Youth Peer-to-Peer Support: A Review of the Literature

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Reason for the Review

Peer-to-peer support has been an essential component for successful recovery in the adult mental health and substance abuse systems. The same support is urgently needed for youth in transition. However, peer-to-peer support for youth must be developmentally appropriate and specific to the unique needs of youth in transition. This literature review will look at peer support history, programs, outcome studies, and resources with an emphasis on youth.

Historical Background

According to mental health historians, Harry Stack Sullivan was the first psychiatrist in the United States to value peer support in the treatment of mental disorders. In the 1920s, Sullivan ran an inpatient facility in Baltimore where he actively recruited young men recovering from their own mental disorders to work as aides on the unit. Sullivan felt that those who had experienced psychosis and recovery could better understand the work (Davidson et. al., 1999). At this time, recovery was largely considered to be a process of learning to live with one's disability and building a new life in spite of the limitations of one's disorder (Davidson & Strauss, 1992).

Alcoholics Anonymous (AA) is cited by numerous authors as one of the oldest examples of a peer-to-peer support program (Van Tosch & del Vecchio, 2000; Salzer, 2002). Founded in 1935, AA demonstrated that self-help groups were more effective in alcoholism recovery than the strategies traditionally used by the medical community. The success of AA introduced a new philosophy—that peers can help each other and improve their own conditions without relying on the "experts." Prior to this development, the medical community dominated mental health.

In the 1950s, many self-help groups for people with mental illness emerged, including Schizophrenics Anonymous, the National Depressive and Manic-Depressive Association, GROW, and Recovery, Inc. (Salzer, 2002).

In the 1960s, the self-help movement took on an advocacy focus. This was the era of protests and civil rights movements. In the mental health field, former patients engaged in acts of civil disobedience by protesting the conditions in mental hospitals. The actions of these protesters led to the publication of such documents as Judi Chamberlin's *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (Chamberlin, 1978). Chamberlin was involuntarily confined to a mental hospital in the 1960s.

Mental health advocacy groups met in homes and churches to lobby for mental health reform. These groups educated themselves about services available in the community, shared problems they experienced after being released from hospitals, and educated others about abuses they had experienced.

In the 1970s, the federal government began to take notice of these peer advocacy efforts and created the Community Support Program (CSP) within the National Institute of Mental Health. This program was charged with the task of engaging people who had experienced mental health services in the process of policy-making and program development. The term "consumer" began to be used as a result of these efforts.

Throughout the 1980s and 1990s, the Substance Abuse and Mental Health Services Administration (SAMHSA) funded research, conferences, and consumer-operated programs designed to determine and examine the effectiveness of such activities.

In 1999, the Office of the Surgeon General released its first-ever report on mental health, *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999). This landmark report identified mental illness as an urgent, growing health concern and the second leading cause of disability and early mortality in the United States. The report identified the following courses of action to hasten progress toward the major recommendation of the report:

- continue to build the science base;
- overcome stigma;
- improve public awareness of effective treatment;
- ensure the supply of mental health services and providers;
- ensure delivery of state-of-the-art treatments;
- tailor treatment to age, gender, race, and culture;
- facilitate entry into treatment; and
- reduce financial barriers to treatment.

Mental Health was also a turning point for the peer support movement. This report validated the effectiveness of peer support, stating "Consumer organizations have had measurable impact on mental health services, legislation, and research. One of their greatest contributions has been the organization and proliferation of self-help groups and their impact on the lives of thousands of consumers of mental health services" (U.S. Department of Health and Human Services, 1999, p. 95).

> A lot of people ask me what the difference is between a medical model of treatment for mental illness and a recovery model.
>
> You want to know what that difference is, in a nutshell?
>
> The medical model treats me like a disease; the recovery model treats me like a person.
>
> —Anonymous

Ultimately, what emerged from mental health consumers' advocacy efforts, innovative federally funded programs, and evidence-based research was the recovery movement. Recovery-focused services move the professional away from acting as the "expert on other peoples' lives," and "towards supporting individuals in their own ways of dealing with problems and struggles" (Borg & Kristiansen, 2004, p. 494). Recovery services provided at the community level aim to support individuals as they live, work, learn, and participate in their communities in spite of their disabilities.

