Virginia Opioid Abatement Authority Application for Individual Awards to Cities and Counties

1. Contact Information

a. Name of City or County: Hampton ☑ city ☐ county

b. Physical address: 22 Lincoln Street, Hampton, VA 23669

c. Mailing adress: _____
(if different than physical address)

d. Contact Person for this application

i. Name: Steven D. Bond

ii. Job Title: Assistant City Manager

iii. Office Phone: 757-727-6392 Cell Phone: 757-719-3198

iv. Email: sbond@hampton.gov

2. Distribution Information

a. Provide the following regarding how the city or county has used (or is planning to use) its direct distributions (from the settlement administrator):

i. For the **Distributors Settlement**:

Amount of direct distributions received during FY2023 (Amounts can be found here)	108,483
Amount appropriated by the governing body in FY2023	0
FY2023 actual expenditures	0
FY2023 encumbered but not yet expended	0
FY2023 remaining unspent and unencumbered balance	108,483
FY2024 anticipated direct distribution from Distributor Settlement (Amounts can be found here)	65,727

ii. For the **Janssen Settlement**:

Amount of direct distributions received during FY2023 (Amount can be found here)	271,336
Amount appropriated by the governing body in FY2023	0
FY2023 actual expenditures	0
FY2023 encumbered but not yet expended	0
FY2023 remaining unspent and unencumbered balance	271,336

iii. Provide a narrative reflecting the uses (actual or planned) of the direct distributions for the city or county from the Distributors and Janssen for both FY2023 and FY2024. Include a description of project(s) funded with these direct distributions, the target audience or population, names and responsibilities of subrecipients or contractors, and any outcomes that have been achieved. If no funds have been used, state the city or county's plans for these funds. (Attach additional sheets if needed).

The City of Hampton in partnership with the Hampton-Newport News Community Services Board plans to use the direct distributions from the Distributors and Janssen for both FY2023 and FY2024 for the following two (2) projects:

1. Hampton City Jail Substance Use Jail-Based Services (see attached project description).

2. Hampton Peer Drop-in Center (see attached project description)

b. Does the city or county intend to reserve any portion of its direct distributions from FY2023 or FY2024 for future year abatement efforts?

☑ Yes

☐ No

If yes, see Terms and Conditions item #2.d.

c. Does the city or county intend to apply for the OAA's city or county "Gold Standard" incentive program in FY2023 and FY2024?

☑ Yes

☐ No

If yes, complete the form entitled "Application and Terms and Conditions to Receive OAA Incentive Funds"

d. For each proposed project in FY2023 and FY2024, complete and attach Part 4 "Project Proposal" of this application. If there is more than one project, use the additional project proposals file. The total amount of funding requested should not exceed the amount for the city or county as published in this document.

e. Attach a copy of a resolution from the governing body of the city or county providing signatory authority. If the city or county is requesting the Gold Standard incentive, ensure this is noted in the resolution from the governing body. A sample resolution can be found in this application packet.

3. Signature

Signature section must be completed by the person designated with signatory authority in the resolution noted in Part 2.e of this application.

"I swear or affirm that all information contained in and attached to this application is true to the best of my knowledge."

Signature 

Print Name Mary B. Bunting

Title City Manager

Date May 5, 2023

4. Project Proposal

Complete the information below **for each project** the city or county is requesting to be funded.

a. Name of City or County: Hampton ☑ city ☐ county

b. Project name: Hampton Peer Drop-in Center

c. Contact Person for this application

i. Name: Seven D. Bond

ii. Job Title: Assistant City Manager

iii. Office Phone: 757-727-6392 Cell Phone: 757-719-3198

iv. Email: sbond@hampton.gov

d. Is this project:

☑ A new effort for the city / county.

☐ A proposed supplement or enhancement to a project or effort that is already in place.

☐ How long has the project existed? _____

☐ A combination of enhancing an existing project/effort with new components.

☐ How long has the project existed? _____

e. Provide a brief narrative description of the proposed project.

(Please see attached proposal for complete answer)
We are proposing to provide a comprehensive Peer Recovery Oriented System of Care that will expand our outreach and service accessibility to individuals with substance use disorder/opioid use disorder (SUD/OUD). This proposal includes opening a Peer Drop-in Center, with Peer Recovery Specialists (PRS) onsite in a Hampton location, providing targeted outreach in communities identified by law enforcement and other community stakeholders.
The Peer-Run Recovery Drop-in Center will operate as a clubhouse model, but will also incorporate Virginia " allowable harm reduction activities." The drop-in center will serve as a non-clinical place where residents can receive information and education about substance use/opioid use and mental health disorders from individual with lived experiences. The drop-in center will " promote wellness and offer hope." It will serve to alleviate the related effects of the opioid use crisis by providing a " safe haven" where social, medical, legal and psychological impacts of opioid use disorder can be addressed. The business hours will be Monday-Friday, 8:30 am until 5 pm.

f. Describe the objectives of this project

(Please see attached proposal for complete answer)
Goal 1: Expand outreach and service accessibility to individuals with SUD/OUD.
Objective 1: Within the first year of the opening of the Peer Drop-in Center, an estimated 250 individuals will visit the center, and an estimated 10% of those contacts (25 individuals) will enter SUD/OUD treatment or remain engaged in peer recovery support services.
Objective 2: Within the first year of expanded outreach, a minimum of 500 harm reduction kits (which will include Narcan & overdose prevention education) will be distributed in the targeted neighborhoods.

Goal 2: Expand education to help prevent SUD/OUD overdoses and deaths.
Objective 1: Peer recovery specialists will attend a minimum of six (6) community events within the first year of drop-in center operations to inform the community about the drop-in center.
Objective 2: Within in first year of operations, peer recovery specialists will partner with a minimum of 12 community partners such as churches, colleges, hospitals and human services organizations, to

g. How was the need determined and how does that need relate to abatement?

(Please see attached proposal for complete answer)
According to CDC (May 11, 2022), overdose deaths in the U.S. increased by half as much in 2021 compared to 2020; but deaths still increased by 15%. In fact, 72% of the 100,000+ deaths are due to opioids (National Center for Drug Abuse Statistics 2022). The most recent overdose reports (through October 2022) from the Hampton Police Department revealed 127 overdoses, with 28 fatalities. This compares to 85 overdoses, with 19 deaths in 2021. Although fatalities decreased, primarily due to Narcan distributions, substance use emergency incidents continued to be high; 248 emergency visits (most active after 11 pm) were reported in Hampton (Virginia' s Framework for Addiction Analysis and Community Transformation, 11/11/2022).

Even with the expansion of treatment resources in Virginia (DMAS, April 28, 2021) and nationally, people with substance use disorders/opioid use disorders (SUD/OUD) are not coming in to seek treatment. There are various reasons, some were cited at the most recent American Association for the Treatment of Opioid Dependence (AATOD) Conference, October 31-November 5, 2022, and they

h. Briefly describe (name or organization, description of role, budget, etc.) the organization(s), including any sub-recipients or contractors (if known) that will be involved in this project. Attach any contracts and/or memoranda of understanding/agreement. If not fully executed, a draft or a narrative describing the scope of services may suffice.

