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Supporting Peer Services in Behavioral Health

Strengthening Behavioral Health Through Peer Services: Advancing Recovery Across the Continuum of Care

By Adam Viera
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New York State Office of Addiction Services and Supports (OASAS)

Recovery from addiction is often strengthened through connection with others who have lived experience. Across New York State, peer professionals - individuals with lived recovery experience - are playing an increasingly important role in behavioral health services. Through strategic policy development, workforce investment, and service integration, the New York State Office of Addiction Services and Supports (OASAS) is advancing peer services as a core component of the addiction treatment and recovery support system.

Peer professionals provide mentorship, encouragement, advocacy, and practical guidance grounded in their own recovery journeys. This shared experience fosters trust, improves engagement in care, and helps individuals navigate pathways toward recovery and stability.

Recognizing the value of lived experience alongside clinical expertise, New York State has prioritized peer integration across the continuum of care - from outpatient clinics and residential treatment programs to crisis services and community-based recovery supports. Embedding peer professionals within multidisciplinary teams helps address the emotional, social, and practical needs individuals and families face throughout the recovery process.

Integrating Peers into Treatment Settings

One of the most significant policy advances in New York has been the requirement that all Part 822 outpatient addiction treatment clinics include a Certified Recovery Peer Advocate (CRPA), or provisional CRPA, as part of their staffing model. This ensures that individuals entering treatment have access to recovery support from someone who brings both lived experience and professional training.

Peer professionals are also increasingly integrated into Certified Community Behavioral Health Clinics and Crisis Stabilization Centers, where their presence can be particularly impactful during moments of vulnerability. In these settings, peers often play a key role in building trust, engaging individuals in services, and connecting them to treatment and community-based supports.

Residential treatment programs across New York are similarly expanding the role of peers within their levels of care. In residential settings, peers support recovery planning, facilitate connections to mutual

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Meeting Crisis With Connection: The Power of Peer Specialists on Mobile Crisis Teams

By Laura Savino, LCSW-R
Senior VP of Care Management
Institute for Community Living (ICL)

Over the past several years, New York City has increasingly shifted toward community-based responses to behavioral health crises. In the past, individuals experiencing psychiatric emergencies were often limited to hospital emergency departments or interactions with law enforcement. While those systems still play an important role, there has been a growing effort to develop alternatives that meet people where they are and focus on stabilization within the community. Mobile treatment models such as Intensive Mobile Treatment (IMT) and Assertive Community Treatment (ACT) are central to this approach, providing ongoing support to individuals with serious mental illness who may struggle to remain engaged with traditional outpatient care. Within these teams are our talented Peer Specialists, who are individuals with lived experience of mental health recovery. Peer Specialists play an important and critical role in engagement, stabilization, and long-term support.

In my role as Senior Vice President of Care Management at the Institute for Community Living (ICL), I have had the opportunity to see this dynamic play out across several programs. ICL currently operates six Intensive Mobile Treatment (IMT) teams and seven Assertive Community Treatment (ACT) teams across New York City. These programs rely on multidisciplinary teams that include clinicians, nurses, case managers, and peer specialists, all working together to support individuals in the community. While each discipline brings important expertise, peer specialists often serve as a bridge between clinical treatment and personal recovery.

ACT teams in particular rely heavily on relationship-based work. Participants served by ACT programs typically require intensive, long-term support to remain stable in the community. Staff meet individuals where they live and help address a wide range of needs, from medication management to housing stability and daily routines. Within this structure, peer specialists frequently focus on helping participants reconnect with a sense of purpose and autonomy in their recovery.

During a conversation with several of our ACT teams, they shared that peer specialists often become the person participants feel most comfortable talking to. Participants may initially see clinicians as authority figures or representatives of the system, while peers are often viewed as people who genuinely understand their experiences. Because of that connection, peers frequently help open the door to deeper conversations about recovery goals, medication concerns, or frustrations with treatment. Once that trust is established, the rest of the team can often engage more effectively as well.

IMT teams share a similar philosophy but often work with individuals who experience frequent crises or repeated hospitalizations. The work can be fast-paced and unpredictable, with staff responding to urgent situations in supportive housing programs, shelters, or other community settings. In these moments, peer specialists can be particularly valuable in helping to de-escalate tense situations.

One incident that stood out to me happened in the lobby of one of our Health HUB sites. A participant became increasingly agitated and began loudly threatening staff members while visitors and other clients were present in the space. Several staff members attempted to calm the situation, but the participant continued pacing and yelling. The tension in the room was noticeable, and it was clear that the situation could escalate further. What ultimately shifted the interaction was the voice of one of our peer specialists. Instead of approaching the situation from a clinical or directive standpoint, the peer spoke calmly about understanding what it feels like to feel overwhelmed and unheard. The tone was more personal and less authoritative. The participant paused, focused on the peer, and gradually began responding directly to them rather than escalating toward the rest of the staff. Within a few minutes the intensity of the situation had noticeably decreased, and the conversation shifted toward what the participant needed in that moment. Experiences like this highlight something that is difficult to quantify but easy to observe in practice. When someone in crisis feels seen and understood, the emotional intensity of the moment can shift. Peer specialists often help create that shift because their presence signals that recovery is possible and that the person in crisis is not alone in their experience.

Another important part of crisis response is what happens after the immediate situation has stabilized. De-escalation is critical in the moment, but long-term recovery requires ongoing support. Without that support, many individuals end up cycling through repeated crises or hospitalizations.

To help address this gap, ICL has piloted a step-down program known as STEPS. The goal of this program is to support individuals transitioning from intensive services such as IMT to a more sustainable level of care. Recovery rarely happens in a straight line, and the period following a crisis can be especially vulnerable. Programs like STEPS provide continued support while individuals rebuild routines, strengthen coping strategies, and reconnect with community resources.

Peer specialists are particularly effective during this transition period. After a crisis, many individuals feel discouraged or uncertain about their ability to maintain stability. Having someone who has personally navigated recovery can help normalize those feelings while also offering practical encouragement. Within programs like STEPS, peers often work with participants to develop wellness plans, recognize early warning signs of relapse, and explore goals that extend beyond simply avoiding another crisis.

From my perspective, integrating peer services across ACT teams, IMT teams, and step-down programs reflects an important shift in how behavioral health care approaches crisis intervention. Stabilization remains essential, but recovery involves more than managing symptoms. It also requires hope, trust, and meaningful connection. Peer specialists bring those elements into the work in a way that complements the clinical expertise of the rest of the team.

As community-based crisis services continue to expand in New York City, programs that combine professional training with lived experience will likely remain central to effective care. Time and time again, I have seen how the presence of a peer specialist can change the dynamic of a difficult situation. Programs like ACT, IMT, and STEPS demonstrate that combining clinical expertise with lived experience creates a more balanced and responsive system. By meeting individuals where they are (both geographically and emotionally) mobile crisis teams can move beyond short-term stabilization and support the larger goal of sustained recovery.

Laura Savino, LCSW-R

Laura Savino, LCSW-R, is Senior VP of Care Management at Institute for Community Living (ICL).

ICL's Children and Family Treatment and Support Services

The program offers:

- Community-based therapy
- Rehabilitative services
- Crisis intervention
- Family peer support

Institute for Community Living (ICL)'s Children and Family Treatment and Support Services (CFTSS) offers comprehensive mental health services for children and youth under 21 in East New York.

Located at ICL's East New York Health HUB, our person-centered model of care can help children and youth identify mental health and substance use challenges, provide practical support services to improve well-being, and strengthen family relationships.

From Awareness to Action: How SAFE Workplace Mental Health Training Helps Workplaces Recognize, Respond, and Connect

By Jeffrey McQueen, MBA, LCDC
Executive Director
Mental Health Association
of Nassau County

Workplace mental health challenges are often visible long before they are addressed. Changes in mood, attendance, communication, focus, or behavior may signal that an employee is struggling, yet many workplaces lack a clear and practical way to respond. Supervisors and coworkers are not trained clinicians, nor should they be expected to act as therapists. What they do need, however, is a framework that helps them recognize concern, approach others with care, and connect people with appropriate support before challenges escalate.

Research consistently shows that employees often delay seeking help because of stigma, fear of consequences, or uncertainty about what qualifies as "serious enough" to warrant support (American Psychological Association, 2023). When people feel isolated, misunderstood, or fearful of judgment, they often wait until distress becomes a crisis. Workplaces - where most adults spend a significant portion of their lives - can either reinforce that silence or become environments where support and connection are normalized.

That is the intent behind the Mental Health Association of Nassau County (MHANC) SAFE Workplace Mental Health Support Training, a practical model designed to help organizations take meaningful, human-centered steps when someone may be struggling. SAFE is not clinical training, nor is it intended to turn managers into therapists. It is a structured approach for building a supportive culture - one that encourages recognition, respectful communication, and timely connection to help.