In 2006, SAMHSA released a consensus statement on mental health recovery intended to help states operationalize the recovery concept (SAMHSA, 2006). This consensus statement identified peer support as one of 10 fundamental components of recovery. A year later, the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, issued guidance to states on how to apply for reimbursement for peer support services under Medicaid.

Defining Peer-to-Peer Support

Over the years, a number of terms have been used to describe peer-to-peer support, including self-help, mutual support, and consumer-delivered services.

Self-help	Self-help is based on the principle of helping oneself and others at the same time. Thus, self-help is a mutual process, without a dichotomy between the helper and the person being helped. Membership in self-help is neither mandated nor charity (Carpinello, 2002).
Mutual support	A process by which persons voluntarily come together to help each other address common problems and shared concerns (Davidson et. al., 1999).
Consumer-delivered services (CDSs)	A consumer is someone who has experienced, or is currently experiencing, symptoms associated with a diagnosable mental illness, and has received services to address these symptoms. CDSs are those services where identified consumers interact with other identified consumers in services that are uniquely consumer-delivered (e.g., self-help groups) or as part of services that involve both consumer and nonconsumer staff (e.g., case management) (Salzer, 2002).

A man falls into a hole so deep he can't get out. A doctor walks by, and the man calls for help. The doctor writes a prescription, tosses it into the hole, and walks on. A priest walks by, and the man tries again. The priest writes a prayer, tosses it into the hole, and walks on. Finally a friend walks by, and again the man asks for help. To his surprise, the friend jumps in with him. "Why did you do that?" the man asks. "Now we're both in the hole." "Yes," the friend responds. "But I've been in this hole before, and I know the way out."

—Rebecca Clay, SAMHSA News 2004

Peer support is the term commonly used today to describe a helping relationship based on shared experiences where at least one person has recovered or is in recovery.

SAMHSA defines peer support as "mutual support—including the sharing of experiential knowledge, and skills, and social learning," which "plays an important and invaluable role in recovery. Residents encourage and engage each other in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community" (SAMHSA, 2006, p. 1).

The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) defines peer support as a system that "relies on individuals who live with mental illness to provide peer-to-peer support to others, drawing on their own experiences to promote wellness and recovery. Peer support is about getting help from someone who's been there. Based on mutual respect and personal responsibility, peer support focuses on wellness and recovery rather than on illness and disability. Peers share with one another their experiences, their strengths, and their hope—a powerful combination for recovery" (TDMHDD, 2010, p. 194).

The International Association of Peer Supporters (iNAPS), formerly known as the National Association of Peer Specialists, specifically includes youth in their definition of peer support. iNAPS states that peer support is "casual, intermittent, volunteer and informal support from one who has had the same or similar experiences in a broad range of settings including but not limited to psychiatric and general hospitals, correctional institutions, juvenile and geriatric residential facilities, substance use disorder treatment facilities, educational institutions and community and private mental health provider agencies." iNAPS defines a peer specialist as "one with a mental health recovery experience who helps others with a psychiatric condition on their recovery journeys in a formal manner and is paid for his/her services" (Harrington, 2011,p. 6).

Mead and colleagues (2001) define peer support as a process of giving and receiving that is based on three key principles: respect, shared responsibility, and mutual agreement of what is helpful. She goes on to say, "Peer support is not based on psychiatric models and diagnostic criteria," but "is [instead] about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others [whom] they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships" (Mead, Hilton, & Curtis, 2001, p. 7).