The City of Hampton will contract with the Hampton-Newport News Community Services Board (HNNCSB) to manage project outlined above utilizing Opioid Abatement funds. We have partnered on numerous successful projects, and the HNNCSB continues to serve as the city' s public provider of mental health, intellectual disability and substance use services. These abatement funds will be utilized to provide a support to the community that will help reduce the overall incidence of overdose and deaths related to SUD/OUD.

i. Who are the targeted beneficiaries, and how many persons are expected to participate per year?

The targeted beneficiaries will be Hampton residents who have an SUD/OUD as well as their family members and the community at large. Within the first full year of operations, we expect to interact with over 250 individuals in the drop-in center with 10% of those individuals agreeing to enter MAT treatment services or remain engaged in recovery support services. We also project that we will engage with a total of over 500 individuals when accounting for contacts made at community events and activities with partnering agencies.

j. Is the project classified as evidence-based?

☐ Yes

☐ No

If yes, attach supporting information to this application.

k. Is the project classified as evidence-informed?

☐ Yes

☑ No

If yes, attach supporting information to this application.

l. Has this project been certified or credentialed by a state/federal government agency, or other organization/non-profit?

☐ Yes

☑ No

If yes, attach supporting information to this application.

m. Has this project received any awards or recognition?

☐ Yes

☑ No

If yes, attach supporting information to this application.

n. Does this project have components other than opioid-related treatment as defined?

☐ No, it is 100% related to opioid treatment

☑ Yes, there are other substances involved

If yes, what is the approximate percentage of the project that covers opioid-related abatement (i.e., 20% of the patients who seek services have opioid-related disorders)?

Individuals with MH and SUD needs may come to the drop-in center. Therefore, there will be individuals with a mix of MH needs, SUD needs and opioid use disorder. It is hard to say how many of these individuals will have needs only related to OUD. I will predict that 25% of the individuals served will have opioid-related disorders.

o. Attach a budget for FY2023 and a budget for FY2024 with line-item details for the project. If carry-over of OAA funds from FY2023 into FY2024 is expected, include this in the line item budget.

p. Complete and attach the project timeline workbook for each project covering both FY2023 and FY2024

q. Complete and attach the performance measurement workbook for each project covering both FY2023 and FY2024

r. *(Optional)* Attach any letters of support, articles, or other items that may assist the OAA Board of Directors in making an award decision for this project.

Opioid Abatement Project Proposal

Project Name: Peer Drop-in Center

Provide a brief narrative description of the proposed project

We are proposing to provide a comprehensive *Peer Recovery Oriented System of Care* that will expand our outreach and service accessibility to individuals with substance use disorder/opioid use disorder (SUD/OUD). This proposal includes opening a **Peer Drop-in Center**, with Peer Recovery Specialists (PRS) onsite in a Hampton location, providing targeted outreach in communities identified by law enforcement and other community stakeholders.

The Peer-Run Recovery Drop-in Center will operate as a clubhouse model, but will also incorporate Virginia "allowable harm reduction activities." The drop-in center will serve as a non-clinical place where residents can receive information and education about substance use/opioid use and mental health disorders from individual with lived experiences. The drop-in center will "promote wellness and offer hope." It will serve to alleviate the related effects of the opioid use crisis by providing a "safe haven" where social, medical, legal and psychological impacts of opioid use disorder can be addressed. The business hours will be Monday-Friday, 8:30 am until 5 pm.

Examples of services to be offered include:

- Offering judgment-free support without the pressures of "expectations or requirements"
- Providing opportunities to see that hope is possible through peer recovery supports provided by individuals with lived experience who have been on their journey
- Providing supports and linkages for addressing basic needs, such as shelter, food, clothing etc.
- Empowering individuals to be able to have an immediate life-saving response to an overdose by offering overdose education, Revive Training and naloxone
- Providing education about medication assisted treatment (MAT) and MAT treatment resources and assist in linking individuals into treatment, case management and recovery supports whenever the individual is ready
- Providing the opportunity to address the physical impact of addiction through medical referrals and helping to reduce the incident of the transmission of communicable diseases through education, screening and testing
- Providing education and support and harm reduction to family members and others directly impacted by an individual suffering from OUD.

We believe that by having *Peer Recovery Specialists (PRS) onsite at strategic locations* in Hampton, we can meet more people in need and possibly engage them into treatment and/or recovery services.

In order to reach those in need and promote the drop-in center within the community, we will utilize Peer Recovery Specialists to conduct *outreach in targeted communities*. The targeted communities may be identified by law enforcement, first responders and other community stakeholders, such as our local churches and community-based agencies. The targeted areas may also be identified as neighborhoods that are underserved and have various health disparities. Our Peer Recovery Specialists will provide information about our drop-in center, offer harm reduction kits to residents and other useful information about treatment and recovery supports. In addition to their work at the drop-in center, PRS will attend community events and activities in targeted areas to distribute materials and provide harm reduction kits.

Describe the objectives of this project

Goal 1: Expand outreach and service accessibility to individuals with SUD/OUD.
Objective 1: Within the first year of the opening of the Peer Drop-in Center, an estimated 250 individuals will visit the center.
Objective 2: An estimated 10% of those contacts (25 individuals) who make contact with the drop-in center will enter SUD/OUD treatment or remain engaged in peer recovery support services.
Objective 3: Within the first year of expanded outreach, a minimum of 500 harm reduction kits (which will include Narcan & overdose prevention education) will be distributed in the targeted neighborhoods.

Goal 2: Expand education to help prevent SUD/OUD overdoses and deaths.
Objective 1: Peer recovery specialists will attend a minimum of six (6) community events within the first year of drop-in center operations to inform the community about the drop-in center.
Objective 2: Within in first year of operations, peer recovery specialists will partner with a minimum of 12 community partners such as churches, colleges, hospitals and human services organizations, to educate on the drop-in center and provide referral resources.
Objective 3: At the end of year 1, a minimum of 500 individuals will receive education about overdose prevention and where to go for help if they or a loved one have problems with opioids.

How was the need determined and how does that need relate to abatement

According to CDC (May 11, 2022), overdose deaths in the U.S. increased by half as much in 2021 compared to 2020; but deaths still increased by 15%. In fact, 72% of the 100,000+ deaths are due to opioids (*National Center for Drug Abuse Statistics 2022).* The most recent overdose reports (*through October 2022*) from the Hampton Police Department revealed 127 overdoses, with 28 fatalities. This compares to 85 overdoses, with 19 deaths in 2021. Although fatalities decreased, primarily due to Narcan distributions, substance use emergency incidents continued to be high; 248 emergency visits (*most active after 11 pm*) were reported in Hampton *(Virginia's Framework for Addiction Analysis and Community Transformation, 11/11/2022*).