Why Workplaces Need a Simple, Supportive Framework

Many organizations are investing in mental health awareness, Employee Assistance Programs, and workplace wellness benefits. While these resources are valuable, individuals do not always access them in the moments they are needed most. Employees experiencing stress, burnout, or emotional strain may still feel uncomfortable discussing these concerns with supervisors or colleagues.

Coworkers and supervisors often report the same uncertainties:

- What should I say?
- What if I say the wrong thing?
- Is it my place to step in?
- Could I unintentionally make things worse?

Without guidance, people may avoid the conversation altogether or respond in ways that feel transactional, disciplinary, or dismissive - even when their intentions are good.

SAFE provides a shared language and a clear path forward.

The SAFE Model

SAFE is a four-step framework designed to help workplaces recognize concern, approach with care, and connect individuals to appropriate support.

S - See the Signs. Recognize potential

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Supporting Recovery Through Peer Services: How Community-Based Support Helps People Reconnect, Heal and Thrive

By Jeffrey McQueen, MBA, LCDC
Executive Director
Mental Health Association
of Nassau County

Peer services are often described as supportive, but at their best, they are transformational. Recovery is rarely a straight line, and it rarely happens in isolation. For many people living with mental health or substance use challenges, progress is shaped not only by treatment, but also by connection, trust, and the opportunity to be understood by someone who has walked a similar road.

Across behavioral health systems, clinical services remain essential. Yet clinical care alone cannot always address the fear, stigma, loneliness, and disconnection that often accompany crisis, hospitalization, incarceration, or prolonged emotional distress. Peer support helps fill that gap. Grounded in lived experience, it offers credibility, connection, and hope - the kind that helps people believe recovery is possible and worth pursuing (SAMHSA, 2023).

What Peer Support Uniquely Provides

Peer support is not simply conversation. It is a relationship rooted in mutuality, respect, and self-determination. Peer specialists help people rebuild confidence, strengthen coping skills, and navigate complex systems—often at moments when traditional services feel intimidating or inaccessible.

Engagement is often the first barrier. People who have felt judged, dismissed, or misunderstood may hesitate to seek help or may disengage from care when life becomes complicated. Peers build trust by meeting people as equals. That trust can open the door to clinical care, recovery groups, and community-based wellness. Research has shown that peer support can improve engagement, reduce hospitalizations, and strengthen recovery outcomes (Repper & Carter, 2011; Chinman et al., 2014).

Peer Services in Action

At the Mental Health Association of Nassau County (MHANC), peer services operate across the continuum of care—from early engagement to sustained community support. Our peer-led work helps bridge people from institutional settings back into community life, offering a steady point of connection during some of the most vulnerable transitions.

For individuals leaving inpatient care or returning from involvement with the justice system, the move back into everyday life can feel overwhelming. Peer support offers both practical guidance and emotional steadiness: helping individuals identify triggers, plan for stressful moments, rebuild routines, and reconnect with healthy supports. Just as importantly, peer services remind people that they are more than a diagnosis, a crisis, or an event in their history.

At MHANC, this work includes Consumer Link, a range of community support groups that foster self-care, emotional wellness, and healthy social connection. These groups help create supportive environments where individuals can practice recovery in real time, build confidence, and reduce isolation.

Our peer work also includes Turning Point, which brings empowerment groups into both jails and community settings. These groups offer encouragement, perspective, and recovery-centered dialogue to individuals who may otherwise feel

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Peer Services in Behavioral Health: New York State Leading the Way

By Dr. Ann M. Sullivan
Liz Breier
Em Wasserman
and Ian Pickus
New York State Office of Mental Health

Individuals with lived experience with mental illness have a unique perspective that can play a crucial role in helping others on the path to recovery. A key facet of reaching and forming bonds with individuals seeking support is the strong connection peer support workers offer.

We have made significant progress in promoting peer services within recovery over the entire lifespan, particularly in supporting individuals experiencing complex mental health challenges. Mental health professionals now recognize the value of incorporating peer support workers into the continuum of care, making them part of planning and delivering services.

Peer support helps to build trusted relationships with individuals connected to the mental health system, improving outcomes by focusing on promoting hope, choice, self-determination, and mutuality. These bonds grow stronger because peer support workers emphasize the expressed goals of individuals in care — they listen, and they understand.

Today's peer support services have deep roots in the Civil Rights movement. New York State is a trailblazer in recognizing the benefits of mutual support and implementing peer work. In fact, the late Celia Brown was a pioneering civil service peer specialist in our agency. While it has taken time to fully embrace peer work, over the past decade New York has forged a professional career path for peer work that includes certification pathways and Medicaid-billable peer services. This historical context provides a crucial foundation for understanding the significant advancements made in supporting peer services in mental health services today.

Peer workers successfully engage people into life. Going beyond clinical or traditional services, mutual support focuses on forging relationships, connecting with communities of choice, and promoting holistic perspectives built on the notion that everyone can and will recover. Peer organizations as we know them were born outside of psychiatric facilities, in diners and community settings where community organizers with lived experience in the mental health system would bring people together. Many of these organizations still exist today, building on this framework to offer formal programming. Today, peer support workers are present throughout our service landscape from psychiatric centers, clinics, crisis services, peer-led recovery centers, specialized teams, and more.

At the New York State Office of Mental Health, training and certifying individuals with lived experience in peer support roles has become a fundamental focus of our work. This includes peer specialists, family peer advocates, and youth peer advocates — who all offer connections and support across diverse programs and services. Also playing a critical role are peer bridgers, who help patients establish and maintain a trusting relationship as they leave hospital care and then engage in ongoing support as they reintegrate into their community.

Simply put, peer support workers work with people to identify their goals and wishes, connect with chosen supports, and improve outcomes, especially within inpatient settings. They have often experienced similar challenges and can provide inspiration and guidance at critical moments in care. Relating to a peer support worker can help individuals in recovery adopt better coping skills, improve their outlook, and reengage with the community. Of utmost

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Bridging Families and Systems: Family Peer Support in Children's Mental Health Services

By Amy Piroli, FPA-C
and Lydia Franco, PhD, LMSW
NYU McSilver Institute

As soon as one learns that they are going to be a parent, the planning and preparation begins. It is a new journey. A journey that does not necessarily come with a handbook of how-tos, sure there are books, resources, literature etc. that can 'guide' you but there really isn't a one tell all way to be a parent. You grow and learn with your child. When I discovered I was to be a mother, I was both overjoyed and terrified. I did what every new parent would do, I bought the books, I read the articles, I learned which bouncy seat was the safest, which bottle would reduce the tummy upsets, which diapers were all natural, and how to schedule with the best rated pediatric practice. I prepped the nursery, filling my heart with dreams and aspirations for my daughter and the person she would become. At no time during the baby clothes shopping or wallpapering the nursery did I stop and consider learning about the children's mental health system. I did not have a need to, why would I?

Fast forward 7 years…my daughter had just celebrated her birthday. She was a healthy, vibrant, active, and intelligent little girl. Her smile and laugh would light up every room, until one day it didn't. Overnight, I found myself thrust into this uncharted system, the children's mental health system. I became obsessed with navigating terminology, services, medication, therapies…without direction, without a handbook. I was lost, heartbroken and overwhelmed with guilt. I couldn't help her feel better and didn't understand what I had done wrong. I was alone and running in survival mode. I was no longer learning with her; I was learning for her - to support her health, her safety and happiness.

The children's mental health system, a piece of a larger vast system of care, is a system that as a parent can at times be challenging and frightening to navigate. As a single parent, I was searching for any direction that would support recovery for my daughter. At times, it felt as if I was running at top speed on a treadmill unable to reach a final destination. It wasn't until a fellow parent from a play group asked if I had heard of Family Support. Family Support was not something I was familiar with. It took a bit of time to make the connection with a Family Peer Support provider, also known as a Family Peer Advocate (FPA), however I quickly realized the incredible value this connection would bring to me and the journey of recovery for my daughter.

Connecting with another parent with similar lived experience was uplifting and encouraging. I found strength in our connection, I no longer felt alone. I had a co-captain that was supporting me through the uncharted system. Having an FPA walking alongside me provided me with moments to catch my breath and clear my mind, allowing me to see what it was my daughter and family needed.

The unique lived experience that Family Peer Advocates provide is an unmeasurable connection through strength. Supporting the family voice, respecting that you are the expert of your child, that a plan needs to work for you, your family and your home allows for successful engagement. When a person's voice is valued and

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Implementation of Peer Support Roles in Street Medicine and Outreach: Challenges and Possibilities

By Adamina Serratos and Samuel Jackson, MD

"We're not here to belittle you. We're not here to down talk you. We're not here to tell you what you should or shouldn't be doing because that's not our place."

