PEER SUPPORT – Starting with the Why!

Presentation for the *Behavioral Health Partnership Oversight Council*

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Agenda

- Starting with the Why?
- What is Peer Support?
  - Brief History of Recovery Supports provided by People with Lived Experience
  - Gifts of Peer Support and Lived Experience in Behavioral Health
  - How peers can assist in the field of mental health and addictions
  - Evidence
- Why National Competencies and CT process

Getting Grounded… Starting with the Why?

We need you, our brothers, our sisters, our people;

help us reaffirm ourselves in

Loving ourselves;

Hold us when we can’t stand

‘cause soles of shoes have traveled on our backs for so long;

We need you, our brothers, our sisters, our people!

(adapted “I need you” by Imani Harrington)

Introducing Peer Support

In an ideal world, we could all provide peer support based on our life experiences – we do it every day – different issues, but similar results.

Peer support has been defined by the fact that people who have like experiences can better relate and can consequently offer authentic empathy and validation.

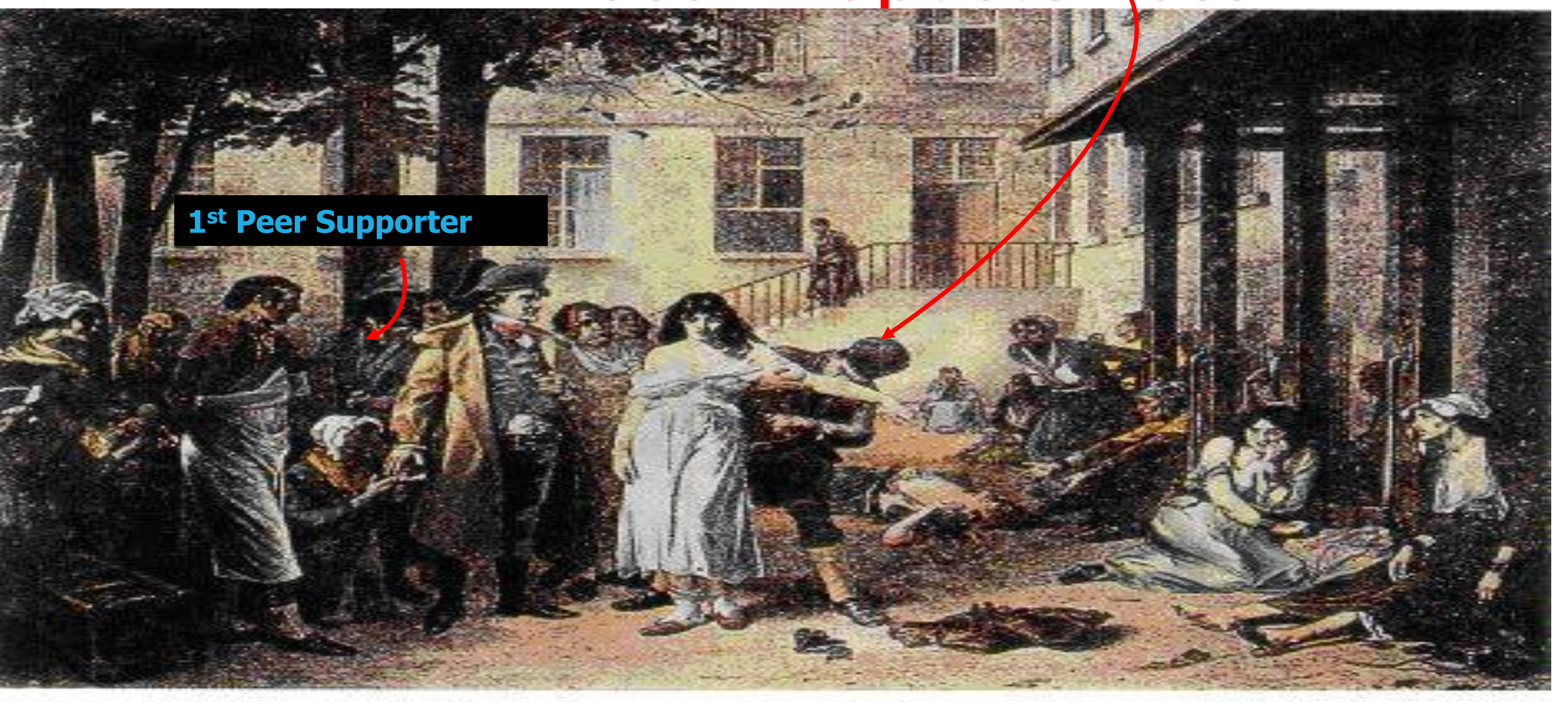
People with lived experience can offer each other practical advice and suggestions for strategies that professionals may not offer or even know about.