Even with the expansion of treatment resources in Virginia *(DMAS, April 28, 2021*) and nationally, people with substance use disorders/opioid use disorders (SUD/OUD) are not coming in to seek treatment. There are various reasons, some were cited at the most recent American Association for the Treatment of Opioid Dependence (AATOD) Conference, October 31-

November 5, 2022, and they are: no healthcare coverage, healthcare coverage did not cover the full cost, did not know where to go, not ready to stop using, waiting lists, could handle problems without treatment, impact on my jo-b, did not want others to find out, don't believe treatment can help. With these reasons given, we must explore other options to find, encourage and engage people with SUD/OUD into treatment and recovery support services. We believe that with our peer-oriented Approach, especially with the Peer Drop-in Center and pro-active outreach, we will broaden our network in reaching the people that will need our treatment or recovery support services. In fact, a study conducted by the *Texas Health and Human Services (2016)* find that "Peer Recovery Services saved $3,422,632 in healthcare costs, representing a 72% reduction in costs over 12 months."

Evidence Based Practices

The Peer Drop-in Center will provide access to the evidence-based practices of peer support and harm reduction.

In 2007, the Center for Medicare and Medicaid services issued a letter describing peer support services as "evidence-based models of care consisting of qualified peer support providers who assist individuals with their recovery from mental illness and substance use disorders."

The minimal requirement for employment as a Peer Support Specialist with the H-NNCSB is lived experience with at least 12 months of recovery. All Peer Support Specialists are required to complete a 72-hour course to become a Certified Peer Recovery Specialist within six months of hire. In addition to the lived experience and required training, Peer Recovery Specialists must also have 500 hours of experience providing support and 25 hours/*- of supervision.

Mental Health America (MHA) defines peer support as "an evidence-based practice" supported by both qualitative and quantitative data that "lowers the overall costs of mental health services by reducing the occurrence of re-hospitalization and increasing the use of outpatient services." MHA also identifies the following outcomes for peer support services:

- Reduction in involuntary hospital admissions;
- Increased likelihood of employment;
- Better engagement and improved satisfaction with treatment services;
- Increased self-advocacy;
- Overall health improvement.

Meta-analytic data show that including peer providers in an individual's mental health treatment is positively correlated with feelings of hope and empowerment that these outcomes extend beyond the intervention by the peer provider *(Mental Health and Social Inclusion, 2017).*

Harm reduction aims to reduce the harmful consequences associated with drug use *without* requiring abstinence or treatment to gain access to resources (Tatarsky & Marlatt, 2010). The National Institute on Drug Abuse defines harm reduction as "a model separate from treatment and recovery that improves well-being while an individual is actively using drugs." Research has shown that harm reduction strategies have a number of public health benefits including preventing overdose deaths. Harm reduction programs also provide opportunities for individuals to connect with treatment and recovery resources in settings that reduce stigma. Offering harm

reduction resources such as Narcan and overdose prevention and education in the Peer Drop-in Center will assist in these efforts that have been proven effective in combating overdose deaths.

Briefly describe the organizations that will be involved in the project

The City of Hampton will contract with the Hampton-Newport News Community Services Board (HNNCSB) to manage project outlined above utilizing Opioid Abatement funds. We have partnered on numerous successful projects, and the HNNCSB continues to serve as the city's public provider of mental health, intellectual disability and substance use services. These abatement funds will be utilized to provide a support to the community that will help reduce the overall incidence of overdose and deaths related to SUD/OUD.

Who are the targeted beneficiaries, and how many persons are expected to participate per year

The targeted beneficiaries will be Hampton residents who have an SUD/OUD as well as their family members and the community at large. Within the first full year of operations, we expect to interact with over 250 individuals in the drop-in center with 10% of those individuals agreeing to enter MAT treatment services or remain engaged in recovery support services. We also project that we will engage with a total of over 500 individuals when accounting for contacts made at community events and activities with partnering agencies.

Budget

The budget includes Peer Recovery Specialists to staff the center as well as the cost for rental space and maintenance of the site. Equipment, office furnishings and supplies, and training for staff are included in the budget. Funding related to client support to assist with transportation, food and clothing needs and other necessities to support the operation of the center is requested. Subsequent years' funding includes a 3% escalation in most categories.

Proposed Budget

Peer Drop-In Center

Budget Items	Service Descriptions	Year 1 Funding	Year 2 Funding
Peer Drop-in Center			
PRS staff (5 FTE)	The PRSs will staffed the center (2/shift), which will be opened 6 days/week.	$202,800.00	$212,940.00
Total Personnel Expense (salaries & benefits)		**$202,800.00**	**$212,940.00**
Staff Development (SD)	SD includes participation in workshops, training, purchase of books, etc	$ 2,500.00	$ 2,575.00
Rent	5000 sq. foot space @ $18.23.sq.ft.	$ 91,150.00	$ 93,885.00
Utility costs (Virginia Power, VN Gas)	5,000 sq. foot space @ $2.10/sq. foot	$ 10,500.00	$ 10,815.00
Water & Sanitation	Estimate	$ 650.00	$ 670.00
Telephone		$ 425.00	$ 425.00
Cell Phones	We want our PRS to be accessible; cell phones will allow that.	$ 2,600.00	$ 2,678.00
BLDG/Equip Maintenance		$ 400.00	$ 412.00
Janitorial Services		$ 3,000.00	$ 3,090.00
Computer Equipment		$ 500.00	$ 515.00
Equip Maintenance/ Service Contracts		$ 6,500.00	$ 6,695.00
Office/Meeting supplies	Printing/duplicating/promotion materials & general supplies	$ 2,400.00	$, 2,472.00
Office & related furnishing	Office and related furnishing to outfit the facility	$ 7,500.00	$ 0.00
Vehicle operating expense	Rental & general operating costs of a minivan	$ 6,000.00	$ 6,180.00
Client support & miscellaneous expenses	To support transportation for clients; possibly food, clothing's & other expenses that support the mission of the center	$ 12,500.00	$ 12,500.00
Total Operating Expense		**$ 146,625.00**	**$140,440.00**
Total Budget: Peer Drop-in Center		**$ 349,425.00**	**$353,380.00**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #07-011

August 15, 2007

Dear State Medicaid Director:

The purpose of this letter is to provide guidance to States interested in peer support services under the Medicaid program. The Centers for Medicare & Medicaid Services (CMS) recognizes that the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

Background on Policy Issue

States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers.

As States develop behavioral health models of care under the Medicaid program, they have the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system. When electing to provide peer support services for Medicaid beneficiaries, State Medicaid agencies may choose to collaborate with State Mental Health Departments. We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service.

States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date:

- Section 1905(a)(13)
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority

Delivery of Peer Support Services

Consistent with all services billed under the Medicaid program, States utilizing peer support services must comply with all Federal Medicaid regulations and policy. In order to be considered for Federal reimbursement, States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies. Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must provide an assurance that there are mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services. The following are the minimum requirements that should be addressed for supervision, care coordination and training when electing to provide peer support services.

1) Supervision

Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

2) Care-Coordination

As with many Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

3) Training and Credentialing
Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place.

