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EDITORIAL

Peer-Delivered Wellness Recovery Services: From Evidence to Widespread Implementation

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A growing body of evidence suggests that peer-provided, recovery-oriented mental health services produce outcomes as good as and, in some cases superior to, services from non-peer professionals. As evidence continues to mount, the stage has been set for a coordinated, national peer workforce development and maintenance initiative.

Reviewing the evidence for peer-delivered services, writing in 2004 in this journal, researcher Phyllis Solomon commented on the "high level of evidence" for peer-provided services, including four randomized studies and three quasi-experimental design studies using a variety of meaningful outcome measures (Solomon, 2004). The past two decades have witnessed a number of important studies of these models and services that meet these evidence criteria. For example, Paulson and his colleagues randomly assigned community mental health center clients to a peer-staffed Assertive Community Treatment (ACT)[1] team, an ACT team staffed by non-peers, or services as usual (Clarke et al., 2000; Herinckx, Kinney, Clarke, & Paulson, 1997; Paulson et al. 1999). Results revealed no differences between the two ACT teams in participants' symptom severity or any clinical or social outcome for the first two years of service delivery. However, both ACT teams had significantly greater treatment retention than usual care. In another study, clients of a community mental health center were randomly assigned to peer-run intensive case management (ICM) versus non-consumer-run ICM teams (Solomon & Draine, 1995a, 1995b). At two years, clients of both teams had equivalent symptoms, quality of life, and a variety of clinical and social outcomes. Service delivery patterns differed, however, in that the consumer case management team provided more face-to-face services and services outside of an office setting than did the non-consumer team.

In another controlled study (Kaufmann, 1995), job-seekers were randomly assigned to a consumer vocational program partnered with a traditional vocational program versus services as usual enhanced by information on local employment programs. The two-phase experimental program began with traditional job training, placement, and follow-up, followed by peer support for job seeking and commonly encountered employment problems. Those in the peer program achieved employment and higher vocational status than those in usual services, and employed clients worked a greater number of hours. Importantly, unemployed peer program participants were more likely to be looking for a job, working as a

trainee, or volunteering than unemployed individuals in the services as usual condition.

Since Solomon's review in 2004, additional studies have shown similar results. An article from the federally-funded, multisite Consumer-Operated Service Program (COSP) study (Rogers et al., 2007) found that participants who received COSP plus traditional mental health services reported higher levels of personal empowerment than those who received traditional services only. The current issue of *Psychiatric Rehabilitation Journal* also includes an article showing the effectiveness of peer services delivered as part of the national COSP study.

Davidson and his colleagues (2004) conducted a three-arm controlled study comparing: 1) a financial stipend only; 2) a stipend plus supported socialization with a peer; and 3) a stipend plus supported socialization with a non-peer. These investigators found that those receiving peer-delivered services achieved outcomes as good as those in the other two conditions in areas such as symptoms, well-being, self-esteem, social functioning, and employment. Similarly, Sells and colleagues (2006) conducted a randomized study comparing "broad based" peer and non-peer case management. Participants reported that they perceived higher positive regard from peer case managers than non-peer case managers at 6 months, but not at 12 months, indicating that perhaps peers have special skills in engaging clients into supportive services. A randomized study by Druss and colleagues (2010) examined a peer-led medical illness self-management program for people with psychiatric disabilities, using an approach adapted from a well-known chronic illness self-management intervention (Lorig et al., 1999). Called the *Health and Recovery Peer* (HARP) *Program*, its focus was on helping people cope more effectively with physical health conditions. At 6-month follow-up, HARP participants reported significantly greater improvements in physical activity, visits to primary care doctors, medication adherence, physical health-related quality of life, and perceived ability to manage their illness and health behaviors when compared to study participants receiving usual services only. Finally, Cook and her colleagues (2011) randomly assigned public mental health clients to receive Wellness Recovery Action Planning (WRAP) versus services as usual, and found lower symptom severity as well as greater hopefulness and higher quality of life among WRAP participants compared to those receiving usual services only.

These randomized controlled trial studies show that outcomes of peer-provided services are as good as or better than services from non-peers. This is especially true when peers deliver well-defined interventions, such as supported employment, ACT, ICM, HARP, or WRAP. While there is still research work to be done, the evidence in support of peer delivered services qualifies as Level 1b ("evidence obtained from at least one randomized controlled trial"), using the United States Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research) guidelines published in 1992.

With this available evidence, state systems are ready to move beyond deciding whether or not to fund peer-delivered services to how best to support peer workforce development initiatives. The state of Georgia led the way by being the first to certify consumers in the delivery of peer support services that were billable to Medicaid (Sabin & Daniels, 2003). Other states soon followed by developing their own Certified Peer Specialist (CPS) programs. In 2004, the National Association of Peer Specialists was formed to promote the growth of the CPS movement through training, education, and advocacy. In November 2009, a summit convened at the Carter Center in Atlanta, called *Pillars of Peer Support,* brought together a number of states seeking to develop and nurture a strong and viable mental health peer workforce (Daniels et al., 2010). The intention was to assemble a blueprint for states that wished to expand and enhance their peer-delivered services and supports. At the Summit, peer program data submitted by 17 states was reviewed in order to present a national picture of the members of this workforce, how they are trained and certified, the services they provide, and how these are funded. At the conclusion of the Summit, participants endorsed a set of 25 best practices for strengthening state peer specialist programs. Known at the "pillars" of peer support, they include having clear job descriptions, job-related competencies, competencies-based testing, continuing education, opportunities for training and professional advancement, a strong consumer movement, media and technology access, peer workforce development initiatives, ongoing evaluation efforts, commitment to consumer-run organizations, multiple training sessions, sustainable funding, a culturally diverse peer workforce, training for supervisors, and opportunities to deliver peer support whole health services.

The field of psychiatric rehabilitation has long been a friend to peer-provided services, and we have spent much time helping to incubate new peer programming and build the case for its effectiveness. Many CPSs now work in psychiatric rehabilitation programs and other community program settings (Salzer, Schwenk, & Brusilovskiy, 2010). While continuing to develop the re-

search base, we also must begin dialogue about a coordinated national effort to build and maintain a well-trained and well-supported peer workforce in psychiatric rehabilitation settings. The *Pillars of Peer Support*, available at http://www.pillarsofpeersupport.org/, along with other peer workforce development literature (Hebert, Drebing, Rosenheck, Young & Armstrong, 2008; Solomon, Jonikas, Cook, & Kerouac, 1998; Shore & Curtis, 1998; Wolf, Lawrence, Ryan et al., 2010), provides an excellent springboard for this effort.

1. ACT is a model in which services are provided exclusively in the community through mobile teams comprised of psychiatrists, nurses, case managers, and other staff.

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