"Who then can so softly bind up the wound of another as he who has felt the same wound himself?"– Thomas Jefferson

Poll:
When did mental health peer support begin?

1. 1790s
2. 1840s
3. 1920s
4. 1950s
5. 1980s
6. 1990s

Jean Baptiste Pussin



Dr. Philippe Pinel at the Salpêtrière, 1795 by Robert Fleury.
Pinel removing the chains from patients
at the Paris Asylum for insane women.

When did mental health peer support begin?

1. **1790s:** Jean Baptiste Pussin hired recovered “patients” to staff his hospital in France because they would not abuse the other patients and would be role models for them (beginning of “moral treatment”)
2. **1840s:** Dorothea Dix (also a recovered “patient”) started state hospital movement
3. **1920s:** Harry Stack Sullivan also hired former patients as staff in the 1920’s and was himself in recovery (Davidson, 2010)
4. **1950s:** U.S. started community mental health movement (initially envisioned by Clifford Beers, also recovered)
5. **1970/80s:** Strong Ex-Patient Survivor Movement starting
6. **1990s:** Consumer/survivor movement spawned contemporary peer support phenomenon – peer support as service delivery model

Rapid Expansion Nationwide

- Peer services introduced in the early 1990s
- Medicaid reimbursement began in 2007
- 48 states and DC reimburse peer support services
- 49 states have peer certification programs
- Over 30,000 (100,000 pdv) trained peer supporters

CT Peer and Recovery Supports

Advocacy Unlimited, Inc. Recovery University, RSS, (2008) and now Peer Support Training for CPSRP 2008-9

Connecticut Center for Addiction Recovery (CCAR), Recovery Coaching and Recovery Professionals (2000s; early id)

Later joined by Hartford Healthcare Recovery Leadership program (2018)

New Life II Integrated Healing Facilitators Peer Support Training

Prior to Peer Support as a role and profession – it's been in Connecticut!

The need for lived experience and peer support has always been essential but here's why today!

People with Mental Illness are dying 15-25 years earlier than the rest of society[1]

People with histories of mental illness, substance use, and addictions have often experienced stigma, discrimination, feeling of demoralization, exclusion from society, etc.

A Call To Action

Decreasing Health Disparities and Improving Health Outcomes

[1] National Association of State Mental Health Program Directors Medical Directors Council, (2006). Morbidity and Mortality in People with Serious Mental Illness