Please feel free to contact Gale Arden, Director, Disabled and Elderly Health Programs Group, at 410-786-6810, if you have any questions.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Debra Miller
Director for Health Policy
Council of State Governments

An update on the growing evidence base for peer support

Article *in* Mental Health and Social Inclusion · June 2017

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An update on the growing evidence base for peer support

Chyrell Bellamy, Timothy Schmutte and Larry Davidson

Abstract

Purpose – *As peer support services have become increasingly used in mental health settings as a recovery-oriented practice, so has the body of published research on this approach to care. The purpose of this paper is to provide an update on the current evidence base for peer support for adults with mental illness in two domains: mental health and recovery, and physical health and wellness.*

Design/methodology/approach – *To provide a robust, non-redundant, and up-to-date review, first the authors searched for meta-analyses and systematic reviews. Second, the authors found individual studies not included in any of the reviews.*

Findings – *Peer services are generally equally effective to services provided by non-peer paraprofessionals on traditional clinical outcomes. Although some studies found peer services to be effective at reducing hospitalization rates and symptom severity, as a whole, the current evidence base is confounded by heterogeneity in programmatic characteristics and methodological shortcomings. On the other hand, the evidence is stronger for peer support services having more of a positive impact on levels of hope, empowerment, and quality of life.*

Research limitations/implications – *In addition to the need for further high-quality research on peer support in mental and physical health domains, the authors also question whether measures of hope, empowerment, and integration into the community are more relevant to recovery than traditional clinical outcomes.*

Originality/value – *This paper provides an original, robust, and up-to-date review of the evidence for peer services.*

Keywords *Physical health, Serious mental illness, Consumer-provided, Peer services*

Paper type *Literature review*

Chyrell Bellamy is an Assistant Professor of Psychiatry at the Department of Psychiatry, Yale University, New Haven, Connecticut, USA.
Timothy Schmutte and Larry Davidson are both based at the Department of Psychiatry, Yale University, New Haven, Connecticut, USA.

Q1 It has now been over 25 years since paid peer staff were first introduced into mental health care, building on the successes of the mental health consumer/survivor movement and promising to bring some of the healing aspects of mutual support into formal services for adults with mental illness. While the growth of peer support both inside and outside of formal services has been robust and global in nature, research evidence demonstrating the effectiveness of this new form of service delivery has lagged behind. This is undoubtedly due to multiple factors, but is likely to be at least in part due to the continued confusion or lack of clarity about what precisely constitutes peer support that sets it apart from traditional mental health services, especially those historically provided by paraprofessional staff; that is, other staff that do not have credentials in psychology, social work, nursing, psychiatry, or rehabilitation. In fact, the first few studies of peers who were hired to provide mental health services were feasibility studies of whether or not these peers could provide traditional services, such as case management and residential support, at least, as well as the non-peer staff who had been providing these services previously. Those studies showed that the deployment of peers caused no harm and did not produce any Q2 worse outcomes than traditional services provided by non-peers (Davidson *et al.*, 1996); a finding we will see below has been replicated numerous times since.

A second complication is whether peer staff should simply be added to existing programs, such as assertive community treatment teams or inpatient units, or should rather be conceptualized as offering new and separate services of a different nature with perhaps a different focus or aim. It has taken some time for persons in recovery to develop new approaches that build explicitly and directly on their shared experiences and the value of reciprocity characteristic of the mutual

support groups out of which peer support has emerged. Not all peer-provided services acknowledge, integrate, or are based on these experiences and values, and would not be considered by many in the peer community to embody peer support at all. While a peer providing case management or outreach services may prove to be more effective than a non-peer in doing so, this should not be taken to be a testament to the power of peer support *per se*. Thus, there have been attempts to identify sub-types of peer support such as: mutual support groups characterized by reciprocal relationships; peer support services involving uni-directional support that is different from, but may be combined with, traditional mental health services; and peers as providers of traditional mental health services. Indeed, what peer support consists of remains largely to be determined by people in recovery themselves as they continue to innovate, thus rendering the evidence gathered to date to be preliminary and suggestive, rather than definitive in nature.

It remains important, nonetheless, to continue to assess the effectiveness of peer-provided services as they continue to evolve and mature, and the following review summarizes the nature of the evidence collected to date. To provide a robust, non-redundant, and up-to-date review of the evidence for peer services, first we searched for meta-analyses and systematic reviews using search terms that included combinations such as peer support, mental health services, and consumer-provider. Second, we found individual studies not included in any of the reviews. All articles were found using MEDLINE, Embase, and Google Scholar because collectively these databases provide sufficient review searches (Bramer *et al.*, 2016). To limit the scope of this review to adults with mental illness, we focused on US studies or international studies in English and excluded articles focusing on depression and veterans. As we will see below, the 30 or so studies conducted thus far have been reviewed and re-evaluated in different ways by different teams, using different indicators of quality and methodological rigor, and thus drawing different conclusions. We will try, in what follows, to tease these differences apart and to produce a somewhat coherent, if multifaceted, picture of what has been learned thus far about the effectiveness of different types of services provided by peers in different roles. Following this review, we will examine the implications of this knowledge for future programmatic development and research.

Findings

As peer services have begun to mature, five out of the eight publications appearing in the last two years are primarily either meta-analyses of randomized control trials (RCTs) or systematic reviews of earlier RCTs and observational studies of peer-provided services. We describe both the findings of these reviews and three more recently published studies (not included in these reviews) (Table I). For simplicity, we have divided our review into those which focus on: mental health, psychosocial, and recovery-oriented outcomes; and physical health and wellness outcomes. Despite the uptake of peer services in mental health settings, the authors of these meta-analyses and reviews uniformly note that more rigorous research is needed on this topic. Because of several methodological limitations (e.g. poor randomization, blinding of raters, and reporting of outcomes) and notable variations in program and participant characteristics, a nuanced picture emerges about the strength and generalizability of the evidence garnered thus far.

Mental health outcomes

A Cochrane review of 11 RCTs through 2012 (Pitt *et al.*, 2013) concluded that having peer providers on mental health teams is associated with psychosocial, satisfaction, clinical, or service use outcomes that are equivalent to (no better or worse) those provided solely by non-peer practitioners employed in similar roles, particularly for case management services. There was "low-quality" evidence that care teams with peer providers resulted in small reductions in clients' use of crisis and emergency services compared to teams consisting of only non-peer staff, but no differences were found in quality of life, empowerment, social relations, satisfaction, or hospitalization rates.

