

Additional considerations:
- Have you determined the qualities of the ideal peer supporter for your program?
- Is there a clear process about how peers can join and/or be referred to the program?
- Have you identified churches, local businesses, or community-based organizations for referrals or to assist with advertising?

**Selection**

The selection of peer supporters from a pool of applicants is usually up to the discretion of a few key program staff. The key factors in their decision-making process are the candidate’s connection with the community, background and personality traits, and education and skills at hiring. An individual that has a strong connection with the community will be able to relate to community members and find it easier to establish their peer identity among the people they serve. Peer supporters must bring certain qualities to their work that cannot be taught in training, such as compassion, communication skills, problem-solving ability, ability to work in teams, willingness to learn, reliability, nonjudgmental, warmth, and resilience (See Table 8). These personality traits are more important to the success of a peer supporter than his/her formal education and skills. However, it may be difficult to accurately assess whether a candidate possesses these desirable qualities and program staff may have different ideas about which qualities are most important.

Additional considerations:
- Are the peer supporters representative of the population being served?
- Does your system of selection of peer supporters identify those with the desired qualities?
Table 8: Desired CHW Traits Reported by Employers (SUHI Report)

<table>
<thead>
<tr>
<th>Study Description</th>
<th>Traits</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of CHW intervention studies</td>
<td>Compassion, willingness to learn, interest in subject material, leadership qualities or leadership experience in community</td>
<td>O’Brien et al. 2009</td>
</tr>
<tr>
<td>Structured interviews with eight diabetes management studies</td>
<td>Hard worker, ability to connect with clients, passion for the work, strong commitment to community</td>
<td>Cherrington et al. 2008</td>
</tr>
<tr>
<td>CHW programs at seven health care sites; All programs received federal funding</td>
<td>Open personality, an ability to listen while being compassionate and respectful, strong communication skills, determination, pragmatism, logic, and compassion</td>
<td>Zuvekas et al. 1999</td>
</tr>
<tr>
<td>Allies Against Asthma coalition of community-based asthma programs (7 sites)</td>
<td>Having a clear respect for other people, warmth, dedication, reliability, persistence, the ability to earn and maintain trust, discretion (because of confidentiality), and resilience</td>
<td>Friedman et al. 2006</td>
</tr>
</tbody>
</table>

References


Table References


3.4 What are issues in the training of peer supporters?

Training and career development in the peer supporter workforce varies widely within the health care system, and across states and regions. Currently, there are no nationally recognized training standards, though some states have established formal systems of training and education. The role of peer supporters also varies depending on the population, setting, and disease, but the most important and overarching role is fostering connections that bridge the gap between individuals and the health care system.

Trainings must prepare peer supporters with the knowledge, skills, and resources to face a variety of challenges. Some trainings are meant to strengthen or refine existing qualities, such as communication skills and stress management. Other trainings prepare peer supporters to work within health care settings, paying special attention to clinical protocols, confidentiality, and record-keeping. Any training must be tailored to the type of work that the peer supporter is doing, as well as the needs of the community.

In many peer support programs, training is conducted on site, according to the precepts of adult education theory. Although some states have established formal CHW education programs through community colleges, these types of programs do not represent the best or only solution to workforce training needs. In fact, there are many barriers that individuals may experience with formal training programs, such as limited education, lack of English language proficiency, and lack of funding for tuition. In any case, no matter how comprehensive the training program, onsite training will always be necessary.

Key factors in training and development of peer supporters

- Is training provided to the peer supporter to prepare for his/her role in service delivery and ensure s/he has the necessary skills to provide safe and quality care?
- Is there ongoing training provided to update the peer supporter on new skills, to reinforce initial training, and to ensure s/he is practicing skills learned? (See resources)
- Is there the possibility for growth and advancement for the peer supporter?
- Is there recognition of the completion of training?
Table 9: Recommendations for CHW Training (SUHI Report)