Why Peer Support Matters

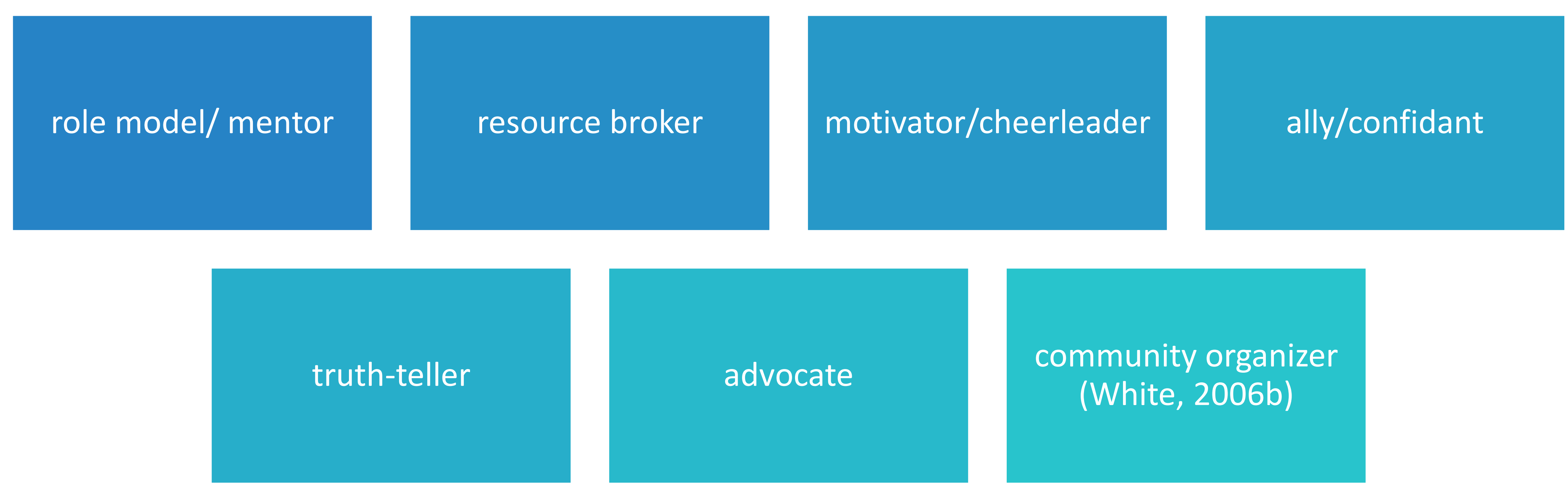
Cornerstone of recovery-oriented behavioral healthcare – which is our state's and our nation's model and framework.

Delivered by individuals with lived experience of recovery

Builds hope, trust, and engagement

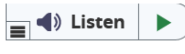
Promotes self-determination and community inclusion

Peer Support – Other Names



What are some gifts Peer Supporters can offer?

- Instillation of hope
- Modeling one example of Recovery
- Mentoring
- Coaching
- Engagement/Connection
- Street Smarts and navigating system or living day-to-day life, e.g., poverty, discrimination, unstable housing, etc.
- Community networking/connecting
- “Lift as We Climb”



Brief Reports

When reality breaks from us: lived experience wisdom in the Covid-19 era

Ana Carolina Florence, Rebecca Miller, Chyrell Bellamy, Pauline Bernard, Claire Bien, Kendall Atterbury,

...show all

Pages 363-367 | Received 05 Jun 2020, Accepted 25 Aug 2020, Published online: 10 Sep 2020

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ABSTRACT

The emergence of Covid-19 disrupted most aspects of life, creating a high degree of uncertainty and unpredictability about the future. Knowledge from a place of lived experience offers insights and strategies to better understand how to live,

Related

From lived experience to experiential knowledge: a working model

Shimri Hadas Grundman, Neta Edri and Renana Stanger Elran

Shimri Hadas Grundman is based at Yozma – Derech Halev Organization, Kfar Saba, Israel.
Neta Edri is based at Kiryat Ono, Israel.
Renana Stanger Elran is based at Yozma – Derech Halev Organization, Kfar Saba, Israel and The Lafer Center for Women and Gender Studies, Hebrew University of Jerusalem, Jerusalem, Israel.

Abstract

Purpose – *This paper aims to present a working model for using experiential knowledge in the work of lived experience practitioners within the mental health field.*

Design/methodology/approach – *The working model is constructed from three key elements, namely, components of lived experience, the Library of Life Experiences and the NISE technique for sharing experiential knowledge (NISE: need identification; inner identification; sharing experiential knowledge and interpersonal encounter).*

Findings – *The model will be described, followed by central themes that emerged from a pilot course that was taught in Israel in 2019 to a group of peers working in the mental health system. The central themes were: developing peer identity; sharing peer language; internalizing the working model; understanding the peer role; and awakening social consciousness.*

Originality/value – *The original working model and training course were co-produced and co-conducted by peer specialists and mental health professionals, for the use of lived experience practitioners.*

Keywords *Lived experience, Peer support, Model, Training, Mental health*

Paper type *Conceptual paper*

Introduction

In this article, we wish to add our contribution to the theory and practice of experiential knowledge by presenting a working model developed for the use of lived experience practitioners working within mental health systems. The development of the model stemmed from our day-to-day work and the need for practical tools that will further conceptualize the work with lived experience. We believe that this model can assist practitioners in turning their experience into knowledge and in using it in a more precise and adequate way, without losing the personal and authentic essence of being a peer.