A second meta-analysis (Lloyd-Evans *et al.*, 2014) of 18 RCTs consisting of mutual support groups ($n = 4$), peer support ($n = 11$), and peer-provided mental health services ($n = 3$) came to similar conclusions. There was little or no evidence that these services resulted overall in positive effects on hospitalization, overall symptoms, or service satisfaction. On the other hand, there was

Table I Review articles for peers support for adults with serious mental illness (SMI)

Study	*Description*	*Main outcomes*	*Conclusions*
Mental health outcomes			
Pitt *et al.* (2012)	Meta-analysis of 11 RCTs from 1979 to 2012 (9 conducted in USA) involving consumer providers to compare to consumers vs professionals staff in the same mental health service role, or mental health services with and without consumer-providers as an adjunct to the service	1. Psychosocial (quality of life, function, social relations, empowerment) 2. Clinical (general symptoms, depression) 3. Adverse outcomes 4. Client satisfaction 5. Use of services 6. Service provision patterns	Involving consumer-providers in mental health teams that results in psychosocial, mental health symptom, and service use outcomes for clients that are no better or worse than those achieved by professionals employed in similar roles, particularly for case management services. Low-quality evidence for involving consumer-providers in mental health teams results in a small reduction in clients' use of crisis or emergency services
Lloyd-Evans *et al.* (2014)	Meta-analysis of 18 RCTs from 1982 to 2013 (15 conducted in USA) consisting of mutual support groups ($n = 4$), peer support services ($n = 11$), or peer mental health providers ($n = 3$)	1. Hospitalization 2. Employment 3. Clinical (overall psychiatric symptoms, psychotic symptoms, depression, anxiety) 4. Psychosocial (recovery, hope, empowerment, quality of life) 5. Service satisfaction	From small numbers of studies in the analyses it was possible to conduct, there was little or no evidence that peer support was associated with positive effects on hospitalization, overall symptoms, or service satisfaction. Some evidence peer support was associated with positive effects on measures of hope, recovery and empowerment at and beyond the end of the intervention, although this was not consistent within or across different types of peer support
Fuhr *et al.* (2014)	Meta-analysis of 14 RCTs (9 conducted in the USA) for SMI ($n = 10$) and depression ($n = 4$) comparing peer services to usual treatment (superiority trials) or provided by health professional (equivalence trials)	1. Psychosocial (quality of life, hope, social functioning, self-esteem, loneliness, recovery) 2. Clinical (changes in symptoms)	For SMI, evidence from three high-quality superiority trials showed small positive effects favoring peer-delivered interventions for quality of life and hope. Results of two SMI equivalence trials indicated that peers may be equal to improving clinical symptoms and quality of life. No effect of peer-delivered interventions for depression was observed on any outcome
Chinman *et al.* (2014)	Systematic review and rating of evidence quality of 20 studies from 1995 to 2012 (11 RCTs, 9 quasi-experimental/correlational studies) involving: peers added to traditional services, peers in existing clinical roles, and peers delivering structured curricula	1.Psychosocial (quality of life, self-esteem, recovery, hope) 2. Social (family burden, social network size) 3. Clinical (symptom change) 4. Service satisfaction 5. Service uptake/engagement 6. Therapeutic relationship 7. Service use	Overall level of evidence for each type of peer support service was moderate and effectiveness varied by type of peer service. Compared with professional staff, peers added to services or delivering curricula associated with reduced inpatient use and improved range of recovery outcomes. Effectiveness of peers in existing clinical roles was mixed
Croft and Isvan (2015)	Service utilization analysis using propensity score to create matching 139 pairs of users and non-users of respite program staffed by trained peers on subsequent service use	1. Inpatient use and duration 2. ED use and duration	Odds of any inpatient or ED service use after start of peer respite program were 70% lower among respite users but odds increased with each additional respite day. Among those who used any inpatient or ED services, longer respite stay associated with shorter length of stay in inpatient or ED settings but with diminishing returns with negligible decreases predicted beyond 14 respite days
Physical health outcomes			
Cabassa *et al.* (2017)	Systematic review of 18 articles from 1990 to 2015 (12 conducted in USA) consisting of various health interventions involving peers. Rated the methodological quality of studies, summarized intervention strategies and health outcomes, and evaluated the inclusion of racial and ethnic minorities in these studies	1. Self-management (patient activation, goal setting, problem solving) 2. Health behaviors (diet, activity level, smoking) 3. Self-rated health status and symptoms or complaints 4. Body weight and BMI	Beneficial intervention effects observed for a limited number of health outcomes related to self-management, dietary habits, and communication with doctors. Mixed and limited intervention effects were reported for all other health outcomes. The most promising interventions were self-management and peer-navigator interventions. None of the

(continued)

Table I

Study	*Description*	*Main outcomes*	*Conclusions*
		5. Cardiometabolic indicators (A1c, fasting glucose and lipids, blood pressure) 6. Health care use 7. Quality of life	articles were able to disentangle the unique contributions of using peer specialists from the overall effects produced by actual health interventions since none compared the impact of peer-based health interventions to the same health intervention delivered by non-peers
Swarbrick *et al.* (2016)	Within-subjects pre-post study to examine impact of peer-delivered wellness coaching with 33 consumers on wellness goals and health-related quality of life	1. Physical health (number healthy days and Duke Health Profile form) 2. Self-rated wellness goal attainment	Coaching participants reported significant progress toward attainment of individually chosen wellness goals at 2-4 weeks and 8-10 weeks after establishing their goals. Participants also reported significant improvement in self-reported physical health, general health, and perceived health that were sustained 90 days later
Dickerson *et al.* (2016)	Observational pre-post study to evaluate impact of peer mentors to enhance smoking cessation intervention for 30 consumers. Peers co-facilitated 3-month professionally led behavioral group and provided 6-month individual mentoring	1. Breathalyzer carbon monoxide levels 2. Smoking History Questionnaire 3. Fagerstrom test of Nicotine dependence	Program participants had a significant decline in carbon monoxide levels and number of cigarettes smoked per day. A total of 22/30 (73%) made an attempt to quit smoking but only 3 (10%) achieved sustained abstinence

Notes: BMI, body mass index; ED, emergency department

some evidence that these services had an overall positive effect on self-rated hope, recovery, and empowerment at, and beyond, the end of the intervention. However, this effect was not consistent within or across the different types of peer services. More specifically, mutual support programs tended to be associated with enhanced empowerment but not hope or recovery, whereas peer support had positive effects for recovery and hope but not empowerment. As in the Cochrane review, the authors cited weaknesses in the studies, including high risk of bias and a great deal of variation in participant characteristics and program content, which make it difficult to identify which factors in implementation might affect reported outcomes.

A third meta-analysis (Fuhr *et al.*, 2014) of ten RCTs evaluated the effectiveness of peer-delivered services in improving clinical and psychosocial outcomes among individuals with mental illness. Results revealed evidence from three high-quality RCTs showed peer services were superior to usual care conditions on having positive effects on quality of life and hope. Results of two other trials indicate that peers appear to be equal to non-peer staff at improving psychiatric symptoms and quality of life in clients with mental illness. Results further suggest that individual interventions work better than group-based ones, however, this effect appears to plateau over the long term and does not seem to persist at six months. The observed equivalence in clinical and psychosocial outcomes between interventions delivered by a peer or a non-peer may not be generalizable due to the small number of studies included in the analysis.

Chinman *et al.* (2014) conducted a systematic review of 20 studies consisting of 11 RCTs and nine quasi-experimental or correlational studies. Similar to Lloyd-Evans *et al.* (2014), peer services were divided into different categories: peer providers added to traditional services, peer staff in existing provider (i.e. typically non-peer) roles, and peer providers delivering structured curricula. Chinman *et al.* concluded, based on what they deemed as moderate evidence, that adding peers to traditional services and peers delivering curricula improve outcomes compared to non-peer staff alone. More specifically, traditional services provided by peers reduce inpatient services use, improve patient relationships with traditional providers, and increase engagement with care. On the other hand, the evidence for the effectiveness of peer staff in existing provider roles was more mixed with only one of the three studies that was reviewed reporting positive outcomes. Similar to the findings from Lloyd-Evans *et al.* (2014), peer support services also tend to have a more positive impact on increasing levels of empowerment and hope about recovery. Nevertheless, Chinman and others conclude that the evidence for peer support services is "encouraging (but clearly not definitive)" (p. 8).