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Length, Content, and Scope           | Initial training should be comprehensive, including 1) relevant knowledge and skill-based teaching, 2) core-competency curriculum, and 3) cross-training on co-morbidities, mental health, or other common conditions within the population served.  
Initial training should be spread out over an extended period of time.  
Provide ongoing training throughout the course of employment. |
| Training Instructor, Methods, and Style | Teaching should be interactive, hands-on, participatory, and appeal to a wide variety of learners and literacy levels. Interactive activities include case study, role play, skills practice, field work, discussion, mentoring, and shadowing of more experienced CHWs.  
Employ a team-based approach to training. |
| Training Evaluation                  | Assess the quality and effectiveness of training, taking care to evaluate 1) knowledge, 2) skills, 3) effect of training on performance, and 4) CHW reaction to training. Suggested evaluation methods are pre-post knowledge test, written training evaluation, and evaluated role play. |

Ethical Considerations in Peer Support Programs

- **Confidentiality**
  During the course of peer support programs, participants may reveal intimate details of their lives, family relationships or various problems. To protect the privacy of individuals’ lives, training must cover the concept of confidentiality, how it pertains to peer support programs, and how it can be maintained.

- **Role Conflict**
  Research has shown that communicating clear job roles is a key to success. However, it can be difficult to know where peer supporters’ job boundaries begin and end, leading to poor outcomes. Training should discuss the roles that peer supporters are expected to take on and delineate boundaries.

- **Self-Disclosure**
  Deciding what information to share with participants and how to reveal personal information requires self-disclosure skills. Peer supporters may disclose personal issues that they have successfully resolved and training should provide suggestions or ideas on how to do this in an appropriate manner.

- **Setting Limits**
  Setting limits can be difficult especially for peer supporters that want to help participants. However, training should emphasize that setting limits is appropriate for boundaries that should not be crossed. Specific training exercises can be used to help peer supporters gently refuse personal requests or manage difficult situations.
Skill Development in Peer Support Programs

- **Communication, facilitation, and listening skills**
  Communication is an important component of how peer supporters can help participants. This can be particularly difficult in group support sessions where facilitation is needed to moderate how participants interact with each other. Training should cover key facets of communication skills, including active listening, paraphrasing, empathy skills, constructive feedback, and probing.

- **Nonverbal communication**
  Although verbal communication is often prioritized, nonverbal communication is also an important part of how peer supporters connect with participants. Training should emphasize the importance of attending skills, which recommend facing participants, having an open posture, adopting a “leaned in” position, maintaining eye contact, and having a relaxed stance.

- **Problem assessment & Problem-solving skills**
  During peer support programs, participants will often bring up problems that either the group or peer supporters are expected to discuss and/or solve. Problem assessment can be achieved through techniques such as brainstorming, balancing consequences, goal setting, and developing action plans. Training should cover these skills to help peer supporters in their roles.

Dealing with Potential Problems

- **Burn-out and knowing personal limits**
  Because the job responsibilities of peer supporters can be taxing and burdensome, peer supporters may become “burned out”. Training programs should emphasize that this is both common and manageable and provide resources on how to deal with such situations. Training should also highlight the supportive resources that are available to peer supporters.

- **Stress management**
  Stress is a normal part of life but it can disrupt the recovery process for both peer supporters and participants. As such, training within peer support programs should be dual fold: it should address how peer supporters can manage the stress of providing support to others and it should equip peer supporters with skills that they can share for participants to manage their own stress.

- **Referrals**
  Sometimes individuals may need help beyond that of which peer supporters can provide. In those instances or crises, peer supporters should facilitate referrals of individuals needing professional assistance. Training should cover what cases might necessitate further help or referral.

- **Cultural issues**
  Depending on the region, culture, or population that the peer supporter is working in, the types of support that he or she offers may differ. Training should emphasize the importance of cultural competence and the fact that different cultures may request or receive support in different ways.
Additional training topics for those who work in recovery oriented programs for mental health are listed below.