- Lavaughn Johnson, Peer Navigator at ReVive Center for Housing and Healing

At the intersection of homelessness and substance abuse, the importance of peer specialists is undeniable. Research has shown that peer support in the realms of homelessness and substance abuse has the potential to effectively improve housing retention and reduce substance use-related harm, including overall reductions in drug and alcohol use (Miler 2020). The role of peer workers in this context can vary greatly, but it often involves building relationships with clients and acting as both an advocate and a mentor throughout the process of accessing medical and social services, such as substance abuse treatment and supportive housing (Miler et al. 2020, Barker et al. 2017, MacLellan et al. 2015).

Beyond being able to connect with clients who are already in treatment, peer support workers are uniquely able to act as a bridge from initial engagement to initiating care (Miler et al. 2020). This is especially important in the context of street medicine, where providers deliver healthcare and resources directly to people experiencing unsheltered homelessness on their own terms. Street medicine often takes the form of multidisciplinary outreach teams, with peer workers serving as a point of connection between the communities that they enter and the providers and students who come along on the run (Enich et al. 2023).

In an interview, Lavaughn Johnson, a Peer Navigator at ReVive Center for Housing and Healing, and a lead on ReVive's Street Outreach team, highlighted how lived experience can provide peer support workers with a distinct understanding of care. He explained that a hierarchical approach to care will not be effective within communities that are consistently seen as lesser-than and unable to make decisions for themselves.

Peer support isn't just about relating to the experiences of clients but also understanding on a deeper level how to approach and communicate with people who have often been actively harmed by traditional models of care that are seen in clinical settings (Miler et al. 2020).

However, while the framework of peer support certainly has much to offer to the field of street medicine, peer workers at the intersection of housing and substance abuse services are subject to unique challenges. Synthesizing the findings of Miler et al.'s review of eleven research studies on peer support at the intersection of homelessness and substance use, alongside Lavaughn's experience at his organization, three areas of challenge can be highlighted: vulnerability, responsibility, and compensation.

Vulnerability

While providing services such as street medicine is risky for everyone involved, peer workers can experience risk and vulnerability in very different ways, and the

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How Psychiatric Office Support Directly Improves Mental Health Treatment Outcomes

By Dr. TeeJay Tripp, DO
Psychiatrist and Chief Medical Officer
Serenity Mental Health Centers

When we evaluate why a patient improves or doesn't, we tend to focus on the method itself. Was the medication the right fit? Was the TMS protocol appropriately calibrated? Was the ketamine dosage well-tolerated? These are the right clinical questions to ask. But the quality of support surrounding the treatment also shapes outcomes.

For mental health professionals, patient-centered psychiatric care is worth examining as a measurable contributor to whether patients' complete treatment, report symptoms accurately, and sustain long-term mental health recovery.

What is Patient-Centered Psychiatric Care and Why Does it Affect Outcomes?

Before a patient attends a psychiatric appointment, they most likely have had a discouraging path with their mental health. Many have tried multiple medications without relief. Many may arrive carrying a belief that they are not going to get better.

This is the clinical reality that greets us in our clinics, and it means that every interaction carries a direct weight.

The therapeutic alliance, defined as the quality of the collaborative relationship between a patient and their care team, is one of the most consistently replicated predictors of treatment outcomes across all mental health modalities.

A patient who feels genuinely heard is more likely to share their symptoms. A patient who trusts their team is more likely to complete a full treatment course rather than dropping out. A patient who experiences a safe clinical environment is more likely to tolerate the vulnerability that treatment requires.

Care environments that feel transactional, rushed, or dismissive can actively undermine even the most effective clinical interventions. In treatment-resistant populations, where patients have often disappointing experiences, the support environment may be the deciding factor in whether they remain in care at all.

What Does Meaningful Support Look Like in Psychiatric Practice?

Support in a psychiatric setting directly influences patient retention and treatment efficacy.

Accessibility - For patients with depression, anxiety, OCD, or PTSD, logistical barriers, such as long gaps between appointments, may cause symptoms to worsen. Practices that prioritize same-day appointments and flexible scheduling help patients get the care they need and fast.

Hiring the right staff - At Serenity Mental Health Centers, we have a layered staff model where every role serves a distinct function in the patient experience. Each patient has seven or more staff members on their team, including Patient Care Coordinators (PCCs), Patient Care Advocates (PCAs), Patient Experience Coordinators (PECs), Treatment Technicians, such as nurses or TMS technicians, Psychiatric Nurse Practitioners, Psychiatrists, and Practice Managers. No single staff member is stretched too thin to be genuinely present with any one patient.

Proactive care coordination - When coordinators have the capacity to follow up between appointments and communicate with referring clinicians, outcomes improve. Attentive contact at key moments changes the clinical trajectory of patients' journeys.

How Does Office Support Affect TMS, Ketamine, and Medication Management?

TMS therapy for depression, anxiety, and PTSD involves 5 sessions per week over 6-8 weeks; meaning patients return to the same clinical environment nearly daily. Serenity staff members build trustworthy interactions over the course of treatment.

Ketamine infusion therapy is administered in a quiet, controlled setting where the number of sessions depends on patient needs. Unlike most outpatient encounters, patients receiving ketamine are fully present with their immediate environment. The attentiveness of the care team and the safety of the environment matter.

Psychiatric medication management depends on patients reporting their experience accurately and that happens when they trust their provider. Proactive side effect monitoring and genuine responsiveness to patient feedback are important clinical tools.

What Psychiatric Practices Can Do Today

Four questions are worth examining directly and with careful consideration:

1. Does your patient's path from first contact to first appointment have unnecessary friction points? Which are within your control to reduce?

2. Do your support staff have capacity for proactive communication, or are they managing volume at the expense of depth?

3. Is your staff fully equipped, trained, and supported to effectively meet patients' needs at every stage of their recovery?

4. Do referring providers consistently receive timely, detailed, and meaningful updates about the progress of shared patients?

These are operational questions, and the answers shape outcomes in ways that are easy to underestimate without further thought.

Dr. TeeJay Tripp, DO, is Psychiatrist and Chief Medical Officer at Serenity Mental Health Centers. Call (844) 310-1649 or visit www.serenitymentalhealthcenters.com to learn more.

Lived Experience, Lasting Impact: The Role of Peer Support in Mental Health Intensive Outpatient Programs

By Tasha R. Kalhorn, PsyD
Senior Director, Intensive Outpatient Program
Family Care Center

Beginning an Intensive Outpatient Program (IOP) is not just about addressing symptoms. Many participants enter treatment carrying uncertainty about the process, wondering whether it will work and how they will manage future challenges.

Even with strong therapeutic relationships and evidence-based care, many participants quietly question whether the progress made in the small-group therapy format of IOP will hold up when stress, conflict, or old patterns resurface.

Specialized IOP therapists provide structure, teach skills, and share their expertise. Family members often offer love and encouragement. Yet one of the most powerful elements of treatment is peer support, which often helps individuals move from simply understanding a skill to using it in real life, a concept known as skills generalization.

Peers as Partners in the Mental Health Recovery Process

Peer support is one of the most powerful mechanisms of change in an IOP. Research shows that peer involvement can help people stay engaged in treatment, reduce hospitalization, and increase feelings of empowerment and connection. This is largely because peers bring something unique: real-life experiences. They remember what it feels like walking into a group for the first time. They understand the mix of hesitation, hope, and tiredness that comes with starting over. When a peer says, "I've been there," it carries authenticity. That honesty helps participants feel less alone and more able to continue their recovery after the program ends.

Why Peer Support Matters in IOP

IOPs provide a structured, effective, safe, and supportive environment, often meeting three to four days a week for three hours each day. This format offers a higher level of mental health care while still allowing participants to live at home and maintain aspects of their daily routines.

Within IOP, participants learn valuable skills such as:

- Changing unhelpful thought patterns
- Managing intense emotions
- Coping with stress
- Building healthier relationships

However, learning these skills in a group setting is only the first step. The real challenge comes when participants try to apply those tools during an argument with a partner, a stressful meeting at work, or a quiet evening when difficult thoughts return.

This is where peer support becomes especially meaningful.

Peers help bridge the space between insight and action – between learning new skills and applying them in everyday life. They normalize the difficulty of practicing new tools in daily living and offer practical examples from their own lives. Perhaps most importantly, they remind participants: *You don't have to figure this out alone.*

1. Turning Theory into Usable Action

IOP participants absorb a great deal of information, but translating therapeutic concepts into real-world action can feel overwhelming, especially during moments of distress outside of group hours.

Peers help bridge that gap by:

- Modeling how they have used coping skills in their own lives
- Helping participants troubleshoot real-world situations
- Offering practical, relatable strategies

For example, rather than saying, "You should try grounding," a peer might explain, "Here's what grounding looked like for me when I was sitting in my car before work, trying not to panic."