A more recent study that was not included in any of the previously described reviews provides additional information on the effectiveness of peer-delivered respite services. Croft and Isvan (2015) examined the impact of a public mental health peer respite program on subsequent inpatient psychiatric or emergency service use. Respite users were significantly less likely than matched non-respite users to use any inpatient or emergency services. Moreover, when such services were utilized, respite users had significantly shorter lengths of stay in inpatient and emergency settings.

Physical health outcomes

Q3 Cabassa *et al.* (2017) conducted a systematic review of 18 studies of peer-based health interventions for people with mental illness. The interventions included self-management classes, smoking cessation, peer navigator programs, healthy lifestyle, and multifaceted programs conducted in a range of settings (e.g. community mental health clinics, primary care settings, psychiatric emergency departments, and programs for first episode psychosis). Health outcomes covered a range of areas as well including: self-management attitudes and behaviors (patient activation, goal setting, problem solving); health behaviors (diet, physical activity, smoking, medication adherence); self-rated health status and self-reports of symptoms or health complaints; body weight and body mass index; cardiometabolic indicators (A1c levels, fasting glucose and lipids, blood pressure); use of health care services (primary care, emergency department); and quality of life.

Like other authors, Cabassa *et al.* (2017) concluded that the strength of the evidence generated from these studies is compromised due to several methodological limitations. Beneficial intervention effects are observed for a limited number of health outcomes related to self-management, dietary habits, and communication with doctors. The effects of peer-based health interventions on physical activity, smoking, medication adherence, weight-related outcomes, and cardiometabolic indicators were limited. The most promising interventions were self-management and peer navigator interventions. However, Cabasa *et al.* note that a majority of the research they evaluated were pilot studies consisting of small samples receiving comparatively brief interventions.

Two more recent studies have focused on physical health and wellness. Swarbrick *et al.* (2016) evaluated the impact of a pilot program involving peer wellness coaching on self-chosen wellness goals and perceived health. Using a within-subjects pre-post design with 33 adults in recovery, results included significant progress toward goal attainment and self-reported general health that was sustained for 90-day post-wellness coaching. Dickerson *et al.* (2016) evaluated a structured six-month smoking cessation program in which peer mentors co-led group sessions and worked individually with adults with mental illness trying to quit smoking. Despite rigorous training, supervision, and high working alliance, relatively modest success was achieved for tobacco-related outcomes. Participants demonstrated reductions in number of daily cigarettes and carbon monoxide levels and 73 percent attempted to quit smoking during the intervention, but only 10 percent achieved sustained abstinence.

Conclusions

Based on recent meta-analyses and systematic reviews of studies on peer services in the last 25 years, a number of notable determinations can be made about the evidence for this approach to care for adults with mental illness. In regards to traditional clinical outcomes (e.g. hospitalization rates, symptom severity), the evidence clearly supports the inclusion of peer services is not detrimental to care quality and results in at least equivalent outcomes to usual care conditions and/or services provided solely by non-peer staff. Only one study included in the review articles (i.e. Chinman *et al.*, 2014) observed a negative finding with the presence of a peer on an ACT team being associated with greater hospital days (van Vugt *et al.*, 2012).

Although the specific moderating conditions have yet to be elucidated (e.g. what type of peer service, service delivery mode), there is some evidence that peer services can modestly reduce psychiatric inpatient service use and crisis emergency services. If the scope of outcomes is expanded to include facets of recovery, the evidence is stronger for peer support services having

a greater positive impact on clients' levels of hope, empowerment, and quality of life. In the physical health and wellness domain, the most promising peer support services are for modestly increasing self-management (e.g. self-efficacy, locus of control, problem solving, and action planning), adopting healthier diet, and communicating more effectively with physicians.

Discussion

Reviews of the effectiveness research on peer services paint a picture of mixed results. Whereas the evidence is stronger for peer support enhancing more recovery-oriented outcomes than traditional clinical ones, this may be in part because of heterogeneity in the setting and type of peer support. For example, research suggests that more structured peer-delivered self-management programs, such as the Wellness Recovery Action Planning (Cook *et al.*, 2009) and Building Recovery of Individual Dreams and Goals through Education and Support (Cook *et al.*, 2012), are more consistently associated with positive clinical outcomes, such as decreased symptom severity. Research involving less structured and defined peer roles may contribute to the equivocal evidence for peer support.

Another factor that may contribute to some questions about the generalized effectiveness of peer services is well-documented barriers to implementing peer services. Two recent articles that collectively synthesize over three dozen qualitative studies involving peer staffs' perceptions and experiences at work observed common themes of negative attitudes among non-peer staff, lack of credibility of peer roles, ambiguous roles and tasks, and poor organizational arrangements (Vandawalle *et al.*, 2015; Walker and Bryant, 2013). These sentiments are echoed in a recent national US survey of nearly 600 peer support staff in which 64.3 percent report seeing or feeling stigma or discrimination from non-peer coworkers and in which feeling respected by professional staff emerges as the second strongest predictor of job satisfaction (Cronise *et al.*, 2016).

These findings raise additional questions regarding whether we are in fact targeting the mechanisms of recovery-oriented care and community outcomes, rather than the focus being on traditional psychiatric and medical-related outcomes. Peer supporters are trained to connect with other people in recovery by using their shared lived experiences in ways in which many providers are not trained to do. Few studies measure or describe these mechanisms. More qualitatively driven questions may add to the development of quantitative instruments that can be used to further test the mechanisms of peer support. As these mechanisms are identified, perhaps barriers to implementation of peer services might decrease because part of the challenge is that agencies are trying to fit peers into traditional roles rather than create roles that specifically focus on mechanisms such as connection, relationship building, mutuality, and assisting people to thrive in their communities. In addition, more research is needed to elucidate the concept of "peer" and more specifically, how the concept of "similar lived experiences" contributes to recovery-oriented and community related outcomes.

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Mental Health America

Evidence for Peer Support
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The Case for Peer Support

Peer support is an evidence-based practice for individuals with mental health conditions or challenges. Both quantitative and qualitative evidence indicate that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services, increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with services, and increases whole health and self-management. This document identifies key outcomes of per support services over a range of studies differentiated by program, geographic location, and year. Though many of the studies and programs listed below have some major programmatic differences, one thing is the same – they all demonstrate the value of peer support.