It seems that mutual support offered by people going through similar hardships is a basic human quality. At the basis of lived experience, we find the first-person narratives of coping and recovery. Individuals have their own way to define meaningful life experiences, determine what recovery means to them and choose which parts of their experience they wish to share with others. If they choose to use their lived experience as peers within the mental health system, they are required to transform life experiences into working tools. It is a choice to professionalize the spontaneous and precious personal knowledge and to make it a valuable resource not only for the individual but also for other peers, service users, family members and professionals.

The working model and training course were developed as part of our work in Yozma Derech HaLev, an innovative rehabilitation service. We thank our organization for the time and resources. We would like to add special thanks to our professional manager Yael Shavit-Shotland for her contribution.

Literature review

Informal peer support has existed for decades in natural and spontaneous ways as follows: hospitalized patients supporting each other; independent self-help groups; grassroots movements of advocates outside the formal mental health system. The 1960-1970s brought

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Lived Experience is needed!!!

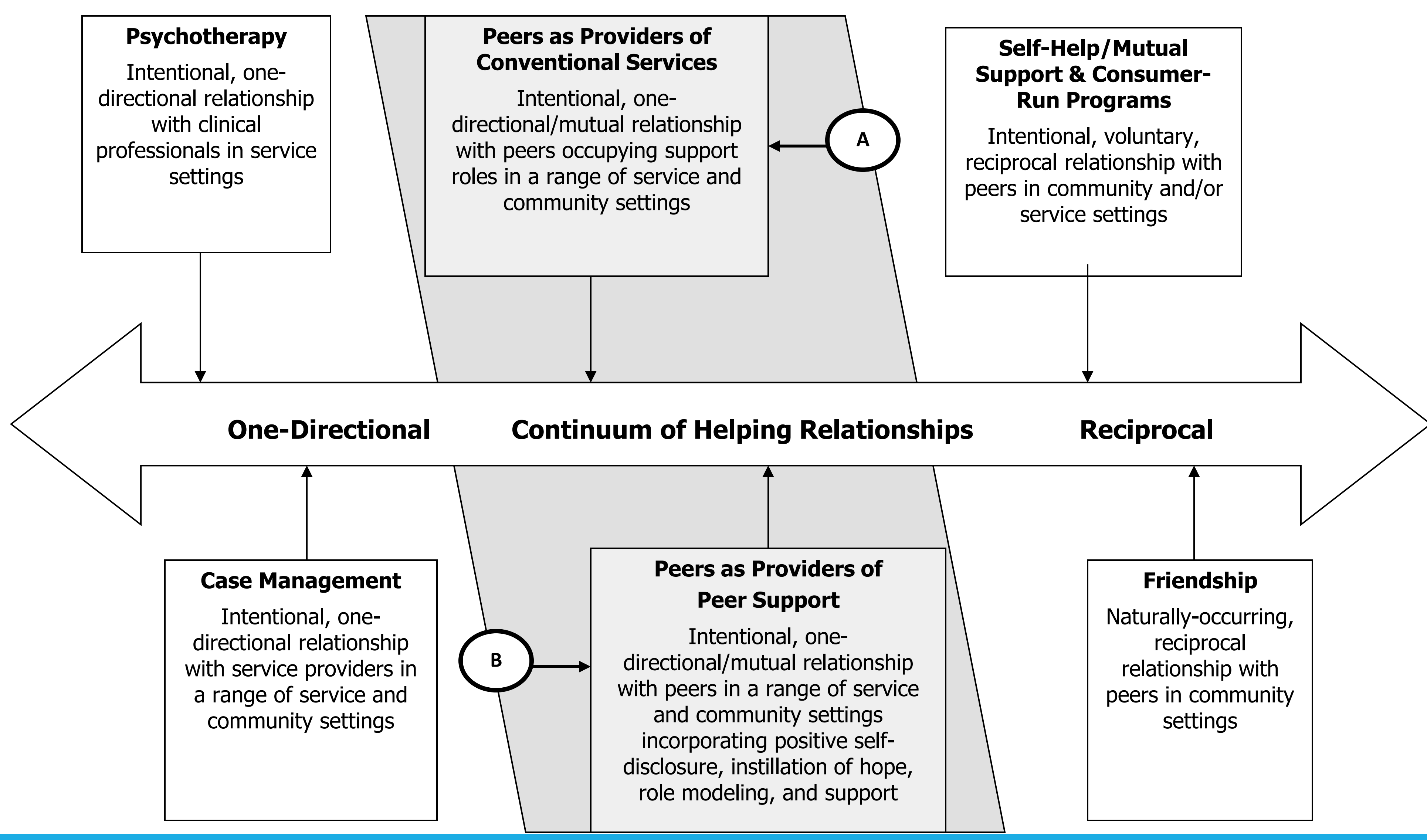
Central and useful components of Mental Health Lived Experience

