Keeping the Peer in Peer Specialist When Implementing Evidence-Based Interventions

Carolina Vélez-Grau, Ana Stefancic, and Leopoldo J. Cabassa

Peer specialists can be found in many fields. They are people with lived experiences of a range of conditions who support others with similar conditions. In this Practice Forum column, we focus on peers with lived experiences of mental illness who are trained to provide support to others with these conditions (Salzer, Katz, Kidwell, Federici, & Ward-Colasante, 2009). Research suggests that evidence-based interventions (EBIs) delivered by peers can improve health outcomes (for example, dietary habits, smoking, communication with doctor) among people with serious mental illness (SMI) (Cabassa, Camacho, Vélez-Grau, & Stefancic, 2017; Chinman et al., 2014). It has been proposed that sharing lived experiences of mental health, treatment, and recovery; engaging in role modeling; and providing support rooted in personal knowledge are some of the unique strengths that peers bring to mental health services (Blash, Chan, & Chapman, 2015; Chinman et al., 2014; Davidson, Chinman, Sells, & Rowe, 2006). Training and support for peers are necessary for the success of peer-delivered interventions; however, there are concerns about the potential for training to overemphasize technical proficiency at the expense of the unique contributions of the peers (Walker & Bryant, 2013). Despite this information on intervention training, ongoing support for peer specialists is generally lacking and omits discussion of how trainings balance standardized intervention delivery with unique aspects of a peer approach. For example, studies of peers delivering health interventions to people with SMI are often limited to cursory descriptions of the type of manual or intervention, training duration, topics covered, supervision, and field requirements (Cabassa et al., 2017).

In this column, we discuss four areas (that is, approach, language, outcomes, proficiency) in which tensions were observed as we trained and supervised peer specialists to deliver the Peer-led Group Lifestyle Balance (PGLB) intervention. These tensions were identified through a year of direct observation; audio recordings of peers' delivery of the intervention; and iterative discussions with peers, the research team, and agency supervisors. Generally, training and supervision as originally designed had overly focused on the concrete components of the EBI, and as these tensions emerged, we adjusted the training to more explicitly integrate peers' strengths and needs as intervention facilitators. In this column, we provide specific examples of these tensions and offer suggestions regarding how researchers can better preserve contributions from peers' lived experiences while maintaining intervention fidelity (amid standardized training).

PGLB

PGLB, a federally funded (1R01MH104574-01) study, tests the effectiveness and implementation of a peer-led healthy lifestyle intervention in supportive housing agencies serving clients with SMI who are overweight or obese (Cabassa et al., 2015). Four peer specialists were trained to deliver the Group Lifestyle Balance program (GLB), a manualized, curriculum-based intervention derived from the Diabetes Prevention Program to help individuals lose weight through nutrition and physical activity (Kramer et al., 2009). All PGLB peers were Certified Peer Specialists with training in core aspects of peer-delivered services including engagement, recovery, and use of life experiences to help others. The peers were all interested in employment that supports people with physical health issues.

A two-day training was provided where peers received the standard GLB manual, but with session agendas that were modified to meet the literacy needs of the population and approved by the Diabetes Prevention Support Center (O'Hara, Stefancic, &

doi: 10.1093/hsw/hly037

Cabassa, 2017). This two-day training was followed by three months of intensive in-person or online supervision by a licensed clinical social worker (LCSW) to further reinforce GLB concepts and provide effective group facilitation skills. Each peer conducted three mock sessions and received feedback regarding their PGLB proficiency and facilitation skills from the LCSW trainer, the research staff, and their agency supervisor. Peers' performance in these mock sessions determined their readiness to deliver the intervention. Once peers began delivering the intervention, the LCSW trainer conducted ongoing weekly supervision, including written and verbal feedback on intervention session. GLB fidelity checklists were used to provide feedback regarding the intervention components of each session, but the nuances of the interactions between peers and participants were discussed in supervision. Peers and the LCSW meetings were collaborative with specific focus on peers' reflections on the barriers, facilitators, and process of delivering the intervention.