**Training on relevant topics:**

- Stages in the recovery process
- The impact of diagnosis on one’s self-image
- Mental health conditions: course, symptoms, treatments
- Addictive disorders: course, symptoms, treatments
- Self-help and mutual support groups
- Boundaries
- Dual relationships (how to avoid or, if unavoidable, how to navigate having multiple relationships with the same person, being both a provider and a friend)
- Cultural competency

**Training on relevant skills and knowledge for the job and the setting:**

- Using one’s recovery story
- The role of peer support in the recovery process
- Advocacy for recovery environments
- Creating relationships that promote recovery
- Beliefs and values that promote and support recovery
- Effective listening and asking questions
- Using dissatisfaction as an avenue for change
- Combating negative self-talk
- Conducting problem-solving
- The role of spirituality in recovery
- Navigating power, conflict, and integrity in the workplace
- Developing and pursuing recovery goals
- The basics of medical record documentation
- Crisis procedures

**References**

[http://www.rand.org/content/dam/rand/pubs/technical_reports/2008/RAND_TR584.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2008/RAND_TR584.pdf)

Advocating and Planning for a Behavioral Health Peer Support Program


3.5 What are some useful training resources?

Following is a list of agencies which provide training and consultation for peer supporters and peer specialists working in recovery oriented programs.

**Peers for Progress Training Resources**
http://peersforprogress.org/tools-training/access-resources
http://peersforprogress.org/take-action/train-peer-supporters#step2

**CDC Training Resources**
http://www.cdc.gov/DHDSP/pubs/chw_elearning/resources_cdc_resources_page_1_dhdsp.html

**Massachusetts Association of Community Health Workers Training Resources**

**Healthcare Education-Industry Partnership**
The Minnesota Community Health Worker curriculum – Standardized 11 credit curriculum available for purchase for schools outside with MN State College and University System.
http://www.heip.org/whats_new.htm

**Washington State Peer Support Training Resources**

**InterNational Association of Peer Supporters**
www.inaops.org/library
For a list of peer support training providers, go to http://inaops.org/training-providers

States have guidelines for those who work in recovery oriented services as a Certified Peer Support Specialist. They may vary in their requirements for certain courses. Below is an example of some of the courses that are recognized by some states. The ones listed below are evidence-based.

- Recovery Innovations, Inc.’s Peer Employment Training taught by META-Certified Facilitator
- Illness Management and Recovery (IMR)
- Wellness Recovery Action Plan (WRAP 1 and WRAP 2) emphasizes the importance of personal responsibility, the need for a well-rounded support system, and the benefits of personal hobbies and interests in addition to careful crisis planning.
- Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) Teacher Training
- BRIDGES Support Group Facilitator Training
Mental Health Peer Support Training

Tennessee Department of Mental Health
Certified Peer Specialist Program: Guidelines, Standards and Procedure
www.state.tn.us/mentalSupSpecCert/TCPSHAndbookRev.pdf

Tennessee Department of Mental Health and Substance Abuse Services
Crisis Training Manual

Georgia Peer Support Certification Project
Comprehensive, classroom-based, 40 hour, 30 module curriculum covering peer support, psychosocial rehabilitation and recovery, the impact of diagnosis on self-image, effective communication skills, and the basics of documentation
http://www.gacps.org/Home.html

Canadian Mental Health Training Resources
http://www.schizophrenia.com/pdfs/psmanual.pdf

Depression and Bipolar Support Alliance
Provides an on-site, classroom-based, 40 hour training program
http://www.dbsalliance.org/site/PageServer?pagename=education_training_consulting

Mental Health Association in New Jersey, Consumer Connections
http://www.mhanj.org/consumer-connections-2/

Recovery Innovations Arizona
http://www.recoveryinnovations.org/riaz/

U.S. Psychiatric Rehabilitation Association
http://www.uspra.org

Philadelphia Department of Behavioral Health and Mental Retardation Services

Peer Specialist Training and Certification Programs: A National Overview
wwwblogs.utexas.edu/mental-health-institute/files/2012/10/Peer-Specialist-Training-and-Certification-Program-A-National-Overview.pdf
3.6 How do you match individuals with peer supporters?

Matching individuals with peer supporters that they find acceptable increases the likelihood that they will be able to connect with each other and find the relationship to be valuable. Unfortunately, there is not very much information in the literature about best practices for matching individuals with peer supporters. While interventions have developed innovative approaches to matching, they have not studied the relative benefits and drawbacks of different matching approaches.