Davidson and his colleagues (1999) describe three forms of peer support—naturally occurring mutual support, consumer-run services, and consumers as providers within mental health settings. Naturally occurring mutual support happens when people come together to help each other with common problems (e.g., people recovering from a natural disaster). Consumer-run services offer an alternative to formal mental health treatment, but the peer providers are paid employees, and there is a degree of structure (Davidson et al., 1999).

Solomon (2004) identifies six categories of peer support, including Internet support groups that were virtually nonexistent before the twenty-first century.

Self-help groups	Oldest form of peer support, usually created by peers for mutual support, usually face to face.
Internet support groups	Lacks face-to-face interaction, highly anonymous.
Peer-delivered services	Services provided by individuals who identify as having mental illness; primary purpose for the individual is to help others struggling with mental illness.
Peer-run or operated services	Services that are planned, operated, administered, and evaluated by people with psychiatric disorders.

Peer partnerships	Peer programs that operate under the umbrella of another organization that has fiduciary responsibility. The sponsoring organization (which may not be peer-run) shares administration and governance but primary control is with the peers.
Peer employees	Individuals who identify as having mental illness who are hired into unique peer positions or who are employed to serve traditional mental health positions.

Both Davidson and Solomon's work describe what Davidson and his associates (2006) later presented as a continuum of peer services within the larger continuum of helping relationships (Davidson, Chinman, Sells, & Rowe, 2006) (see below). At one end of the continuum, the interaction is naturally occurring and mutual; at the other end, the interaction is more closely associated with traditional mental health services that are intentional and one-directional. Davidson suggests that true peer support lies in the middle, and that the challenge facing the mental health community is how to straddle the delicate line between sharing and directing. See figure 1 below.

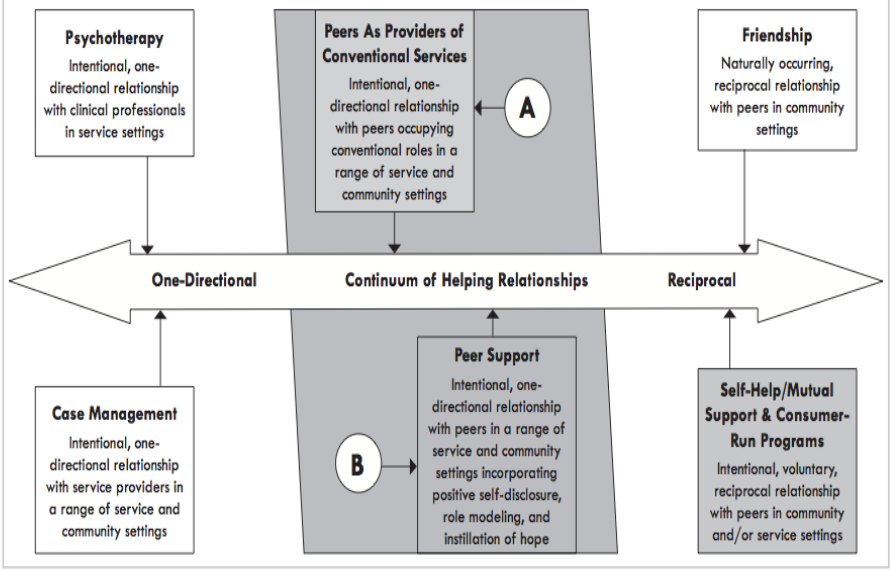

Figure 1: A continuum of helping relationships

Youth Peer-to-Peer Support

Because this literature review focuses on youth peer support, the literature was scanned with youth peer support definitions, examples, research, policies, and resources in mind. The first scan was limited to peer support among school-age students (18 years of age and under) across the fields of education, health, juvenile justice, foster care, mental health, and homeless and runaway youth. Some of the programs had been evaluated prior to this review, but many were not. Below are several examples outlining primary findings in peer support across various systems.

Education– Several examples were found in education where peer support activities were used to promote access to the general curriculum for students with disabilities. Students who are not disabled are trained to provide both academic and social support to students with disabilities. This model was found to benefit both students involved in peer support activities (Carter & Kennedy, 2006).