The Evidence

Reduced re-hospitalization rates

- Recovery Innovations in Arizona saw a 56% reduction in hospital readmission rates[i]
- Pierce County Washington reduced involuntary hospitalization by 32% leading to a savings of 1.99 million dollars in one year[ii]
- Optum Pierce Peer Bridger programs served 125 people and had 79.2% reduction in hospital admission year over year resulting in $550,215 in savings; 100% of consumers had been hospitalized prior to having peer coach, only 3.4% were hospitalized after getting a coach [iii]

Reduced days inpatient

- Participants assigned a peer mentor had significantly fewer re-hospitalizations & fewer hospital days[iv]
- TN PeerLink program: significant decrease of 90% in average number of acute inpatient days per month[v]
- WI PeerLink Program showed 71% decrease in number of acute inpatient days per month[vi]
- In two of their managed care contracts, Optum saw an 80.5% average reduction of inpatient days for individuals who had at least two hospitalizations on average per year[vii]

Lowered overall cost of services

- A Federally Qualified Health Center in Denver (FQHC) that used peer support had an ROI of $2.28 for every $1 spent. In a different program, Recovery Mentors provided individualized support for schizophrenia, depression, bipolar disorder: over 9 months, saw .89 vs. 1.53 hospitalizations, 10.08 vs. 19.08 days in hospital.[viii]

- An effort to reduce depression/anxiety disorders in India demonstrated a 30% decrease in prevalence, 36% decrease in suicide attempts, 4.43 fewer days no work/reduced work in previous 30 days; cost-effective & cost-saving[ix]
- A 2013 review of determined that the financial benefits of peer support exceed the costs, in some cases substantially.[x]
- In a 2013 study, 28.7% of respondents were not employed or had transitional/sheltered employment before CPS training. As a result of their work as CPS, 60% of respondents transitioned off or reduced public assistance and reduced their use of mental health care services. Changes in the respondents' mental health service use are outlined below: [xi]

Changes in Mental Health Service Use

Of the 122 who reported using outpatient therapy prior to CPS training, 71 reported a change in their service use. Twenty-nine (40.9%) reported an increase, and 42 (59.1%) reported a decrease, which was not significantly different, $\chi^2(1) = 2.38$, $p = .123$. Fifty-five of 93 respondents reported a change in use of case management services: More individuals reported a decrease ($n = 38$, 69.1%) rather than increase ($n = 17$, 30.9%), $\chi^2(1) = 8.02$, $p = .005$. Forty-nine of 89 individuals who had gone to an emergency room or crisis response center reported a change in frequency. Significantly more of these reported a decrease ($n = 41$, 83.7%) rather than an increase ($n = 8$, 16.3%), $\chi^2(1) = 22.22$, $p < .0001$. Finally, 37 of the 103 who had been hospitalized prior to CPS training reported a change: A significantly greater proportion of individuals ($n = 55$, 83.3%) reported a decrease versus 11 (16.7%) who reported an increase, $\chi^2(1) = 29.3$, $p < .0001$.

Increased use of outpatient services

- The following are data indicating the effectiveness of the Peer Bridger model created by the New York Association of Psychiatric Rehabilitation Services (NYAPRS).

Decrease in number of people who use inpatient services	**Percentage**
New York*	47.9%
Wisconsin	38.6%
Decrease in number of inpatient days	
New York*	62.5%
Wisconsin	29.7%
Increase in number of outpatient visits	
New York*	28.0%
Wisconsin	22.9%
Decrease in total Behavioral Health Costs	
New York*	47.1%
Wisconsin	24.3%

* The New York-based outcomes were achieved via the application of the Peer Bridger model.[xii]

- 90% of PEOPLe Inc's Rose House crisis respite program (Orange County, NY) participants did not return to hospital in the following two years, 2010 program evaluation data[xiii]
- Mental Health Peer Connection's Life Coaches helped 53% of individuals with employment goals to successfully return to work in the Buffalo, NY area, 2010 program evaluation data.[xiv]
- Western NY's Housing Options Made Easy helped 70% of residents to successfully stay out of hospital in the following year, 2011 program evaluation data.[xv]
- A Mental Health America and Kaiser Permanente Pilot Study showed an increase in supports for individuals as they transitioned from inpatient settings and increased connection with behavioral health team.[xvi]

Increased quality of life outcomes

- Instillation of hope through positive self-disclosure, role modeling self-care of one's illness, empathy & conditional regard may lead to higher demands/expectations for clients[xvii]
- A meta-analysis showed peer support is superior to usual care in reducing depressive symptoms.[xviii]
- Individuals receiving peer support are more likely to have employment.[xix]
- Peer support improves symptoms of depression more than care as usual.[xx]
- A Mental Health America and Kaiser Permanente Pilot Study showed an increased ability to meet participants' social needs with interventions in the community and improved ability to address gaps following inpatient services like housing and access to medications.[xxi]
- Veterans in a peer-to-peer program had significantly higher senses of empowerment and confidence.[xxii]
- A metasynthesis showed that those receiving peer support services had increased social networks.[xxiii]
- The following table demonstrates the results of a survey regarding the impacts of CPS

Table 1
Recovery and Work Impacts of Certified Peer Specialist (CPS) Training

Statement	Score[a]		Strongly agree/agree	
	n	Mean ± *SD*	*n*	%
Your CPS training . . .				
Made you develop skills that are applicable to your life and recovery	151	4.54 ± 0.59	146	96.69
Made you more hopeful about your own future	151	4.42 ± 0.71	134	88.74
Gave you more confidence you can do things to further your recovery	150	4.38 ± 0.77	132	88.00
Gave you more confidence to seek employment	151	4.15 ± 0.98	113	74.83
Working as a CPS, you feel that . . .				
You have an ability to impact the agency where you work	148	4.36 ± 0.8	133	89.86
The work gives you an opportunity to give back to others	146	4.8 ± 0.42	145	99.32
Your confidence and sense that you can help yourself and others has increased	145	4.67 ± 0.58	139	95.86
The work facilitates and allows you to practice your own recovery	145	4.67 ± 0.59	138	95.17
Your job allows you to learn from your peers	145	4.69 ± 0.58	138	95.17
You have opportunities for personal development at agency	148	4.29 ± 0.87	126	85.14

[a] 1 = *strongly disagree*; 2 = *disagree*; 3 = *neither agree nor disagree*; 4 = *agree*; and 5 = *strongly agree* to the statements.

training.[xxiv]

- The following table outlines the outcomes of a variety of peer support programs.[xxv]