The following table provides examples of innovative approaches to matching individuals with peer supporters. The table on the next page summarizes the traits of individuals and peer supporters that are likely to influence matchmaking quality.

<table>
<thead>
<tr>
<th>Approach</th>
<th>Description</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assignment by program staff</td>
<td>Program staff matches patients with peer supporters based on considerations such as age, ethnicity, life experience, geographic proximity, and availability.</td>
<td>Matching process happens faster</td>
<td>Patients don’t choose their peer supporters; Less transparency</td>
</tr>
<tr>
<td>Naturalistic matching through peer support groups</td>
<td>Patients and peer supporters participate in education sessions or support groups, allowing relationships to develop naturally over time.</td>
<td>Building rapport may be easier</td>
<td>Matching process takes longer</td>
</tr>
<tr>
<td>Peers select among short profiles of peer supporters</td>
<td>Peer supporters create short Facebook-like profiles of themselves to provide some personal and background information. Patients are free to select a peer supporter with whom they would feel the most comfortable.</td>
<td>Patients choose their peer supporters</td>
<td></td>
</tr>
<tr>
<td>Software-assisted online matchmaking</td>
<td><strong>SisterMatch</strong> is a piece of online matchmaking software that helps women with diabetes connect with each other. Using the metaphor of a community quilt, women share their stories, opinions, and activities into a visual tapestry. The matchmaking algorithm helps them find suitable peers in the community.</td>
<td>Software may match people more reliably than program staff</td>
<td>Cost of software and web infrastructure; Requires online community managers</td>
</tr>
<tr>
<td>Random assignment</td>
<td>Hotlines are a good example of random assignment in which immediate access is more important than long term relationship development.</td>
<td>Peer supporters are available when needed</td>
<td>No long term or ongoing support</td>
</tr>
</tbody>
</table>
### Table 11: Matching Considerations

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnicity</td>
<td>Individuals may prefer to have a peer supporter with shared cultural background and experiences. Shared language and cultural competency are important factors for hardly-reached populations that may not have many connections with the health care system.</td>
</tr>
<tr>
<td>Education / Socioeconomic status</td>
<td>Differences in education levels and socioeconomic status may be barriers to developing strong peer relationships so it may be beneficial to minimize these differences as much as possible.</td>
</tr>
<tr>
<td>Age / Age of onset</td>
<td>This is important because of differences in life experiences. Age of disease onset will affect an individual's experience with the illness and with illness management strategies. People with a more severe disease course may benefit from having a peer support person who had a similar trajectory. Age is also closely related to level of functioning, which may be an important factor in conditions that cause functional impairment.</td>
</tr>
<tr>
<td>Type of condition (psychiatric condition, type 1 vs. type 2 diabetes, cancer type)</td>
<td>Sharing the same disease condition is one of the most important matching considerations. Peer support programs often need to be disease specific to be acceptable to the patient population.</td>
</tr>
<tr>
<td>Treatment experience</td>
<td>Peers' experience with specific treatment modalities may be a positive influence on peers who fear or have limited knowledge about these treatments. Experienced peer supporters can help individuals cope with the stress and anxiety around medications and therapies.</td>
</tr>
<tr>
<td>Co-morbidity</td>
<td>Individuals may prefer peer supporters who have multiple medical co-morbidities. Their medical needs may be more complex, and strategies needed to navigate medical resources may be more complicated.</td>
</tr>
<tr>
<td></td>
<td>In mental health, many people experience more than one disorder, (e.g., mood disorder and substance abuse, schizophrenia and depression, anxiety and depression), and it may be important for them to have a peer supporter who has had a similar illness experience.</td>
</tr>
<tr>
<td>Community residency</td>
<td>Some people prefer someone who is from their community because they may share cultural backgrounds, life experiences, etc. On the other hand, others may prefer the anonymity of having a peer who is not from their community.</td>
</tr>
</tbody>
</table>
3.7 What are the issues involved in supervision?

Supervision of peer supporters is critical throughout the course of employment. However, there is not much evidence on best practices for supervision, such as ideal CHW-to-supervisor ratio, frequency of supervision, and who should supervise CHWs. Some studies report a preference for CHW supervisors with social work or mental health backgrounds, and other warn against nurse supervision due to potentially dysfunctional relationships that may arise from role competition. The following list of recommended practices may be helpful in improving the supervision of peer supporters.