For many years, the state of Michigan has operated a peer support program called LINKS for students in Kindergarten through twelfth grade with autism spectrum disorder (ASD). Funded by the Department of Education, the LINKS program operates statewide and is part of the Statewide Autism Resources and Training (START) project at Grand Valley State University. Extensive LINKS-related resources are available on the START Project website.

> "A peer-to-peer program is a strategy for providing ongoing support and modeling from one nondisabled pupil to a pupil with an individualized education program (IEP). It encompasses both the academic and social domains. Benefits are derived by both pupils.
>
> Certified teachers at appropriate grade levels MUST be teachers assigned to an elective peer-to-peer course/credit program. Depending on the optional model(s) implemented, the teachers may be in special education or general education programs."
>
> Michigan Department of Education Pupil Accounting Manual

Cross-age mentoring programs are another form of peer support promoted within the Michigan school system. Cross-age refers to mentoring programs where an older student is matched with a younger student. The younger student is guided and supported in academics and social development. Such programs have been found to improve the younger student's social skills, willingness to follow rules, overall sense of self-worth, and school competence (Karcher, 2005).

In the United Kingdom, peer support strategies are being used to reduce bullying in schools. Strategies include "circles of friends," a group of students who work as a team to support a vulnerable student, and "befriending," a process where students are assigned to "be with" or "befriend" another student (Cowie & Hutson, 2010).

Health– Peer support has been used to help pregnant teens stop smoking. Albrecht and her associates (1998) reviewed interventions where a nonsmoking peer acts as a role model for a peer who smokes. This research indicated that the use of peer support in smoking cessation interventions may be helpful in lowering smoking among pregnant adolescents (Albrecht, Stone, Payne, & Reynolds, 1998).

In Manitoba, Canada, Teen Talk is a youth health education program that offers peer support in the form of listening, referring, and educating about

health and safety. Once the peers complete the 32–35 hours of training, they develop and present skits at schools and sponsor informational tables at school and community events (http://teentalk.ca/).

Juvenile Justice– In the field of juvenile justice, the emphasis is less on youth peer support and more on family support. Juvenile Justice 101, operating in King County, Washington, is a good example of a family support program. This program provides community workshops, court orientation, and peer support. Families who had previous experience with the juvenile court system with their own children provide outreach and support to parents who have no experience in the system. Walker and her colleagues (2012) found that parents demonstrated an increased knowledge in the court process and were satisfied with the program; youth, however, were less satisfied. A recommendation for revising the program included implementing a youth-delivered peer support component (Walker, Pullmann, & Trupin, 2012).

One youth peer support program that showed up in the scan was "Teen Peer Court," a program designed to divert first time offenders from the juvenile court system.

There are at least four variations of peer court:

- adult as judge—youth serve in the roles of defense attorneys, prosecuting attorneys, and jurors;
- youth as judge—youth also serve in the roles of defense attorneys, prosecuting attorneys, and jurors;
- youth tribunal—no jury; youth attorneys present the case to a youth judge or judges; and
- peer jury—operates like a grand jury; a case presenter introduces the facts of the case, and a panel of youth jurors addresses questions to the defendant.

In an evaluation of teen court programs in four jurisdictions, teen court youth were significantly less likely to re-offend in two of four programs (Butts, Buck, & Coggeshall, 2002).

Foster Care– The literature shows several examples where foster, adoptive, and kinship parents benefit greatly from peer-to-peer support (Delaney, 2000; Jerve, 2009).

For example, peer support for youth in foster care often occurs informally at state and regional youth conferences and through youth leadership activities. At these events, youth in their mid to late teens have the opportunity to share their experiences and support one another.

Mental Health– The children's charity Let's Erase the Stigma Educational Foundation (LETS) hosted a youth summit in 2011 where Los Angeles County School and transition-age-youth could talk openly about mental illness and stigma.