That level of detail matters. It makes theory practical.

For clinicians, peer support helps reinforce skill generalization across situations. For families, it increases the likelihood that progress continues beyond the program hours.

2. Increasing Engagement and Reducing Dropout

Participant engagement is one of the strongest predictors of positive outcomes in behavioral health treatment. Yet many individuals entering IOP feel ambivalent or uncertain about their ability to change.

Peers are often the first people they feel comfortable opening up to. Because they share similar experiences, peers may feel less intimidating and participants may feel less judged.

This sense of connection helps:

- Reduce stigma
- Build trust
- Strengthen engagement in treatment

When individuals feel understood by their peers, they are more likely to:

- Attend sessions consistently
- Actively participate in discussions
- Reach out during moments of distress

Research shows that having peers involved helps support IOP goals by improving treatment retention and reducing hospital admissions. Engagement then becomes about the relationships, not just following steps.

3. Supporting Transitions into and out of IOP

Starting IOP can feel intimidating. New settings, unfamiliar people, and unclear expectations can make participants hesitant.

Peers help new participants understand what to expect and normalize the discomfort that often comes at the beginning of IOP treatment. This reassurance can reduce early dropouts and help individuals feel safe entering the therapeutic environment.

Peer support is equally important when participants prepare to leave the program.

Peers can help by:

- Assisting with aftercare planning

see Mental Health IOPs on page 39

Integrating Peer Professionals in Complex Behavioral Health Systems

By Gita Enders, LMSW, MA, NYCPS and Sophie Pauze, MPA
NYC Health + Hospitals

NYC Health + Hospitals, the nation's largest municipal health care system and New York City's largest behavioral health provider, serves individuals with complex behavioral health and social needs including homelessness, justice involvement, and chronic medical conditions. In this landscape, peer professionals—individuals with lived experience of mental health and/or substance use recovery—play a critical role in engagement and recovery support.

As NYC Health + Hospitals expands mobile outreach and community-based services, peer professionals help extend care beyond hospital walls. They model recovery, share resources, build trust with individuals hesitant about treatment, and bridge patients to multidisciplinary teams. Their lived experience helps strengthen person-centered care and shared decision-making, enhancing continuity of care and community integration.

Integral to this workforce strategy is the NYC Health + Hospitals Peer Academy (Academy), which serves as a training hub and employment pipeline. The Academy provides foundational instruction in recovery principles, ethics, boundaries, and health care systems operations. Graduates are prepared for roles across mental health and substance use inpatient, outpatient, and community-based service settings. In addition to skill development, the Academy cultivates professional identity aligned with public-sector behavioral health expectations. As placements increase, the Academy represents a significant infrastructure investment in workforce development.

Demand for peer services continues to grow, particularly among individuals with complex needs, for whom NYC Health + Hospitals delivers approximately 53% of the acute care citywide. Caring for patients with such multifaceted needs carries significant responsibility, and without adequate scaffolding, the peer workforce may disengage, experience burnout, or choose to leave NYC Health + Hospitals. Meanwhile, policy shifts recognizing peer services as reimbursable and evidence-informed present an opportunity to leverage their unique talents in service of our most vulnerable patients. The current moment underscores the critical importance of expanding and retaining our peer workforce, yet doing so requires attention to operational and professional challenges.

Challenges and Opportunities

Despite strong organizational support, integrating peers into the large health system presents issues, spanning human resources, organizational buy-in, foundational workplace skills, and demanding working conditions.

Human resources processes are an important component of successfully integrating peer roles into the workforce. Our health system's behavioral health programs operate across multiple service models, each with distinct job descriptions, which can make recruitment and onboarding more complex. Peer candidates may also have limited formal employment history and can benefit from additional support with pre-employment preparation, such as mock interviews and orientation to workplace expectations. In addition, public-sector hiring processes are designed to ensure fairness and compliance, though they can sometimes extend the time required to bring candidates onboard. Addressing these dynamics requires close collaboration among workforce development teams, human resources partners, and program leadership to streamline hiring pathways while maintaining organizational standards.

Obtaining **organizational buy-in** also requires thoughtful engagement. Clinicians who are less familiar with peer roles may inadvertently conflate peer responsibilities with clinical or administrative tasks, which can blur role differentiation. In some settings, peer roles are introduced in response to contractual requirements, which may lead to perceptions of compliance rather than program enhancement. Addressing these dynamics involves fostering a shared understanding of peer roles among leaders and staff, along with establishing clear role definitions. Integration should also be data-driven, demonstrating the impact of peer professionals on metrics such as high utilization and uptake of community services. Collaboration strengthens when peers are recognized as integral members of the interdisciplinary team.

While many trainees prefer hospital-based roles, community-based work, such as outreach in shelters or on the street, can be **emotionally demanding**. Peers who draw on lived experience while meeting productivity and documentation demands face heightened burnout risk without adequate training and support. Ongoing professional development is essential in areas such as motivational interviewing, trauma-informed care, documentation, and boundary management. Without clear career paths and growth opportunities, retention may suffer.

Looking Ahead: A Multipronged Approach

To strengthen integration and meet rising demand, a comprehensive strategy is needed that bolsters both individual peer performance and strengthens the environments in which they work:

- First, **standardized professional development for incumbent peers** can extend learning beyond initial training. A Workforce Foundations program could include advanced engagement techniques, interdisciplinary communication, crisis response, quality improvement, and self-care. Modular formats would accommodate varied experience levels while reinforcing shared competencies.

- Second, **fostering a shared understanding** among facility leaders and clinical staff of the peer role and scope of work is critical to maximizing peers' contributions. Interactive workshops, case presentations, and targeted technical assistance can support supervisors in integrating peer staff effectively, clarifying expectations, and addressing common operational questions. Ongoing feedback from clinicians and leadership helps guide implementation supports and strengthens interdisciplinary collaboration.

- Third, **one-on-one coaching with Academy leadership** can support skill development and reinforce professional identity. Coaching offers structured space to navigate workplace challenges and align recovery values with organizational culture, particularly during the first year of employment when learning about the health care system itself may create additional anxiety.

Finally, and equally important is establishing clear **career pathways** for peers.

Senior peer roles with opportunities for

see Integrating on page 55

Integrating Peers in CCBHCs: The Power of Lived Experience

By Sarah G. Gilliard, LCSW
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Harlem CCBHC
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Certified Community Behavioral Health Clinics (CCBHCs) have shifted the way we approach treatment and the delivery of behavioral health services. Those who hold the designation of CCBHC have been tasked with providing a person-centered model that combines mental health services, substance use treatment, targeted case management, and physical health monitoring under one roof. This "one-stop shopping" approach reduces disruptions in care and helps to eliminate barriers that have historically prevented individuals from accessing the support they need. In this integrated model, Peer Navigators/Peer Specialists (at times used interchangeably) play an integral role in improving engagement, supporting recovery, and acting as a bridge between CCBHCs and the communities that have begun to embrace them as a resource.

"You don't understand." We have all felt this way at some point in our lives. However, for those who are on their recovery journey, this statement is an outward verbalization of the isolation they often feel as they battle the symptoms that have added to the obstacles in their lives. While each person's story is different, peers bring something valuable to the behavioral health workforce: lived experience. Peers are able to meet participants where they are and share their own stories of resilience and overcoming. They understand. Peers have utilized the tools that were shared with them, have successfully navigated that part of their recovery process, and are in a position to give back in the form of modeling and guiding with experiential knowledge. They offer empathy and insight that is different from other interventions because they have lived it. For individuals with mental health and substance use challenges, the peer perspective can make a world of difference.

Because of the integrative nature of CCBHCs, the population served includes individuals with co-occurring mental health and substance use disorders, often referred to as dually diagnosed. These individuals have historically encountered many barriers to care, including stigma and limited social support. Peers have helped to address these barriers by providing resources while creating spaces of trust and understanding. When someone speaks with a peer, the dialogue shifts from a clinical assessment to an authentic human connection. This connection often becomes a powerful source of hope because it is grounded in a shared path. Peers become mentors, advocates, and guides throughout the recovery journey. They help participants navigate complex systems, access resources, and build the skills necessary for maintaining overall wellness. Perhaps most importantly, peers within CCBHCs help reduce stigma related to mental illness and substance use. By sharing their stories of recovery, they demonstrate that goals are attainable and success is not out of reach. For many participants, this visible example of recovery provides a concept that clinicians may not be able to convey: if you can see it, you can be it.

Within CCBHCs, peers are not meant to function in isolation. Instead, they are an integral part of a multidisciplinary team that may include prescribers, case managers, substance use counselors, psychotherapists, nurses, and administrative staff. When peers are woven into this collaborative environment, they contribute a different lens through which treatment planning and service delivery can be viewed. Their insights can help clinical teams better understand the lived realities of participants and assist with interventions that are both practical and meaningful.