**Key Factors in Supervision**

- Open and ongoing channels of communication between staff and peer supporters
- Opportunities for regular feedback and troubleshooting of peer supporters
- Supervisors should monitor CHW performance and set reasonable expectations for quality assurance purposes
- Supervisors have work time allocated to work closely with the peer supporters
- Supervisors are capable of providing mentorship and professional development opportunities
- Supervisors need to believe in and support the CHW model and role
- Supervisors should treat CHWs as full members of the health care delivery team
- Policies and procedures are clearly communicated to peer supporters and staff
- Policies to address dual relationships, boundaries, confidentiality

In addition, the following are important areas to address:

- **Performance and Job Support**
  Peer supporters should have the same degree of supervision as other staff. As with other staff, supervision should focus on job performance and job support, rather than clinical support. It is also important to provide accommodations consistent with the Americans for Disabilities Act. Frequent team meetings and individual supervision are beneficial. It is important to hold peer support specialists fully accountable as you would other paid staff. If peer supporters working in recovery programs need to receive ongoing treatment while serving in their role, it is always preferable for them to receive treatment in another facility. In the case of relapse, to the point where they cannot perform their job, sick time should be taken.

- **Peer Integration**
  Research has shown that some clinicians are skeptical about the contribution that peer supporters can make. Supervisors must advocate on behalf of peer supporters and act as their champions within the organization. Some peer supporters have faced challenges integrating into clinical organizations. Supervision should include discussion about the integration of the peer supporter within the organization and/or clinical team.
• **Peer Identity**
  It is important to talk about peer identity and peer role. The peer supporter is not a therapist. Their lived experience allows them to fulfill a unique role, but this role may be in conflict with the traditional medical treatment model. Regular group meetings for peer supporters will allow them to support one another. The VA recommends monthly group supervision to foster community and fellowship among peer supporters.

• **Peer Drift**
  Drift can occur when the peer supporter does not feel comfortable in his/her role and they begin to shift toward a more medical treatment model; for example, focusing on problems, barriers, symptoms and diagnoses rather than on strengths, skills, and opportunities. Supervisors should periodically shadow peer supporters to guard against peer drift.

**References**


3.8 What are ways to monitor and share feedback?

Program monitoring is important for continuous quality improvement and for demonstrating the program benefits. Collecting feedback on the program allows program staff to respond rapidly to emerging issues and provide troubleshooting. Program successes should be shared early and often in order to boost morale and strengthen organizational support.

The following list provides suggestions on sharing feedback on peer support programs:

- Send regular reports to local leadership and key stakeholders on outcomes. Include easy-to-read graphs and visuals. Report outcomes in ways that highlight clinical significance.

- Use story-telling to share success stories.

- Send short emails to leadership and key stakeholders to highlight success.

- Invite peer supporters or individuals who have been through the program to talk about their success in departmental meetings.

- Talk to your public relations officer about ideas to spread the word to the community.

- Have individuals in the program provide information on how the program benefited them. Put this on bulletin boards or pamphlets for others to see.

- Give talks to stakeholders and community organizations in which you discuss outcomes.

- Hold annual gatherings in which individuals involved in your peer support program come together. Invite local leadership and your public relations officer to attend.
## Appendix A-1. Peer Support Models for Depression