Central useful components

- Familiarity with emotions and emotional states
- Interactions with professionals
- Encounters with treatment and rehabilitation systems
- Experience of using psychiatric medications
- Family and dealing with family
- Social and self-stigma
- Coping Strategies
- Change
- Perspective
- Hope

Grundman, S. H., Edri, N., & Elran, R. S. (2020). From lived experience to experiential knowledge: a working model. *Mental Health and Social Inclusion*.

A Continuum of Helping Relationships

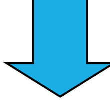
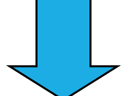
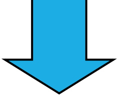


How Peers Can Assist

Issue or Concern

Social isolation	Disconnection with ongoing outpatient treatment or wellness	Powerlessness & demoralization regarding illness or trauma

How Peers can assist

Enhance social networks by facilitating peer support activities Reconnecting with family	Engages individuals; makes treatment more relevant through collaboration	Activates individuals; Offer coping and street smarts; provides hope through role modeling of living life on life's terms

How Peers Can Assist

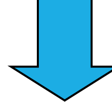
Issue or Concern

Overburdened/under-resourced providers

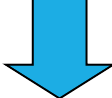
Fragmented services

Systemic lack of emphasis on recovery

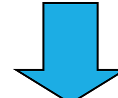
How Peers can assist



Supplement existing treatment



Provide support in system navigation



Emphasize recovery

-liaison

-challenge stigma

-community inclusion is part of stabilization

Research Evidence to Date

- First generation studies showed that it was feasible to hire people in recovery to serve as mental health staff.
- Second generation studies showed that peer staff could generate at least equivalent outcomes to non-peer staff in similar roles; could also engage people into care and reduce readmissions.
- Third generation studies are investigating whether or not there are unique contributions that peer support can make; thus far these have been in …

Evidence

Initial evidence shows

- Outcomes equivalent to non-peer support providers, with some studies showing slightly better outcomes with peer support staff (Solomon, 1995; Davidson, 2004)
- Longer community tenure in those receiving peer support in one RCT (Clarke, 2000; Min 2007)
- Peer support staff show ability to reach people who have more vulnerabilities and or are harder to engage (Rowe, 2007; Sells, 2006)

Evidence

Peer Support has been found to:

- reduce readmissions by 42%
- reduce days in hospital by 48%
- Improve relationship with providers
- increase engagement with care
- decrease substance use
- decrease depression
- Increase hopefulness
- increase activation and self-care
- increase sense of well-being

(Recent review by Chinman et al in Psych Services)

More Benefits of Peer Support

- Organizational benefits:

- Improved outcomes
- Can fill identified service-gaps
- Provides “expert” knowledge across agency as a whole, e.g., organization’s committee structures, materials, etc.
- Influences agency culture and overall recovery-orientation (Chinman, CAI and O’Connell et al., RSA)
- Establishes a cohort of known talent for career development

We’ve made many advances…. But much more needs to be done:

More research is needed examining effectiveness of peer supports throughout a variety of settings and communities

More work with Implementation in Organizations focused on:

- Organizational Readiness and Buy-In – Leaders, Champions, Health Providers, Clinical Staff, Family, Community, Individuals living with mental illness and addictions at the table
- Role Clarification
- Supervision and Sustainability

More on identifying and building leadership in the User/lived experience movement.