Table 2. Program Description and Outcomes of Peer Support

Study	Program Description	Study Participants	Outcome
Peer Employees (Employed Consumers)			
Solomon & Draine 1994; 1995 [20-22]	A randomized trial of a team of case managers who are mental health consumers compared to a team of non-consumers.	Recipients of case management (n=94)	Case management services delivered by consumers were as effective as those provided by non-consumers (symptomatology; QOL; social contacts; medication compliance; alliances with clients). Clients served by a consumer team were less satisfied with mental health treatment.
Felton *et al.* 1995 [23]	An intensive case-management program with peer specialists.	Recipients of case management (n=104)	Clients served by teams with peer specialists demonstrated greater gains in several areas of QOL and an overall reduction in the number of major life problems experienced.
Rivera *et al.* 2007 [26]	Consumer-assisted case management with standard clinic-based care.	Recipients of case management or clinic-based care (n=203)	There were no significant differences between the consumer-assisted program and other programs in terms of symptoms, satisfaction, subjective QOL, objective ratings of contacts with family or friends, and objective ratings of activi- ties and finances.
Lawn *et al.* 2008 [27]	Early discharge and hospital avoidance support program provided by peers.	Recipients of peer support (n=49)	300 bed days and costs were saved by the peer service.
Sells *et al.* 2006; 2008 [18, 19]	Intensive case-management teams that included peer providers.	Recipients of case management (n=137)	Participants who received peer-based services felt that their providers communicated in ways that were more validating and reported more positive provider relationship qualities compared with participants in the control condition.
Griswold *et al.* 2010 [25]	Trained peers employed by a local community organization provide a variety of services, including connections to social and rehabilitation services, by arranging appointments and providing transport.	Recipients of psychiatric emergency care (n=175)	Participants with peer support were significantly more likely to make connections to primary medical care.
Peer-Led (Peer-Run) Programs			
Chinman *et al.* 2001 [15]	An outreach and engagement program developed, staffed, and managed entirely by mental health consumers.	Recipients of consumer-run service or outpatient service (n=158)	Re-hospitalization rate. (No difference between the intervention group and the control group.)
Yanos *et al.* 2001 [28]	Programs that are staffed and operated completely by self-described mental health consumers provide services such as self-help, activity groups, and drop-in groups.	Recipients of mental health services (n=60)	Involvement in self-help services was associated with better community adjustment, the use of more coping strategies, and a greater proportion of problem-centered coping strategies.
Corrigan 2006 [29]	Consumer-operated services.	People with psychiatric disability (n=1824)	Participation in peer support was positively correlated with recovery or empowerment factors.
Nelson *et al.* 2007 [30]	Consumer / survivor initiatives run by and for people with mental illness.	Participants of peer-run organization (n=102)	Continuously active participants scored significantly higher on a measure of community integration than the non-active group.
Mutual Help Groups			
Galanter 1988 [31]	Self-help program designed by a psychiatrist to help participants cope with general psychiatric disorders.	Participants in self-help group (n=356)	A decline was found in both symptoms and concomitant psychiatric treatment after subjects joined the self-help group.
Wilson *et al.* 1999 [32]	Peer group work, including welcoming members, check-in, group discussion, planning a recreational outing and check-out	Participants in peer support groups (n=165)	Maintained independent or semi-independent living, an increase in the use of community resources and an increase in the size of the social support

Segal & Silver- man 2002 [33]	Self-help agencies that offer mutual support groups, drop-in space, and direct services, including case management, peer counseling, housing, financial benefits, job counseling	Long-term users of self- help agencies (n=255)	The participants showed significant improve- ment in personal empowerment, a significant decrease in assisted social functioning, and no
Bracke *et al.* 2008 [34]	Peer groups of clients of day-activity programs of rehabilitation centers for persons with chronic men- tal health problems.	Users of vocational and psychiatric rehabilitation centers (n=628)	The effects on self-esteem and self-efficacy of the balance between providing and receiving support in the peer groups were evaluated. The results showed that providing peer support is
Castelein *et al.* 2008 [14]	A closed peer-support group discussing daily life experiences. The group has 16 90-minute sessions biweekly over 8 months.	Users of healthcare centers (n=106)	Peer support groups had a positive effect on social network and social support compared with the control condition.

Increased engagement rates

- Peer support led to improved relationships with providers & social supports, increased satisfaction with the treatment experience overall, reduced rates of relapse, increased retention in treatment.[xxvi]
- Programs like WRAP increase self-advocacy with providers.[xxvii]
- Individuals working with peers felt more empowered to be outspoken about pursuing their goals.[xxviii]
- HARP participants had significantly greater improvement in patient activation than those in usual care.[xxix]
- When trained peers employed by a local community organization provide a variety of services, including connections to social and rehabilitation services, arranging appointments and providing transport, participants with peer support are significantly more likely to make connections to primary medical care.[xxx]
- Participants who received peer-based services felt that their providers communicated in ways that were more validating and reported more positive provider relationship qualities compared with participants in the control condition.[xxxi]
- A Mental Health America and Kaiser Permanente Peer Support Pilot Study showed participants who received peer support had increased trust in services and increased team collaboration.[xxxii]

Increased whole health

- The preliminary study findings of the Peer Support Whole Health and Resiliency (PSWHR) randomized controlled trial demonstrated the following results: [xxxiii]
    - 100% self-reported reaching whole health goal
        - Sample goals: eat five healthy meals per week, jog 20 minutes twice a week, eat seven servings of fruits and vegetables a week, etc.
    - Significant decreases in bodily pain, significant increases in hopefulness
    - Participants reported an average of 3.8 health conditions
    - 100% liked getting peer support
    - 78% of PSWHR participants were very satisfied
    - 100% strongly liked listening to other people's challenges & successes

- 100% strongly liked the chance to form a meaningful relationship with PSWHR teachers
- 100% strongly liked the focus on setting simple, achievable health goals
- 89% self-reported improvement in whole health since starting PSWHR

- Individuals receiving peer support show a significant decrease in substance use.[xxxiv]

Existing State-Level Standards for Certification

- Based on the research done by the Texas Institute for Excellence in Mental Health, The following statements indicate the differences in peer support standards.[xxxv]
  - Extent of work/professional experience
  - Extent of involvement as a peer leader or doing peer support
  - Differences in the number of hours before taking the exams
  - Differences in recertification/continuing education requirements
  - Individuals must self-identify as a peer vs. provide documentation of diagnosis/treatment in the mental health care system
  - Criminal background check required by some but not most
  - Substance use disorder as co-occurring vs. primary
  - Length of time in recovery differs (range if specified: 6 months – 2 years)
  - Exam requirement (e.g. Wyoming has no exam, only requires that certain documents be provided showing training)
- As of May 2018, 45 states and the District of Columbia have established or are developing programs to train and certify peer specialists. Five states had no certification and no process or plan to develop or implement one.[xxxvi]
  - States with certification include: Alabama, Arizona, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming
  - States planning certification include: Arkansas, Colorado, Mississippi, Nevada, New Hampshire, Vermont
  - States without certification include: Alaska, California, Montana, North Dakota, South Dakota
- As of January 2017, States reimbursing peer support through Medicaid:[xxxvii]
  - Alaska, Arizona, California, Colorado, Connecticut, DC, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, Utah, Washington, Wisconsin, Wyoming

National Certification

- As of March 2017, Mental Health America (MHA) launched the first national, advanced peer support specialist certification.[xxxviii] The MHA National Certified Peer Specialist (NCPS) certification has the following requirements:
    - Hold current state certification with a minimum training requirement of 40 hours **OR** hold a certificate of completion of an MHA approved training program;
    - 3,000 hours verifiable work and/or volunteer experience providing peer support services in the with the last six years
    - One supervisory letter of recommendation for certification
    - One professional letter of recommendation for certification
    - High School Diploma or General Equivalency Degree
    - 10 hours per year of Continuing Education Units (20 CEUS per two-year renewal period)
- Individuals with the MHA NCPS certification must pass a 125-qusetion examination across the following six domains of practice:
    - Foundations of Peer Support
    - Foundations of Healthcare Systems
    - Mentoring, Shared Learning and Relationship Building
    - Activation and Self-Management
    - Advocacy
    - Professional and Ethical Responsibilities

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