<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>Setting or Location</th>
<th>Design of Program</th>
<th>Peer Supporter</th>
<th>Recruitment of PSs</th>
<th>Training of PSs</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapin et al., 2013</td>
<td>Older adults receiving Medicaid</td>
<td>Midwest USA</td>
<td>Paired Peer Supporter (PS) based on gender, location, and interests. Met once a week for 10 weeks</td>
<td>Older adult volunteers</td>
<td>Community presentations, flyers, word of mouth, referrals from agencies</td>
<td>2-hr session: mental health and aging, community resources, safety issues</td>
<td>Decreased depression Increase in health and functioning quality of life</td>
</tr>
<tr>
<td>Dennis et al., 2009</td>
<td>Women at high risk of postnatal depression</td>
<td>Ontario, Canada</td>
<td>Telephone-based. 4+ contacts starting ~1 week postpartum, continue as necessary</td>
<td>Mothers recovered from postpartum depression</td>
<td>Flyers, local newspaper ads, word-of-mouth</td>
<td>4-hr session: providing phone-based support. Received training manual</td>
<td>Less likely to have symptoms of postnatal depression Lower anxiety</td>
</tr>
<tr>
<td>Rahman 2008</td>
<td>Pregnant, married women with perinatal depression</td>
<td>Rural Rawalpindi, Pakistan</td>
<td>Met once a week in last month of pregnancy, 3 in first postnatal month, and 9 once a month thereafter</td>
<td>Female primary care health workers (Lady Health Workers - LHWs)</td>
<td>None necessary – LHWs are assigned to the administrative units</td>
<td>2-day workshop, 1-day refresher: Preventive mother and child health care and CBT.</td>
<td>Decreased maternal depression and disability scores Increased overall functioning, perception of social support</td>
</tr>
<tr>
<td>Travis et al., 2010</td>
<td>Patients with persistent depressive symptoms</td>
<td>Michigan, USA</td>
<td>Telephone-based. Paired on age, gender, and experience with therapy. Contact once a week for 12 weeks, met face to face twice.</td>
<td>Dyadic peer support, so patients were the peer supporters</td>
<td>Electronic administrative data, clinician referral, and flyers in waiting rooms</td>
<td>90-min session: communication skills and self-management practices. Provided a manual.</td>
<td>Decreased depression scores 94% would be more satisfied with healthcare if peer support was available</td>
</tr>
<tr>
<td>Weber et al., 2007</td>
<td>Prostate cancer survivors</td>
<td>USA</td>
<td>Dyads met face to face once a week for 8 weeks</td>
<td>3-year prostate cancer survivors</td>
<td>Identified by participating urologists from pool of former patients thought to have successful recovery</td>
<td>Training: signs and symptoms of clinical depression and active listening skills</td>
<td>Decreased depression Increased self-efficacy for prostate cancer management</td>
</tr>
</tbody>
</table>
## Appendix A-2. Peer Support Models for Severe Mental Illnesses

<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>Setting or Location</th>
<th>Design of Program</th>
<th>Peer Supporter</th>
<th>Recruitment of PSs</th>
<th>Training of PSs</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chien and Thompson, 2013</td>
<td>Individuals with schizophrenia</td>
<td>Hong Kong</td>
<td>9-month family-led peer support group program. 14 2-hour group sessions held every 2-3 weeks</td>
<td>Caregivers living with and caring for a relative with diagnosis of schizophrenia</td>
<td>Participants selected randomly from regional psychiatric outpatient clinic list</td>
<td>Peer leader elected by participants received two-day group coordination and leading workshop</td>
<td>Greater improvements over 3 years in overall functioning Reduced duration and number of hospitalizations</td>
</tr>
<tr>
<td>Forchuk et al., 2005</td>
<td>Severe mental illness in individuals leaving psychiatric ward</td>
<td>Ontario, Canada</td>
<td>Peer support available for 1 year. Face to face and telephone-based</td>
<td>Volunteers formerly in mental health care system who had been in community for at least 1 year</td>
<td>Not specified</td>
<td>Peer-training program completed by participating consumer-survivor groups</td>
<td>Improvement in social relations Shorter length of stay in psychiatric wards</td>
</tr>
<tr>
<td>Hibbard et al., 2002</td>
<td>Individuals with traumatic brain injury (TBI) and family members</td>
<td>New York, USA</td>
<td>Telephone-based</td>
<td>Volunteer individuals who had successfully adjusted to living with challenges of TBI</td>
<td>Through Brain Injury Association of New York State, local professionals, consumer advisory groups</td>
<td>8 full-day workshops: communication, listening, advocacy skills, knowledge on TBI and community resources</td>
<td>Improved quality of life in individuals with TBI and family members Improved ability to deal with depression post-TBI</td>
</tr>
<tr>
<td>Landers et al., 2011</td>
<td>Individuals with schizophrenia and affective psychoses</td>
<td>Georgia, USA</td>
<td>Outpatient-based peer support delivered for at least 12 hours/week</td>
<td>Consumers of mental health services</td>
<td>Peer supporters are assigned to state hospitals</td>
<td>Certified Peer Support Specialists. Identifying resources and support to achieve goals</td>
<td>Fewer psychiatric hospitalizations Less likely to have substance abuse claims</td>
</tr>
<tr>
<td>Proudfoot et al., 2012</td>
<td>Individuals with bipolar disorder</td>
<td>Australia</td>
<td>Coaching provided by email to augment online intervention</td>
<td>Individuals successfully managing bipolar disorder for 2+ years</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Decrease in depression, anxiety, stigma Greater adherence to program</td>
</tr>
</tbody>
</table>
### Appendix A-3. Peer Support Models for PTSD and Suicide Prevention