In summary, many of peer support activities for youth under 18 show that they were largely initiated and implemented by the adults rather than the peers. In many cases, the peer supporters lacked the same life experiences as the peer they were supporting (e.g., smoking cessation program in Canada, LINKS program in Michigan). Often the only element that connected youth peers together was that they were of the same age.

Young Adult Peer-to-Peer Support

When the scan was expanded to include the peer-to-peer support activities of young adults over the age of 18 and up to the age of 25, elements described in adult peer-to-peer efforts began to emerge, including mutuality, naturally occurring support, advocacy, and peer-run services. The following programs serve the expanded age range and are good examples of peer support programs.

Education– At the postsecondary level, there are many examples of peer support programs to assist minority students, first-generation college students, veterans, and students with attention-deficit hyperactivity disorder (ADHD) in the completion of their educational programs. (Zwart & Kallemeyn, 2001; Dennis, Phinney, & Chuateco, 2005; Harper, 2006)

Mental Health– Transition Resources and Community Supports (TRACS) offers peer support for youth and young adults ages 16–25 with mental health and substance abuse issues. This program hires young adult peer mentors who have experienced living with and overcoming mental health challenges. The program reports that, at the end of three months, youth achieved 69% of the goals they had set in five domains and, at the end of 6 months, the percentage of goals achieved increased to 82% (Butman, 2009).

In Connecticut, the Super Advocate Program is where young people ages 18 to 25 with mental illness and/or addiction issues continue their recovery and provide support and hope to other young adults with mental health and/or addiction issues (http://www.mindlink.org/ed_young_adult.html).

The 2009 Portland National Peer Summit brought together "system-experienced young people ages 16–25 to create a call to action focused on improving mental health services for youth and young adults." One of the top five priorities that the Summit decided to address was "creating opportunities for peer-to-peer supports" (Strachan, Gowen, & Walker, 2009, p. 10).

Foster Care– Peer-led groups, such as the California Youth Connection, the Youth Leadership Advisory Team (YLAT) in Maine, Foster Youth Coalition in Hawaii, and Elevate in Iowa, provide educational experiences, leadership opportunities, and peer support for current and former foster youth. The youth and young adults partner with adults to carry out the mission of the group, but retain activity direction.

> In Pennsylvania, Youth Support Partners (YSP) fills an important role within the Allegany County Department of Human Services. These young people have personal experience with the foster care system, or other child service systems, and YSPs are trained to provide peer-to-peer mentoring and advocacy for youth at risk of or currently in out-of-home placement. As of 2008, the county had employed 15 YSPs operating out of their own unit under the supervision of four "youthful coaches/supervisors" and a full-time manager (Cherna, 2012).
>
> In San Diego, California, Family/Youth Support Partner services are provided through the county's Health and Human Services Agency, Children's Mental Health Services. The policies and procedures manual provides the following definition for this position: "Family/Youth Support Partner**:** An individual with experience as a consumer or care giver of a consumer of Children's Mental Health Services (CMHS), the Juvenile Justice System, or Special Education who is employed full-or part-time to provide direct (potentially billable) services to a child, youth, or family with a mental health case" (County of San Diego, 2010, p. 2).

Benefits of Peer-to-Peer Support

The use of peer support has helped change the culture of mental health from illness and disability to health and ability (Mead et al., 2001). Peer support specialists are better at promoting hope and the belief in a possible recovery then their nonpeer counterparts (Repper & Carter, 2011).

Peer support specialists often benefit personally from the work that they do. Providing a valued service impacts personal self-esteem, increases confidence, and helps with personal recovery (Solomon, 2004). In fact, a study in Belgium found that providing peer support was more beneficial than receiving it (Bracke, Christiaens, & Verhaeghe, 2008).