TENSIONS

Lived Experience versus a Manualized Approach

The tension between lived experience and a manualized approach refers to peers' emphasis on using their lived experiences as an approach to help others, versus the research emphasis on using the manualized intervention. Studies suggest that peers' lived experience is what differentiates them from other professionals (Mahlke, Krämer, Becker, & Bock, 2014). A *manualized approach* refers to the use of evidence-based knowledge to improve participant outcomes and promote replicability of an intervention (Goldstein, Kemp, Leff, & Lochman, 2012). Peers expressed concern that fitting the session agenda within limited time precluded them from sharing their personal experiences, such as how side effects of psychiatric medication (that is, feeling hungry) were a barrier to achieving their weight loss goal. To address this tension, we helped peers identify the main session takeaways, prioritized activities that reinforced these takeaways, and encouraged them to tap into their experiences when relevant to illustrate the key concepts of the session. We used fidelity checklists to ensure that the core elements of the session were delivered, but we also learned to include explicit discussion in supervision of how peers' lived experiences could inform their role as facilitators.

Lay versus EBI Language

The tension between lay versus EBI language refers to the use of vocabulary developed by peers through their personal experiences, which is often in conflict with the language used in EBI research. EBI language is technical language used by professionals to explain theoretical concepts and behavioral skills (Goldstein et al., 2012). We noticed that peers' language had begun to drift toward more technical concepts after training and supervision. For instance, one peer learned that acknowledging others' feelings was referred to as "validation" and began using the term in group. This adoption of technical and clinical language replaced phrasing that had previously been more straightforward, such as "I can see why you feel this way and it's OK, I also have felt that before," and resulted in missed opportunities to make information more relatable to participants. To address this tension, we devoted significant time in supervision to train peers to break down the language of EBI and to have them write down and rehearse how they would explain EBI concepts using nontechnical language. For instance, in describing a study of GLB, peers developed a diagram to talk about the three different study groups (metformin, placebo, healthy lifestyle) and replace research terms such as placebo with "group who received a sugar pill." Also, instead of relying on percentages to describe intervention effectiveness, peers relied on simpler language to convey the positive outcomes of the intervention such as "weight loss" and "improved health."

Process versus EBI Outcome

There is tension between peers' emphasis on processes of care, meaning steps leading to potential outcomes, and the EBI emphasis on treatment outcomes. Literature concurs that peers' efficacy relies on their ability to relate to the experiences of those whom they help (Chinman et al., 2014; Davidson et al., 2006; Moran, Russinova, Yim, & Sprague, 2014). This places peers in a unique position to observe and acknowledge subtle changes in participants' outlook and behaviors, which may be imperceptible to the research team. In contrast, EBIs tend to focus on more objective, concrete outcomes that are monitored over the course of the intervention, such as achieving a 7 percent weight loss as in the case of PGLB.

Tension was observed when, over time, peers began to shift their emphasis from positive changes in participants' outlook, such as hopefulness, and

process-related outcomes, such as small dietary changes, to the intervention's goal of weight loss. This was problematic as peers shifted from their broad strengths-based perspective that had helped participants sustain hope and motivation, to one where success became more narrowly defined as changes in weight on a weekly basis. This also led the peer specialists to reflect more negatively on their own performance, despite our positive evaluations of their intervention delivery. To address this tension in supervision, we had to explicitly inquire about peer specialists' perceptions of participants' outlook, their rapport with the peer, and small behavioral changes. We also devised strategies for helping peer specialists work with participants around small changes. For example, peers reviewed participants' healthy lifestyle logs, in which participants reported their weekly food intake, to identify and monitor small steps and barriers related to eating habits while also monitoring weight. Peers were then encouraged to use part of their individual meetings with participants—in person or on the telephone—to go over these small changes and address barriers to attain ultimate goals. Overall, training efforts were tailored toward encouraging peers to focus on the ultimate intervention outcomes, without losing their emphasis on the interim progress participants were making in a wider array of domains.

Job Skills versus EBI Proficiency

The tension between job skills versus EBI proficiency refers to the challenges of training and supporting peers in both an EBI's content as well as skills that are necessary for being in the workforce. This tension emerged as training and supervision had originally focused on enhancing peers' EBI knowledge without addressing the need for support in general job skills (for example, writing Word documents, managing schedules, checking e-mail) that were necessary to successfully perform the tasks related to the EBI. To resolve this tension, we expanded our ongoing training and support to include skills such as using word processing, sending attachments, maintaining online calendars, and navigating cloud storage applications such as Dropbox.