Training and development/ Training on the Art of disclosure

Supervision and Co-Supervision

The Opportunity and The Need for National Core Competencies

Peer support implemented differently across programs and states

Roles and responsibilities vary widely

Research often measures outcomes but not how peer support is delivered

Difficult to determine which components drive outcomes

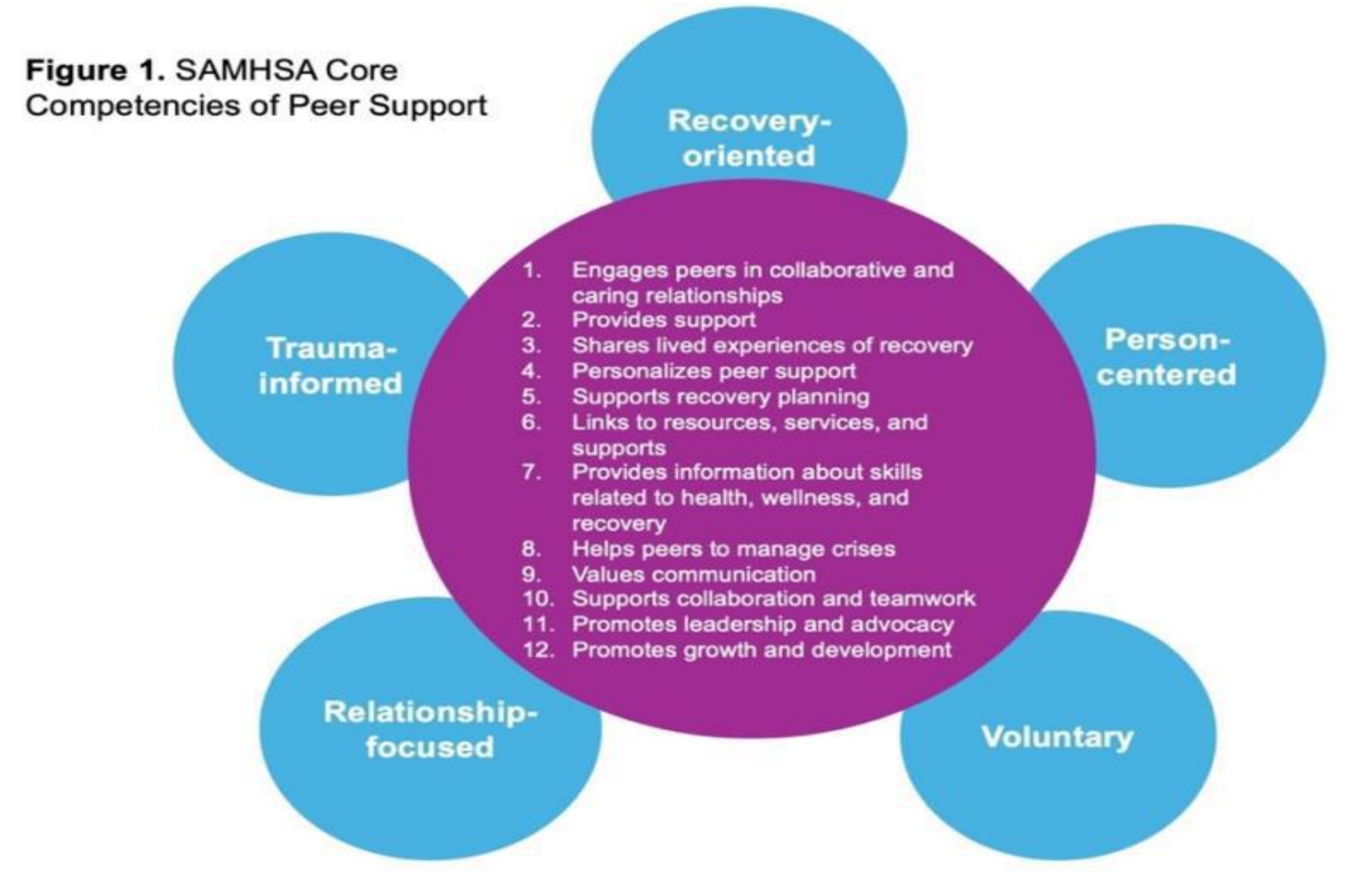
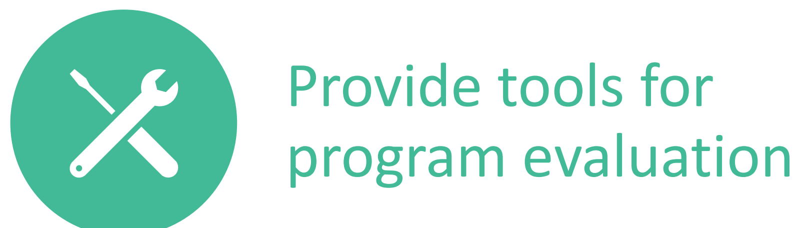