Repper and Carter (2011) summarize the results of seven randomized controlled trials in their 2011 review of the literature. The programs studied incorporated peers in a variety of capacities: peers provided case management, served on treatment teams, filled unique peer specialist positions, and provided both community services as well as inpatient services. In four of the studies, the peer support effort produced improved outcomes. In the remaining three studies, no significant differences were found between peer and nonpeer services. Repper and Carter (2011) looked at 16 additional studies to gain a broader understanding of peer support efforts. These studies looked at the relationship of peer support and measures of recovery and empowerment, the level of personal satisfaction with mental health services when provided with a peer support component, impact on social support and quality of life, and the effect of peer support on self-esteem and destigmatization.

Challenges of Peer-to-Peer Support

One of the most basic challenges related to peer-to-peer support is that it represents a change for many professionals in the way mental health services are provided. It requires an altogether different relationship with clients, and is therefore especially challenging when the client is a

youth. Cowie and Wallace (2000) talk about the benefits of understanding the cycle of change before implementing a peer-to-peer program.

There are a number of challenges related to the evaluation of peer support services. For example, random assignment, a preferred approach in research, is difficult to achieve and, in some cases, unethical. Outcome studies require long-term follow-up and are expensive. In addition, the roles of peer support specialists are many and the sites are varied, making it hard to make comparisons (Daniels et. al., 2010). Several researchers talked about the need for more systematic research on peer support in order for peer support to be viewed as an evidence-based practice (Salzer, 2002; Davidson, et.al., 2006; Repper & Carter, 2011; Walker, et. al., 2012).

There is also a concern that the philosophy and values of peer support will not be maintained as peer support services become Medicaid reimbursable (Daniels et. al., 2010). Peer support specialists offer "a non-professional vantage point [that] is crucial in helping people rebuild their sense of community when they've had a disconnecting kind of experience" (Mead & MacNeil, 2006, p. 30). Mead contends that developing standards is the only way to remain true to the essence of peer support.

Standards

MacNeil and Mead (2003) presented standards for peer support developed by peer support providers, traditional service providers, and people who accessed support services. Seven standards were identified:

- Standard #1: Peer support promotes CRITICAL LEARNING and the re-naming of experiences.
- Standard #2: The culture of peer support provides a sense of COMMUNITY.
- Standard #3: There is great FLEXIBILITY in the kinds of support provided by peers.
- Standard #4: Peer support activities, meetings, and conversations are INSTRUCTIVE.
- Standard #5: There is MUTUAL RESPONSIBILITY across peer relationships.
- Standard #6: Peer support is being clear about and SETTING LIMITS.
- Standard #7: Peer support involves sophisticated levels of SAFETY.

For each standard, MacNeil and Mead also provided indicators as a way of measuring whether the standard is being practiced personally or within the organization.

Since 2009, the Pillars of Peer Support Initiative has convened two summits to facilitate discussion between states, national experts, and stakeholders on how to use Medicaid funding to support peer-to-peer services. Prior to the first summit, states were asked what infrastructure needed to be in place in order for peer support services to run successfully, and several states identified the need for standards (ME, MN, NC, NJ, TX) (Daniels et al., 2010). Establishing standards for excellence was the theme of the fourth summit (Daniels et al., 2013). At this event, participants in the Standards and Credentials work group concluded that:

- more information is needed on how other professions have approached the development and implementation of standards;
- the process should be inclusive and representative;

- core values need to be represented in the standards; and
- leadership and planning are needed.

The International Association of Peer Supporters is currently in the process of establishing standards for peer support providers. iNAPS is surveying peer support providers about the core values common to all peer support practices in the fields of mental health, trauma, and substance use. The results of the survey will inform the development of the National Practice Standards for Peer Support Providers. Standards will provide guidelines and offer greater credibility to the emerging peer support professionals.

Federal Guidelines

Medicaid is a complicated but flexible program that allows states to determine the health and mental health services they will provide. In 2001, Georgia and Arizona were the first states to use this flexibility to incorporate peer support services into their Medicaid programs.

