Academy for Policymakers Podcast
Policy and Practice Recommendations for Peer Support Training and Certification Programs
Recorded by Amy Lodge, Sam Shore, and Kelsi Urrutia

Announcer: Thank you for visiting the University of Illinois at Chicago's Health & Recovery Academy for Policymakers. The following recording comes to you from the UIC Center on Integrated Health Care and Self-Directed Recovery. Visit our online Academy to obtain free information and resources about policies that promote health, self-direction, and employment for the behavioral health field.

KU: Hello, my name is Kelsi Urrutia and today, we will be talking about peer support programs in the United States. Joining today is Sam Shore. Sam is the Director of the Academy for Policymakers at the University of Illinois at Chicago's Center on Integrated Health Care and Self-Directed Recovery. Welcome, Sam!

SS: It's great to be here.

KU: Also with us today is Dr. Amy Lodge. Amy is a Research Associate at the Texas Institute for Excellence in Mental Health. In 2016, the Institute completed a national overview of peer support training and certification programs. Sam will be interviewing her for today's podcast. Welcome, Amy!

AL: Thank you.

SS: Thank you, Amy, for talking to us today about the work you and your team did on the national overview of peer support training programs in the United States. Could you tell us a little bit about this overview, and what led to its creation?

AL: Of course. In 2010, Texas was just starting their certification program and there was no good source of information out there to establish what peer training and certification programs looked like across the country. You could find some information here and there on specific programs, but there was no comprehensive source that allowed you to see what different states were doing and compare them to each other. Creating this report and posting it online makes the information more accessible, not just for the academic and provider communities, but also for people who want to know how to get certified in their state. Once we started, we realized why no one had done this before. We scoured the internet for information and spent a lot of time calling and emailing people all over the country for information. It was a time-consuming process.

SS: In your report, you provided a list of recommendations for states to consider. One of your suggestions is that states could solicit feedback on the strengths and challenges of their training and certification process. You also suggest that feedback should come from people who completed the certification process, and from people who applied, but were not accepted into the program. Can you talk about why these are important, and what states could gain?

AL: Definitely. The challenges that a training program face might not always be obvious. For example, a state's peer training and certification application might be excluding people for unclear or unnecessary reasons. This is hard to determine if people who were not accepted aren't surveyed. And it's just as important to get feedback from people who did complete the training and became certified. You would want to know things like:

Is what they learned in the training applicable where they work?
Was there an important topic or topics that were missing?
Do you have empty chairs because people find it difficult to travel to the training location?

Making the effort to get and use those answers could mean the difference in whether your training program is effective or not. Programs also need to be able to adapt to the changing needs of the workforce and the state. For example, a program might receive feedback about a need for Spanish-speaking peer providers. In order to ensure that trainees reflect the cultural diversity of people receiving services, they could respond to this feedback by advertising and creating trainings in Spanish as well as providing written materials in Spanish. Because ultimately, you want the most competent peer workforce out there to work with people on their recovery journeys.

SS: You also recommended that each state assess the fidelity of peer practice to the training, and build the evidence for both the training and the competency of peers. Can you describe what you mean by that?

AL: Sure. Yes, it's really important to follow up with people after they've completed the training and have had a chance to apply the knowledge and skills that they learned. States should collect data on whether peer providers are staying true to the model of peer support that the training teaches. Sometimes this can reveal where there may be organizational environments or policies that conflict with peer ethics and competencies. For example, we've heard people say, "I'm not allowed to work with people one-on-one without another employee watching," or on the flip side, "My supervisor expected me to build the entire peer support program by myself after attending the core training." So states should collect that kind of data so they may be able to say, "Yes, our training is effective, but not at a place that won't allow peers to be peers," and of course, we need more research on the outcomes of peer provided services.

SS: That's interesting. Can you say more about how a state would do this?

AL: Surveys can be an effective way to find out what is happening out in the field. Alternatively, with more resources, evaluators could organize site visits, focus groups, and interviews to get a greater depth of information.

SS: What could states gain from using this approach?

AL: Peer support that works! When people are getting better in the communities of their choosing, that is ultimately going to be good for the state too. Some studies have suggested that

effective peer support programs reduce the use of emergency and inpatient care, which is the most expensive kind of care. Studies also suggest that peer support results in people becoming more empowered, having greater patient activation, greater independent living skills, and so on. So, peer support seems not only to help people get better, but it gives them the resources they need to stay better – we call that recovery capital.

SS: I see that you also recommend that states provide recovery-oriented implementation initiatives to support peer specialist integration into the workforce. Can you tell me more about this?

AL: Yes. Peer support can't work in a vacuum. States should support provider organizations to shift toward a recovery-oriented model of care. Peer providers are evidence of a recovery-oriented system, but they aren't the whole thing. They can only be effective in places that are at least beginning to embrace ideas of recovery.

SS: Can you describe successful initiatives, and how they impacted those organizations?

AL: Yes. Texas has funded ongoing recovery-oriented initiatives in the last decade to begin moving providers to a recovery-oriented system. To do this they've partnered with Via Hope, which is a training and technical assistance organization here in Texas, along with tons of people in recovery, peers, consultants, and evaluators. And organizations have seen more person-centered services, improved client outcomes, and greater employee satisfaction.

SS: Thank you for talking about this today. Is there anything else you would like to share?

AL: Thank you so much for having me. We're really glad to have the opportunity to talk about the results of this project. It's been exciting to see the number of states with training and certification programs increase so much over the 6 years that we've been working on this.

KU: To access the full report with the overview of peer support programs by state, and the full list of recommendations, please visit the Academy web page where you found this podcast. You also can learn more by visiting http://sites.utexas.edu/mental-health-institute/.

Announcer: Thank you for listening. You can obtain additional recordings, or download a transcript, by visiting the Academy for Policymakers on the Center's web site.