Figure 1. SAMHSA Core Competencies of Peer Support
Recovery-oriented
Trauma-informed
Person-centered
Relationship-focused
Voluntary
1. Engages peers in collaborative and caring relationships
2. Provides support
3. Shares lived experiences of recovery
4. Personalizes peer support
5. Supports recovery planning
6. Links to resources, services, and supports
7. Provides information about skills related to health, wellness, and recovery
8. Helps peers to manage crises
9. Values communication
10. Supports collaboration and teamwork
11. Promotes leadership and advocacy
12. Promotes growth and development

Introducing the new CT Peer Support Recovery Professional (CPSRP) credential and Its Implications for CT

Strengthen peer workforce development

Improve consistency and quality of peer services



Support statewide recovery system transformation

Questions?

Thank You!

CERTIFIED PEER SUPPORT & RECOVERY PROFESSIONAL CREDENTIAL

Elsa Ward, Director of Recovery Community Affairs

2026

Defining Peer Support Worker

Recovery Peer Support workers are trained individuals with lived and/or living experience with a behavioral health condition and have been successful in their recovery process to help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.

Defining Community Health Worker

Community health worker is a public health outreach professional with an in-depth understanding of the experience, language, culture and socioeconomic needs of the community and who provides a range of services, including, but not limited to, outreach, engagement, education, coaching, informal counseling, social support, advocacy, care coordination, research related to social determinants of health and basic screenings and assessments of any risks associated with social determinants of health.

Certification Vision

A credential that integrates Recovery Support Specialists and Recovery Coaches under one certification, administered by a credentialing-body. and is in alignment with SAMHSA’s National Standards.

Building a strong Recovery Peer Support workforce

Ensuring all individuals trained have been taught SAMHSA's Twelve Core Competencies with indicators and DMHAS' Peer Ethics & Values (2024) while keeping “Specialties” intact.

Ensuring the credential maintains the highest ethical and professional standards, with real-time verification for employers.

Ensuring the Recovery Community and stakeholders have active participation in the development of the credential.

Origin of CPSRP Credential

2018. The idea of an integrated Recovery Peer Support certification under one credential was adopted by previous DMHAS leadership.

2018. DMHAS Office of Recovery Community Affairs Lived-Experience Advisory Committee created a blueprint.

2018. DMHAS and Yale-PRCH met with CT's two Peer Support/Coaching Training Organizations to collaborate.

2019. The Connecticut Certification Board (CCB) was asked to assist in the creation of the credential with SMEs, a psychometrician and DMHAS.

2019. DMHAS and Yale-PRCH posted a “Call for Commitment” to the Recovery Community to assist in the development of the credential requirements.