CONCLUSIONS AND IMPLICATIONS

This column aimed to expand on the call for increased understanding of peer training (Davidson et al., 2006; Mahlke et al., 2014; Salzer et al., 2009; Walker & Bryant, 2013) and how this training may compromise peers' strengths (Blash et al., 2015; Mahlke et al., 2014; Walker & Bryant, 2013). There appears to be an implicit expectation that peers receiving EBI training can seamlessly integrate standardized methods and protocols with their lived experiences; yet, our identification of four tensions related to the approach, language, outcomes, and proficiency within a peer-led manualized intervention suggests that this is not the case. These tensions emerged because initial training and support had not been designed to address the "peer" aspects of intervention delivery and had to be adjusted. The tensions were addressed during training and ongoing supervision by explicitly building in discussion time and training assignments that reintegrated components of a peer approach and involved the peers in decisions about how to best integrate their knowledge and experiences with the EBI.

By acknowledging and understanding these specific tensions, and the potential pull away from peers' strengths, we can better prepare peer specialists for the challenges that arise when incorporating a peer approach to EBIs. We recommend that practitioners and researchers who train and supervise peer specialists in EBIs strive for a balance between the manualized knowledge of the EBI and maintaining peers' strengths. Future research should focus on developing training curricula to further examine how different training approaches can work best to preserve the peers' unique strengths. More specifically, there is a need to develop strategies that can not only be generalized across diverse peer intervention trainings, but also be flexible enough to be adapted to the particularities of different interventions. Social work practitioners and researchers in collaborations with peers need to continue bringing these issues to the front line to avoid compromising the very components that make peer services unique and effective. HSW

REFERENCES

Blash, L., Chan, K., & Chapman, S. (2015). *The peer provider workforce in behavioral health: A landscape analysis*. San Francisco: UCSF Health Workforce Research Center on Long-Term Care.

Cabassa, L. J., Camacho, D., Vélez-Grau, C. M., & Stefancic, A. (2017). Peer-based health interventions for people with serious mental illness: A systematic literature review. *Journal of Psychiatric Research, 84*, 80–89.

Cabassa, L. J., Stefancic, A., O'Hara, K., El-Bassel, N., Lewis-Fernández, R., Luchsinger, J. A., et al. (2015). Peer-led healthy lifestyle program in supportive housing: Study protocol for a randomized controlled trial. *Trials, 16*, 388. doi:10.1186/s13063-015-0902-z

Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon,

M. E. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services, 65*, 429–441.
Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin, 32*, 443–450.
Goldstein, N. E., Kemp, K. A., Leff, S. S., & Lochman, J. E. (2012). Guidelines for adapting manualized interventions for new target populations: A step-wise approach using anger management as a model. *Clinical Psychology: Science and Practice, 19*, 385–401.
Kramer, M. K., Kriska, A. M., Venditti, E. M., Miller, R. G., Brooks, M. M., Burke, L. E., et al. (2009). Translating the Diabetes Prevention Program: A comprehensive model for prevention training and program delivery. *American Journal of Preventive Medicine, 37*, 505–511.
Mahlke, C. I., Krämer, U. M., Becker, T., & Bock, T. (2014). Peer support in mental health services. *Current Opinion in Psychiatry, 27*, 276–281.
Moran, G. S., Russinova, Z., Yim, J. Y., & Sprague, C. (2014). Motivations of persons with psychiatric disabilities to work in mental health peer services: A qualitative study using self-determination theory. *Journal of Occupational Rehabilitation, 24*(1), 32–41.
O'Hara, K., Stefancic, A., & Cabassa, L. J. (2017). Developing a peer-based healthy lifestyle program for people with serious mental illness in supportive housing. *Translational Behavioral Medicine, 7*, 793–803.
Salzer, M. S., Katz, J., Kidwell, B., Federici, M., & Ward-Colasante, C. (2009). Pennsylvania Certified Peer Specialist initiative: Training, employment and work satisfaction outcomes. *Psychiatric Rehabilitation Journal, 32*, 301–305.
Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal, 36*(1), 28–34.

Carolina Vélez-Grau, LCSW, *is a doctoral student and graduate research assistant, School of Social Work, Columbia University, New York.* ***Ana Stefancic, PhD,*** *is associate research scientist, Department of Psychiatry, Columbia University, New York.* ***Leopoldo J. Cabassa, PhD, MSW,*** *is associate professor, George Warren Brown School of Social Work, Washington University in St. Louis. Address correspondence to Leopoldo J. Cabassa, George Warren Brown School of Social Work, Washington University in St. Louis, One Brookings Drive, St. Louis, MO 63130; e-mail: ljcabassa@wustl.edu.*

Original manuscript received February 9, 2018
Final revision received June 4, 2018
Editorial decision June 11, 2018
Accepted June 11, 2018
Advance Access Publication December 15, 2018