Successful integration of peers requires thoughtful planning and clear workflows that focus on delivery of high quality, wraparound services. Peers should be supported through training and supervision. CCBHC training of peers often includes topics such as professional boundaries and ethics, motivational interviewing, trauma-informed care and recovery-oriented practices, and similar areas. While knowledgeable and trained in some clinical interventions, peer roles should be clearly defined as their responsibilities differ from counseling. Peer supervision should embrace the duality of their role: professional responsibilities and personal experience. Work in a CCBHC can be emotionally taxing for all, but perhaps particularly for peers who are on their own recovery journeys. An ongoing focus on wellness and self-care is needed in addition to workplace support to ensure optimal peer service delivery and peer retention.

When integrated effectively, peer support can enhance engagement in CCBHC services. Participants who may have struggled with consistent engagement often appreciate being able to speak with someone who understands what they have experienced firsthand. This increased engagement can lead to improved outcomes when one measures treatment adherence, symptom management of co-occurring disorders, improved physical health, and connections to stable housing and employment. However, success in peer support cannot be measured solely through traditional metrics such as achieving objectives, goals, and successful program completion. Peer support is fundamentally about connection. It is about building relationships that help participants rediscover their strengths and envision a future beyond a diagnosis.

In many ways, peer support functions as an intervention in itself. A connection that instills hope, a moment of shared understanding, or a simple affirmation that recovery is possible can significantly influence a person's journey. Peers provide support not only to participants, but to the broader multidisciplinary team. Their insights often help staff better understand participant perspectives and community dynamics. As CCBHCs continue to evolve, the integration of peers will remain central to delivering truly person-centered care. By combining clinical expertise with lived experience, CCBHCs create comprehensive systems of support that address the full complexity of behavioral health needs—treating the whole individual. Peers represent another line of defense in the journey of treatment and recovery: one grounded in empathy, authenticity, and the belief that healing is possible.

The integration of peers into CCBHCs is not simply a workforce strategy. It is a commitment to honoring the voices and experiences of those who have lived through mental health and substance use challenges. When peers are fully supported, respected, and integrated into multidisciplinary teams, they strengthen the fabric of behavioral health care and help ensure that recovery remains at the center of every service delivered.

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Overcoming Barriers to Integrating Peer Support in Mental Healthcare Systems

By Maggie G. Mortali, MPH
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NAMI-NYC

Peer support is one of the most promising approaches in behavioral health, demonstrating measurable improvements in recovery outcomes for people living with serious mental illness. Yet despite decades of research and growing policy support, peer specialists remain underutilized across many healthcare systems. Understanding and addressing the structural barriers that limit peer integration is critical if behavioral healthcare systems are to fully realize the benefits of recovery-oriented care.

Peer support refers to services provided by individuals who draw upon their own lived experience with mental health challenges or recovery to support others navigating similar journeys (Ibrahim et al., 2019). Peer specialists, family peer advocates, and recovery coaches offer unique forms of support that differ from traditional clinical roles. Rather than focusing solely on symptom management, peer services emphasize hope, empowerment, and practical strategies for navigating complex healthcare and social systems.

The concept of peer support has deep historical roots. Mutual aid approaches in mental health date back centuries and were foundational to the modern recovery movement. Today, peer support is increasingly recognized as an essential component of behavioral health systems. Federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS) have both promoted peer services as part of comprehensive mental health care delivery.

A growing body of research demonstrates the effectiveness of peer-led services. Individuals who engage with peer support report fewer psychiatric hospitalizations, improved quality of life, increased engagement in treatment, and stronger feelings of hope, recovery, and empowerment (Shalaby & Agyapong, 2020). Peer services also support family members, providing education, coping strategies, and shared understanding that strengthen recovery environments.

Health systems are beginning to recognize these benefits. In New York City, for example, NYC Health + Hospitals recently expanded its Peer Bridger Program as part of a $32.2 million initiative designed to support individuals with complex behavioral health needs following hospital discharge. Peer specialists working within Critical Time Intervention (CTI) teams accompany patients home after discharge, assist in securing benefits, and help connect individuals to community-based care. The initiative is projected to serve approximately 650 New Yorkers and reflects a growing recognition that peer support can improve continuity of care during vulnerable transitions (NYC Health + Hospitals, 2025).

Despite these advances, integrating peer support into healthcare systems remains challenging. Many of the barriers stem not from lack of evidence, but from the structural and cultural changes required to incorporate peer roles into traditionally clinical environments.

One persistent challenge is the power imbalance between peer specialists and clinical staff. Peers often report that their contributions are undervalued or misunderstood

see Overcoming Barriers on page 40

Peer Support in Practice: Workplace Strategies and Professional Development

By Christopher Doherty, CRPA and Jill Mastrandrea, LMHC, CASAC New York Psychotherapy and Counseling Center (NYPCC)

The field of peer support is quickly gaining prominence and visibility across the domains of behavioral health and substance use services. Georgia was the first state to provide Medicaid-billable mental health peer services in 1999 - it was not until 2012 that Medicaid billing was authorized for the provision of substance use services. Now, 49 out of the 50 states have allowed for the provision of Medicaid-billable peer services (Bell et al., 2024). It has been shown that peer support can bridge the gap between patients and clinicians, improving treatment outcomes and engagement. However, lack of training and adequate supervision, unclear expectations of role clarity and differentiation, and limited opportunities for career advancement are all structural barriers that impact the provision of these services.

The onboarding process is crucial for peers in the workforce, in getting the opportunity to be informed, welcomed, and guided into the policies and procedures of a particular company. Being included in the onboarding process and getting to see how the company operates is crucial to ongoing success. At New York Psychotherapy and Counseling Center (NYPCC), onboarding also provides an opportunity to introduce oneself as a peer and explain the importance of the work and how it can support clientele by focusing on shared, lived experiences, and bridging the gap between providers. NYPCC believes that it is important in combating stigma and misunderstanding of the peer role and unique function of the services provided (BJA, COSSUP, 2023).

Having access and encouragement to attend a wide variety of trainings, both in-house and outside of the company is at the core of NYPCC's values. This is meant to provide further development within the peer role as well as future professional development opportunities and it is paramount to a peer's continued engagement and motivation in continuing to learn and develop important skills. Some of these trainings at NYPCC include workshops and presentations on evidence-based practices that may benefit the population served, and getting linked to state-wide peer networks and coalitions to continue networking and seeking advice and support from others in the field, particularly for peers on small, tight-knit teams, where immediate support may not always be available.

At NYPCC, supervision is a space where peers are provided with the resources necessary to perform in their role and allow space for discussions of transference/countertransference that may arise in the working relationship between peer and client. Having regular supervision from a supervisor who has worked with peers in the past and has had training on trauma-informed approaches to peer supervision is especially important to retain peers long-term. Supervision is not only a place to be held administratively accountable, but also a place where there is room for discussion around continuing education and being provided additional support and guidance as necessary. It is also especially important for the peer specialist to be included in group clinical supervision, to provide unique insights into approaches to clients and be a valuable voice to a team of mostly clinical staff (Stefancic et al., 2021).

As a peer, shadowing other departments and individual clinicians can help to see where the responsibilities of a peer differ from those of a clinician or a case manager. It is also important for peers to remain mindful of their scope of practice, and if necessary, to revisit their ethics policies if they are certified or credentialed within their state of practice. The phenomenon of "peer drift" or "co-opting" occurs when peers find themselves outside of their scope of practice, navigating into solely administrative or clinical tasks in nature. This is why it is important for peers and supervisors to continue to be mindful of "peer drift" when a peer evolves into a role that is strictly clinical or administrative in nature and forgets the importance of peer-driven work (Whitson et al., 2025). These practices are part of peer training, onboarding and ongoing development at NYPCC.

It is equally important to be nurtured and grown professionally and intentionally, as peers may choose to seek certification in a more clinical scope of practice or decide to go back to school for further education. This is why supervision is important to be able to discuss professional development openly and be encouraged to grow in areas self-defined by the peer's background and future goals (SAMHSA, 2023).

In conclusion, peers can be supported in their workplace and professional development, by having an onboarding process that highlights the importance of the peer role and its unique space in both behavioral health and substance use treatment, continuing to have ongoing trainings that further develop the peer's skills and knowledge, and having supervision that is tailored to the needs of the peer. These protective factors can help a peer navigate the workplace and their role, while also providing resources for professional advancement and continued development.

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View article references here.