2020. A Scoring Committee was formed and selected candidates for an Advisory Committee and Subject Matter Expert Committee-SME.

2021. The Administrative Planning Team was developed to start implemntation (DMHAS, PRCH, CCB).

2022. DMHAS and Yale-PRCH conducted 2 Town Hall Meetings to inform Peer Support Workers of the new credential.

2022. The Advisory Committee commenced- facilitated by Yale-PRCH.

2023. The SME Committee commenced- facilitated by the CCB, Prometric- psychometrician, and DMHAS.

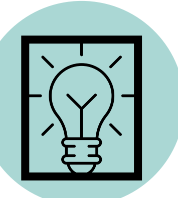
Our Process

Having various committees that included training organizations, Recovery Support Specialists, Recovery Coaches, a psychometrician, the recovery community-at-large, and employers.

Guided by the recovery community

Training Curriculum

Recovery Community-at-large



CCB, Prometric, and SMEs

Engagement with Everyone

Where We Are Today

The Grandparenting application process for the credential is open and ongoing. Ove 900 people have received the credential.

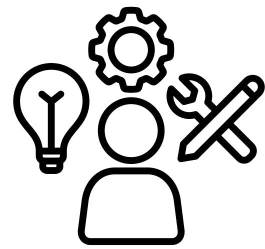
Informational Sessions and Open Office Hours are ongoing for Employers and the Recovery Community-at-large.

Testing for the beta exam was completed in January 2026.

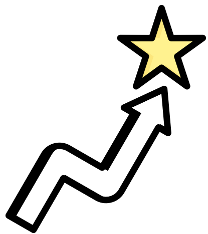
Approved Training Organizations are projected to begin using the new curriculums on or before June 1st, 2026.

The new credential requirements is projected to be activated on June 15th, 2026.

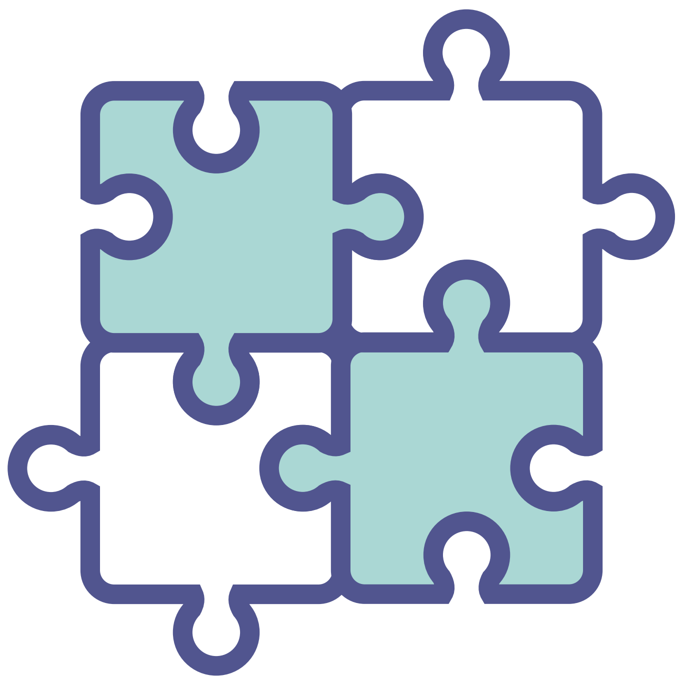
STRENGTHS

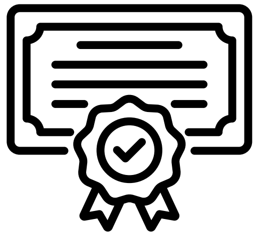


Everyone trained will have the same base skills and knowledge regardless of where they are trained.

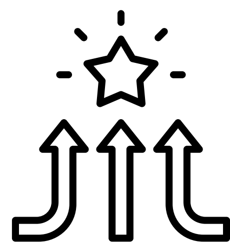


There is a higher expectation of the Certified Peer Support & Recovery Professional worker.





The credential is administered and overseen by a credentialing organization.



The credential is alignment with SAMHSA's National Standards.

Questions?