In 2007, the Center for Medicaid and State Operations provided guidance to all states that were interested in including peer support services in their Medicaid programs. This guidance outlined state options for obtaining Medicaid reimbursement for peer support services and the requirements of supervision, care-coordination, and training and credentialing that must be in place.

"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) [State Plan Amendment]
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority" (CMS, 2007)

The 2007 guidance letter provided additional information about the supervision, care-coordination, and training and credentialing requirements.

> "(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." (CMS, 2007)

In *Peer Specialist Training and Certification Programs: A National Overview*, Kaufman and her colleagues (2012) describe how states are meeting these requirements. In this document, Florida, Illinois, and Kansas provide detailed information about the training requirements, the training competencies, and the code of ethics for persons seeking certification as a peer support specialist (Kaufman, Brooks, Steinley-Bumgarner, & Stevens-Manser, 2012).

State Peer Support Programs

Each state's Medicaid billable peer support program is different and designed to meet the unique wellness and recovery needs of state citizens. Not everyone who is eligible for Medicaid will have the option to receive peer support services. It is up to each state to decide whether to amend the State Medicaid Plan or apply for a waiver to make peer support a reimbursable service. States must also determine the target service population and the tasks the peer specialist will perform.

In Arizona, peer support services are reimbursed when provided by paraprofessionals in a licensed behavioral health agency or credentialed Community Service Agency. In Georgia, peer support services may be free standing, a program within an existing clinical provider program, or a program within a human service agency (Johnson, 2008).

In 2012, the Center for Health Care Strategies collected information from 14 state websites and charted each state's approach to peer support services. All of the states included targeted families and youth (CHCS, 2012). However, the majority of states focused on the provision of peer support services to parents to facilitate their work with youth. The following chart illustrates how Alaska included youth peer support services. The chart lists the Medicaid financing option selection, description of the service, and the billing codes used.

State	Method	Definition of Service	Service Components	Billing Codes
AK	State Plan Amendment	Peer Support services may be provided on the premises of a Community Behavioral Health Services Provider (CBHP), in the recipient's home, or in any community setting appropriate for providing the services as specified in the recipient's behavioral health treatment plan. These services are rendered by the CBHP staff—in this case, the peer support specialist—who is performing the service as a regular duty within the scope of their knowledge, experience, and education.	May include: provision of psychosocial evaluation and education related to a patient's behavioral health condition; and counseling, teaching needed life skills, encouraging, and coaching behavioral health patients.	• H0038—Peer Support Services—Individual (delivered to the youth) • H0038—HR Peer Support Services—Family (with patient present) (delivered to the adult caregiver) • H0038—HS Peer Support Services—Family (without patient present) (delivered to the adult caregiver)

Training

As of September 2012, 36 states had established peer specialist training and certification programs for people who had initiated their recovery journey and are willing to assist others in earlier stages of the recovery process. *Peer Specialists Training and Certification Programs: A National Overview* provides a state-by-state profile for each of the 36 states (Kaufman et al. 2012).

Most states have contracted for training, and the training curricula are not available in the public domain. However, the curricula used by North Carolina and state of Washington are both available online (see the Resources section). North Carolina also provides an online supervisory training: *Supervising North Carolina Certified Peer Support Specialists* (http://pss-sowo.unc.edu/node/1795).

There are a few training programs and resources that specifically include or are designed for youth. In San Diego, the Family and Youth Roundtable (FYRT) offers both online and face-to-face trainings (http://fyrt.org/).

There are many free training resources online that could be used to develop or revise an existing peer support specialist training program to address the needs of youth and become "youth friendly."

Conclusion

Peer-to-peer support, as defined in the literature, is a relatively new concept for those who work with youth. A review of the history of peer-to-peer support did not offer any examples of peer support provided by experienced youth for youth prior to the 1990s. Only one definition of peer support was found that specifically included youth (Harrington, 2011).

Peer support services for parents do not necessarily include peer support services for youth. This is true even when the purpose of the parent support is to improve outcomes for youth. Juvenile Justice 101 is a good example of parents receiving peer support services and their youth not having a similar experience (Walker, et. al., 2012).