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Transforming Crisis Response: Direct EMS Radio Access for Peer Support Teams in Marion County

By Brooke Goodenow, MS
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SMA Healthcare

Behavioral health crises require rapid response, specialized support, and seamless coordination across emergency systems to minimize unwanted outcomes. Yet, in many communities, traditional Emergency Medical Services (EMS) workflows delay behavioral health intervention until after transport or hospital admission (Crisanti et al., 2022). Postponing behavioral health engagement can reduce critical engagement opportunities and limit the effectiveness of crisis response efforts, particularly in rural communities where access to care and willingness to seek help are already reduced (Bolinski et al., 2019).

Local data underscores why earlier, more coordinated intervention is essential. Over the past five years, Marion County EMS has responded to 6,974 suspected overdose incidents and administered naloxone to 5,339 individuals (Marion County Overdose Dashboard Report, 2026). These figures reflect a high-acuity environment in which behavioral health engagement at these critical moments can shape client outcomes. The volume and severity of these incidents demand crisis response models capable of mobilizing behavioral health support immediately and in coordination with EMS activity.

SMA Healthcare and Marion County Fire Rescue unite for crisis response. Pictured from left to right: SMA team member Pete Fenchette, Ocala Fire Rescue Maria Clark and Captain Jesse Blair.

Marion County, Florida, is doing exactly that. SMA Healthcare's Peer Support team has adopted a unique and highly coordinated model that integrates peer support specialists directly into EMS radio communications. This innovative approach allows peers to receive real-time dispatch information, coordinate side-by-side with first responders, and begin compassionate engagement before, during, and immediately after emergency encounters. The Marion County Hospital District has managed the collaboration and provided funding to support this coordinated program.

"Integrating peer support into the EMS radio system has changed the way we respond to behavioral health crises," says Travis McAllister, Peer Support Director. "Our specialists can now engage individuals immediately, improving response times, reducing the burden on first responders, and making sure people receive help at the moment they need it most."

EMS Radio Integration for Peer Support: Structure and Benefits

Traditionally, peer support specialists engage clients after transport, medical stabilization, hospital intake, or through scheduled follow-up services. Marion County, however, elected to refine this process. Through close collaboration with Marion County Fire and EMS leadership, peer support specialists can now directly access EMS radio channels, allowing:

- **Simultaneous dispatch of peer specialists alongside EMS and fire personnel.** By eliminating the communication lag previously caused by delayed notification, peer support specialists frequently arrive at emergency departments with or ahead of EMS transport to begin rapport-building.

- **Earlier client engagement with peer teams.** With peer support specialists able to receive calls in real time, community members receive support from the start. This early engagement is crucial for individuals in crisis, improving the likelihood of accepting support and minimizing the risk of overdose recurrence (White et al., 2023).

- **Strengthening of interagency coordination and support.** With shared communication channels, peer support becomes part of the coordinated emergency response alongside EMS, fire, law enforcement, and hospitals. This aligns closely with Marion County's broader emergency operations model, which emphasizes multi-agency collaboration and unified communication.

- **Increased support for first responders.** Timely access to peer support services eases the burden on EMS and other first responders in coordinating care with peer support specialists. With support originating on scene, first responders can concentrate on medical care knowing follow-up and recovery supports are already in motion.

This real-time connection creates a seamless link between EMS operations, behavioral health supports, and clients, strengthening the entire crisis response continuum of care.

Alignment with Statewide and National Efforts

Florida's Coordinated Opioid Recovery (CORE) Network emphasizes the transition from crisis response to treatment and ongoing support, with focus on a comprehensive response to the opioid epidemic (Florida Department of Children and Families, 2024). Real-time peer involvement reinforces this model by ensuring the client never leaves a supportive continuum of care. Florida's behavioral health system has emphasized expanding peer-led networks, including regional and local peer coalitions designed to bring recovery supports to every area of the state.

Marion County's approach is consistent with national best practices in crisis response, which prioritize immediate access to peer support, rapid referral to treatment, and reduction of service fragmentation (Substance Abuse and Mental Health Services Administration, 2025).

Looking Ahead: A Scalable Innovation for Crisis Response

Marion County's innovative use of EMS radio to directly dispatch peer support specialists represents a transformative shift in behavioral health crisis response. By integrating peer support into emergency communication channels, the county has been able to enhance response speed, improve continuity of care, strengthen interagency collaboration, and reduce barriers for individuals with substance use disorders. Marion County's radio-integrated model for peer support can serve as a template for:

- Embedding lived-experience practitioners directly into emergency workflows.

- Strengthening the communication infrastructure between emergency responders and community recovery systems.

see Crisis Response on page 41

The Peer Advocate: Role Model, Listener, and Problem Solver for Older Adults

By Catherine Thurston, LCSW
Chief Executive Officer
Service Program for Older People (SPOP)

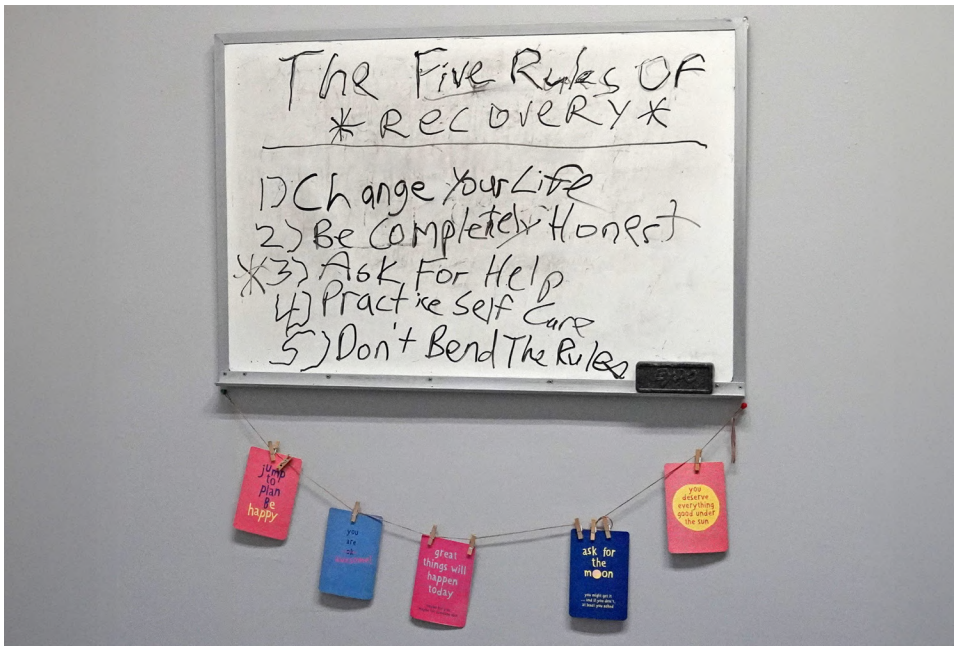
Peer Advocates have changed the way that we practice behavioral healthcare at Service Program for Older People (SPOP) - and have changed the lives of the older adults we treat.

SPOP is a community-based behavioral health provider for older adults (55+) based in New York City. We serve 1,000 clients annually through an outpatient clinic and a psychiatric rehabilitation day program (PROS) for adults with serious mental illness. We offer a full range of services including individual and group therapy, psychiatry, medication management, assessments, bereavement support, group-based psychiatric rehabilitation services, creative arts therapies, social healthcare, and linkages to supports for housing, meals, and financial assistance. Since our founding in 1979, we have partnered with dozens of hospitals, older adult centers, aging services providers, and other agencies to reach out to adults across the city who might otherwise have no access to behavioral healthcare.

SPOP has used "older" Certified Peer Specialists (over age 55) in its PROS program for ten years and recently expanded peer engagement for the clinic population. The peer advocate who is also a contemporary of the client plays a distinctive role with older adults.

Living with mental health challenges while aging is no easy feat. By nature of age and experience, older adults may need to adapt to physical challenges, changes in cognitive function, loss of family members and friends, or social isolation, all while managing the stress of living in a turbulent time. With these barriers, one of the most valuable supports can be another older adult with shared lived experience of mental health struggles who teaches the client self-advocacy, helps them build stamina for navigating difficult systems, and demonstrates what success can look like.

Alice is an example of a client whose experience with a peer advocate was entirely different from that with her therapeutic team. She enrolled in our PROS program a few years ago, hoping to enhance her living skills to help navigate her diagnosis of major depressive disorder and post-traumatic stress disorder. When she joined the program, she found it difficult to make eye contact, spoke so softly that it was almost impossible to hear her, and shared that she was "at the bottom of a deep well, with no place to go but up." She often sought out the peer advocate, who was her contemporary, to talk about their experiences and the challenges of recovery and aging. The peer repeatedly shared his story of depression and the long path to recovery and spoke of how his work helping others also supported his own recovery.



A poster in a psychiatric rehabilitation group room at SPOP, created by the Peer Specialist and group participants.