<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>Setting or Location</th>
<th>Design of Program</th>
<th>Peer Supporter</th>
<th>Recruitment of PSs</th>
<th>Training of PSs</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greden et al., 2010</td>
<td>Returned National Guard soldiers</td>
<td>Michigan, USA</td>
<td>Soldier peers contact every returning soldier through regular “check-in” calls</td>
<td>Soldiers with similar rank and veterans outside the Guard</td>
<td>Identified by Chain of Command</td>
<td>3-hr session: roles, communication skills, and emergency situations. Provided manual and reference cards</td>
<td>Increased use of services. Increased referral to treatment</td>
</tr>
<tr>
<td>Van Voorhees et al., 2012</td>
<td>US veterans from any military branch of Operation Iraqi Freedom and Operation Enduring Freedom</td>
<td>Chicago, Illinois, USA (Online)</td>
<td>Peer educators conducted IM chats with participants</td>
<td>VA Certified Peer Counselors</td>
<td>Through social media (Facebook and Twitter) and Craigslist</td>
<td>Certified through the VA</td>
<td>Decreased depression and PTSD scores. Improved willingness to accept diagnosis</td>
</tr>
<tr>
<td>Vijayakumar and Kumar, 2008</td>
<td>People who lost relatives in 2004 Asian tsunami</td>
<td>Chennai, India</td>
<td>Monthly home visits of 1-1.5 hours</td>
<td>Suicide prevention volunteers from SNEHA, local organization providing support</td>
<td>PEs already affiliated with SNEHA, local organization providing support</td>
<td>8-hr session: providing assistance to bereaved, other emotional support</td>
<td>Lower depression and PTSD scores. No suicide attempts in intervention vs 3 in control</td>
</tr>
</tbody>
</table>
## Appendix A-4. Peer Support Models for Psychosocial Health

<table>
<thead>
<tr>
<th>Reference</th>
<th>Population</th>
<th>Setting or Location</th>
<th>Design of Program</th>
<th>Peer Supporter</th>
<th>Recruitment of PSs</th>
<th>Training of PSs</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preyde and Ardal, 2003</td>
<td>Mothers of very pre-term infants in the NICU</td>
<td>Toronto, Canada</td>
<td>Phone-based support. Paired on infant condition, language, ethnic background, geographic proximity</td>
<td>Volunteer peer mothers with very low birth weight babies who adjusted well</td>
<td>Social workers recruited volunteers</td>
<td>5-hr session: communication skills, self-awareness, boundaries of offering support</td>
<td>Less stress, anxiety, and depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Greater perceived social support</td>
<td></td>
</tr>
<tr>
<td>Thomson et al., 2013</td>
<td>HIV+ adults</td>
<td>Rwanda</td>
<td>Daily home-visits by a community health worker (CHW)</td>
<td>Elected by members of own village</td>
<td>Elected by members of own village</td>
<td>8-day training: comprehensive support, ongoing HIV education and advocacy, directly observed therapy</td>
<td>Increase in perceived mental health quality of life, Reduced prevalence of depression</td>
</tr>
</tbody>
</table>
Appendix A-1 References


Appendix A-2 References


Appendix A-3 References


Appendix A-4 References