At this point in time, very few states have targeted youth as a population to be served by Medicaid-funded peer support specialists; however, there are several good examples as to how youth support partners can be used with youth in transition (Cherna, 2012; Family and Youth Roundtable, 2010.

Training curricula designed for youth and young adults hired to provide youth peer support services are limited, and none were available for this review; however, there are many resources that should be considered by states as they seek to expand their peer support services to youth.

As standards are developed, youth and young adult peer specialists need to be included to ensure that positive youth development values are woven into the final product.

Resources

Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success
This resource introduces clinicians and health care managers to some of the benefits of peer support for chronic disease management. Seven models that have been tested are discussed. They include professional-led group visits, peer mentors, reciprocal peer partnerships, and models of peer support using email and Internet exchange.

http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingPeerSupportPrograms.pdf (Retrieved March, 14, 2013)

Guide to Implementing TAP (Teens for AIDS Prevention) A Peer Education Program to Prevent HIV and STI
This guide provides step-by-step instructions for implementing HIV/STI prevention peer education programs in schools, faith communities, AIDS service organizations, and/or community-based organizations.

http://www.advocatesforyouth.org/storage/advfy/documents/TAP.pdf (Retrieved April 17, 2013)

The Power of Peers: A Guide to Developing a Peer Support Program for Students with Disabilities
Developed by the Florida Inclusion Network, this guide is intended to help schools design and implement peer support in the classroom. The guide includes planning resources, work sheets, and training curriculum.

http://www.floridainclusionnetwork.com/Uploads/1/docs/PeerSupportManualAtAGlance.pdf (Retrieved April 19, 2013)

LINKS Program Resources
LINKS is a peer-to-peer program in the Michigan public school system that is specifically designed for students with autism spectrum disorder (ASD). Many LINKS-related resources including training curricula and student handbooks are available.

http://www.gvsu.edu/autismcenter/peer-to-peer-support-2-140.htm (retrieved April 19, 2013).

Peer Specialist Training and Certification Programs: A National Overview
This resource provides a state-by state profile for each of the 36 states that currently have peer specialists. The profile includes direct links to state websites with detailed information about the peer specialists' training and certification programs.

http://blogs.utexas.edu/mental-health-institute/files/2012/10/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview.pdf (retrieved April 19, 2013)

Peer Support Specialist Participants and Trainers Manual
This training curriculum was developed for North Carolina in 2011 and is divided into 10 sessions. The session topics are as follows:

- Role of the Peer Support Specialist
- Understanding Recovery
- Building Relationships
- Evidence-Based Practice
- Cultural Appropriateness
- Role Models, Coaches & Mentoring
- Fear, Stress & Decision Making
- Avenues of Change
- Employment Matters
- Mental Health Reform & Consumer Rights

http://www.cardinalinnovations.org/pubdocs/upload/documents/PSS%20Manual%20Master-3.pdf

Washington State Certified Peer Counselor Training Manual
This training curriculum was developed and revised by the Washington Institute for Mental Health Research & Training in 2009 for Washington State's Division of Behavioral Health & Recovery. This 40-hour curriculum covers eight objectives, which are:

- The Public Mental Health System
- Resilience and Strengths-Based Models
- The Roles and Responsibilities of Consumer Peer Counselors in Washington State
- Recovery Plan Development
- Working with Groups
- Documentation

- Ethics
- Resources

http://www.dshs.wa.gov/pdf/dbhr/mh/WACertifiedPeerCounselorManualApr2012FINAL.pdf

Transition Service Provider Competency Scale
A one-page self-assessment for those who work with youth (ages 14–29) with mental health disorders. The assessment lists 15 items describing tasks a specialist might experience while working with youth.

http://www.pathwaysrtc.pdx.edu/pdf/projPTTC-Transition-Service-Provider-Competency-Scale.pdf

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