Over time Alice began to speak up more frequently in groups, often adding that it was difficult to discuss her mental health because of the stigma and shame she experienced in her youth. She shared that helping others with their mental health was important to her because "people should not feel ashamed or misunderstood. Society can make you feel so bad about your mental health and even doubt yourself. I want to help others find their voices like I did." With the guidance of her treatment team, Alice applied for training as a certified peer advocate, and when she was accepted, she took her studies seriously. She graduated from SPOP while she completed her training and certification, and she moved across the country to work full-time as a peer advocate.

At SPOP the peer specialist is a confidant, empathic listener, problem solver, advisor, escort for medical appointments, and role model. The peer provides assurance that clients can recover, heal, form new friendships, and even pursue a new career – a goal many clients struggled to conceptualize until they saw the peer in action. These are roles that are beyond the scope of our therapists, social workers, and psychiatrists, and we have learned that they are an essential part of healing. Working with their peers, the clients don't just hear that recovery is possible, they see it with their own eyes.

Peter is another SPOP client who is a long-time survivor of physical and emotional abuse. When he came to SPOP he was deeply mistrustful of others, particularly authority figures and those working at the agencies or hospitals he had visited, and he chose to live in a shelter because he was afraid to return home. The staff tried for two months to engage with him, with limited success.

It was only the peer specialist who was able to nurture and earn Peter's trust, as they sat together, quietly sharing personal stories. The peer also met with Peter in the community to accompany him to medical appointments, often talking or just sitting together quietly during long subway rides. Working with the peer, Peter was able to complete applications for housing and meals assistance, and he expects to move to a safe apartment shortly. He continues to attend the SPOP PROS program and has recently started to participate in groups and engage in conversation during congregate meals.

Our clients often reflect on how they will be remembered and what they wish to leave behind. By leading by example, sharing experiences, and listening with compassion, the peer advocate has shown that each life story has value, and that each individual has the capacity to heal, form friendships, and find community. For an older adult whose life has been largely defined by illness or disability, that is a profound lesson.

Catherine Thurston, LCSW, has served as Chief Executive Officer of Service Program for Older People (SPOP) since 2024, having previously served as Chief Program Officer. She has over 35 years of experience in gerontological social work. She has been a member of the Adjunct Faculty at the Silberman School of Social Work at Hunter College since 2016. She received her Master of Social Work from Hunter College School of Social Work.

A Brief History of Peer Support and its "Integration" into Behavioral Healthcare: The Uneasiest of Bedfellows

By Ashley Brody, MPA, CPRP
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The proliferation of peer services throughout the behavioral healthcare and social welfare systems has transformed them in ways their progenitors might not have anticipated. The peer support and recovery movements originated in eighteenth-century France under the auspices of Phillipe Pinel and Jean-Baptiste Pussin who sought to rectify countless injustices leveled upon individuals with mental illness (Davidson et al., 2012). The psychiatric and mental health professions emerged under ignoble and exceptionally cruel practices that dehumanized the subjects of their "care" and often exacerbated their conditions. Such practices, some of which were borne of noble but misguided intent, were predicated on a false belief that individuals with mental illness were incurable and disposed to inexorable deterioration and death. Pinel, chief physician of a psychiatric hospital, and Pussin, a former patient, espoused more progressive attitudes than their contemporaries and collaborated in enacting essential reforms. Their efforts augured the arrival of the "Moral Treatment" movement whose reforms included the deployment of former patients as caregivers (Davidson et al., 2011).

Moral Treatment reformed but did not upend existing standards of care, whereas subsequent developments in the peer support and recovery movements departed radically from their predecessors and entailed militant critiques of the status quo. The recovery movement in the United States was aligned with and inspired by the civil rights movement of the mid-20th Century that found common cause among oppressed and stigmatized populations. Efforts to end segregation and to advance the rights of racial minorities, women, gay and lesbian, and other marginalized communities coincided with commensurate changes in the paradigm that had governed psychiatric care since its inception. In one of his last official acts before his assassination in November 1963, President Kennedy signed the Community Mental Health Center Act — a watershed moment in the evolution of our treatment of individuals with mental illness that heralded decades of deinstitutionalization and the development of community-based services (Kennedy, 1979). A burgeoning concern for civil liberties coupled with emerging opportunities for individuals with mental illness to enjoy opportunities for community participation provided fertile ground for the rapid expansion of the peer support and recovery movements.

These movements entailed distinct coalitions that shared certain overarching objectives but diverged in significant respects. Patients who had suffered abuse during episodes of treatment remained skeptical of measures that merely aimed to reform a system they deemed inherently oppressive and dehumanizing. Members of the Psychiatric Inmates Liberation Movement of the 1960s were overwhelmingly opposed to conventional psychiatry and its underpinning medical model of mental illness (Chamberlin, 1990). They advocated for reforms regarded as radical for their time that included prohibitions on involuntary commitment and other coercive measures. Some of these reforms gained currency among behavioral healthcare professionals who recognized deficiencies inherent in existing standards of care. Such self-described "Radical Therapists" challenged a system that perpetuated power imbalances between patients and practitioners and cycles of disempowerment that undermined the recovery process (Talbott, 1974). These practitioners were among the first to identify a leading liability in a medical model of care that encouraged individuals' adjustment to oppressive social and economic conditions. In this respect they were united with champions of the Liberation Movement who sought to liberate individuals from structural oppression. Both Radical Therapists and Liberators recognized that existing models of care were prone to pathologize normative responses to abnormal conditions.

Members of the Liberation Movement and others who railed against psychiatry's abuses promoted alternative models of care similar to the "self-help" approaches that had been employed in the realm of substance use. Some believed these approaches were more effective than conventional models, and many regarded them as emancipatory inasmuch as they liberated their participants from psychiatry and its practitioner-centric and paternalistic proclivities (Chamberlin, 1990). Sherry Mead, a leading theoretician and pioneer of the Intentional Peer Support (IPS) model, championed an approach that honored the peer movement's commitment to social change and reconceptualized both the definition and leading objectives of "helping" relationships (Mead, 2010). She espoused a principle of mutuality wherein partners in a relationship would engage in the joint pursuit of knowledge unencumbered by the imperative to interpret or to analyze topics of dialogue. Mutuality eliminates power imbalances and encourages creativity that is too often constrained within hierarchical and outcome-based orthodoxies (Mead, 2010). IPS has become the philosophical foundation of peer support and is widely employed by Certified Peer Specialists.

As the peer support movement matures it faces exciting opportunities and existential threats. These seemingly contradictory trends are inextricably linked and must be successfully navigated if the movement is to deliver on its dual promises. The movement aims to offer effective alternatives to traditional care and to advance social changes that empower individuals and communities to overcome enduring stigma and marginalization, but its continuing expansion is dependent on larger systems in which it is now embedded. It is therefore subject to practices and constraints antithetical to its philosophical underpinnings. Medicaid, the predominant payer for mental health services in the United States, now offers reimbursement for peer services in at least 35 states (Copeland Center for Wellness and Recovery, 2022). This has undoubtedly fostered a rapid expansion of peer services and ensured their availability to individuals in need. Nevertheless, practitioners with even a cursory knowledge of Medicaid regulations understand its reimbursement entails adherence to an exceedingly complex body of regulations and the fulfillment of onerous administrative requirements. Furthermore, mainstream facilities and organizations serving individuals with behavioral health conditions,

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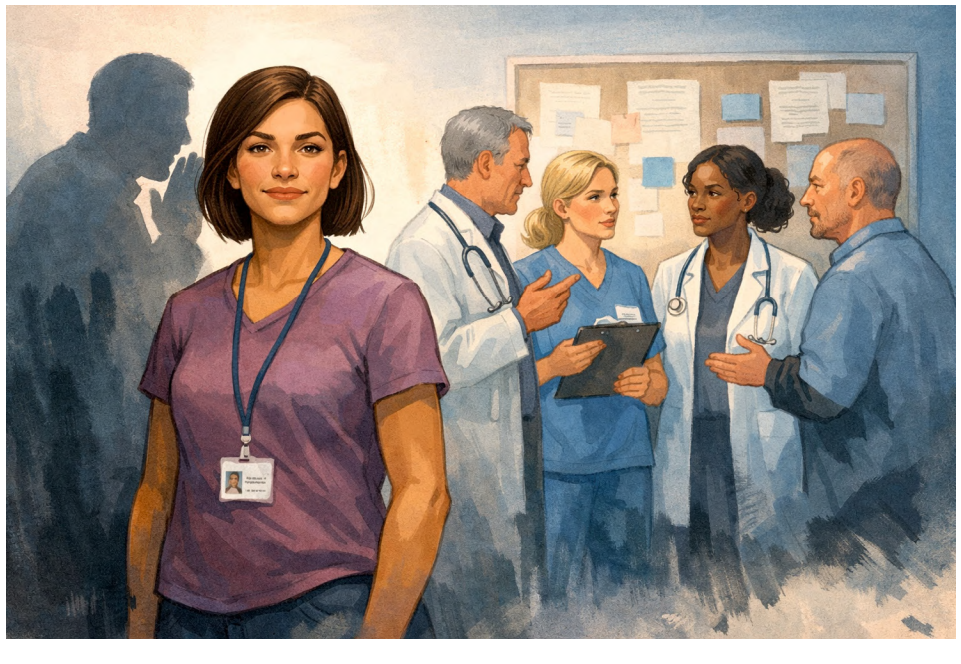
Addressing Workplace Stigmatization of Peer Colleagues Through Institutional Courage

By Gretchen Grappone, LICSW
Training Consultant



It is well documented that people with mental illness and substance use disorders (MI/SUD) are stigmatized across all levels of society. So, it is not a surprise that peer support specialists regularly experience stigmatization in the workplace, including negative messages from colleagues about their role and their MI/SUD (Firmin et al., 2019). Additionally, those of us with lived experience of MI/SUD often face other forms of discrimination. Therefore, it is important to acknowledge and address these workplace harms through an intersectional lens (Grappone & Carr, 2022). Microaggressions experienced by peers in mental health care settings can be considered examples of institutional betrayals (Gómez, 2015 as cited in Benedict et al., 2026; Jones et al., 2017). These happen when the workplace that the peer support specialist depends upon for support mistreats them. Institutional betrayal can also come in the form of harmful workplace responses to reports of stigmatization and is associated with decreased job satisfaction, higher intentions to leave the job, and increased somatic symptoms (Smidt et al., 2023). Gómez et al. (2023) state: "Institutional courage, which is an institution's commitment to seek the truth and engage in moral action by protecting those who depend upon it, can be the antidote to institutional betrayal."

Freyd (2018) developed her *Steps to Promote Institutional Courage* to guide institutions in implementing policies and practices to effectively address and eliminate harm and the harmful responses within institutions. I list her *Steps* below with my additional commentary on each one. I suggest specific strategies for institutions to consider when addressing the stigmatization experienced by peer support specialists.

12 Steps to Promote
Institutional Courage

(based on Freyd, 2018; updated March 2022, August 2025)

1. Commit to seek truth and engage in moral action, despite unpleasantness, risk, and short-term cost. Some of the potentially unpleasant truths that are important to seek include: identifying how stigmatization toward peers (related to MI/SUD, racism, sexism, and other forms of discrimination) is operating in your workplace - Who is perpetrating it? What policies are not being enforced? Who is staying silent when they witness it for fear of retaliation?

2. Comply with civil rights laws and go beyond mere compliance; beware risk management. This means being willing to listen and believe what peers say they are experiencing in the workplace and actively responding to any violations of civil rights laws. It means providing accommodations when requested and creating an environment where peers are encouraged to ask for what they need to succeed in their position. It will likely require a shift for those in Human Resources (HR) or Risk Management who say, "It's too risky to ask those questions of employees because what if they give us information that shows our employees are being harmed or at risk?"

3. Educate the institutional community (especially leadership). Ongoing training

see Institutional Courage on page 42

Your Leadership Style Will Shape Your Organizational Culture

By Isaac Mawuko Adusu, DHA, MSNPM
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Seven Hills Foundation, Rhode Island

Organizational culture is the collection of values, beliefs, and attitudes that shape the way a firm operates, that is, how its people think, feel, and act (Gutterman, 2025). Organizational culture can evolve, but it is not accidental. It is shaped and sustained by its leadership (Jaiyeola et al., 2025). The way leaders of an organization make decisions, communicate, lead, assign priorities, and personally act sends signals to everyone in the organization about the way things are done. Whether intended or not, leadership actions influence employee morale and commitment, creativity and innovation, customer service, productivity, profitability, and the organization's long-term survival (Khassawneh et al., 2022). To appreciate the influence of leadership on organizational culture, we need to examine how leaders communicate ways things should be done, model and reinforce the way. That is the focus of this article.

The Leader as the Cultural Architect

Culture ultimately starts with the leader. The way things are done is mostly influenced by how leaders act and communicate. In times of uncertainty, employees look at their leaders to understand how things should be done. Leaders set the organization's culture by establishing priorities and defining its mission. For instance, if a leader consistently directs that candid communication is a priority and consistently makes decisions openly and truthfully, a culture which values candid communication will be promoted. If a leader consistently makes decisions hierarchically and does not communicate frankly, the culture that emerges is that the way to get things done is through hierarchy and secrecy. The creation of culture begins with a leader's intent. Leaders who intentionally establish cultural goals through establishing mission statements, visioning, setting goals, and behavioral expectations establish a culture that employees can understand and adapt to. Leaders who do not establish priorities create a culture that is confusing, fragmented, or conflicted because employees are left to their own devices to determine the priorities.

Modeling the Way

Perhaps the most important way leaders influence culture is through their actions. Employees focus more on how leaders act than on what they say. For example, if a leader talks about the significance of work-life balance but consistently works long hours, sends late-night emails and texts, or rewards people who do, a culture that supports burnout will be fostered. If a leader models empathy, active listening, and equity, those values will become part of the organization's culture. Leaders' actions have been referred to as the shadow of the leader (Judge, 1999) (Hudson, 2021). The shadow of the leader means that leaders throw a long influence over the organization through their actions (Judge, 1999). The way a leader reacts to a crisis, responds to success, handles failure, and gives feedback all impact how employees do their work. Leaders who model accountability establish a culture of accountability. Leaders who model humility establish a culture of humility. Through their actions, leaders establish the way things are done.

How Communication Shapes Culture

The way leaders communicate is a powerful influence on an organization's culture. Leaders who consistently communicate

see Leadership Style on page 43

Peer Supervision: A Model for Enhanced Vocational and Emotional Support

By Elaine Edelman, PhD, LCSW, CASAC-Adv., Kansas State University
and Michael Collins, CRPA, RCPF, CHW
Interborough Developmental and Consultation Center

For many of us in the field of mental health and substance use disorder, the idea of peer services feels like a new and welcome change that brings with it equity and a workforce with a more complete perspective on lived experience.

Many people are surprised to learn that peer services have a long and distinguished history. Davidson, et al. (2012) points out that peer services were an "innovation" of the late 18h century in France. Pussin and Pinel, in developing their "moral treatment" moved away from standard treatments of their time, which often involved shackling and abuse. "In addition to being 'gentle, honest, and humane,' Pinel found these former patients recruited by Pussin to be 'averse from active cruelty' (which was a common management strategy in the asylums of the day) and 'disposed to kindnesses toward the patients in their care" (Pinel).

While not generally described as "peer services," 12 step programs, which began in the 1930's with Bill W. using his lived experience to help others struggling with alcoholism, are perhaps the most widespread use of peers helping others who share their issues. There can be no disputing the power of identification, both in empathy and role modeling. The hope that comes from someone who has "walked in" your shoes and emerged on the other side, is invaluable.

The authors of this article are of the belief that, in many ways, we "are all peers," in that our lived experience is often what brings us to the helping professions. However, asserting "that we are all peers," obscures the unique challenges of the peer workforce as well as the commitment being made to utilize their, often painful, lived experience. Peer workers, in both mental health and recovery specialists in the field of substance use disorder, have chosen to work with people whose difficulties mirror their own. And that may be a fundamental difference between peer specialists, and mental health and substance use providers at large.

Peer Supervision and Support Work Group

A community health agency in New York State (which chooses to remain anonymous to protect the privacy of their peer workers) began to see a slow but steady deterioration in several of the peers employed by the agency. This agency had trained peer specialists who ran groups and did counseling and enjoyed full employee status (with salary, benefits, and paid time off). They also employed "outreach peers," in their harm reduction program, who were often still using substances. These peers would go out into the community and reach those struggling with opioid addiction. They would use their community connections to deliver clean syringes, fentanyl and xylazine test strips, and inform their friends and peers of harm reduction services available to them. These outreach peers received a significant stipend (totaling a few hundred dollars for two weeks work) for their outreach, and associated paperwork documenting what work they had done (while keeping their contacts anonymous). The third type of peer worker was employed informally and compensated by stipend to perform tasks such as greeting visitors at the front desk and distributing Narcan kits and test strips or assembling Narcan and Safe (crack) Use Kits in the supply room.

Staff became aware of burgeoning problems among the peer workforce when a peer, who had been with the agency for

see Peer Supervision on page 46

From Access to Engagement: Reimagining the Consumer Experience in Behavioral Health

By Jorge R. Petit, MD
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We Better Work, LLC

Behavioral health systems have made significant strides in expanding access to care. Peer services have grown across outpatient clinics, crisis teams, Certified Community Behavioral Health Clinics (CCBHCs), and substance use treatment programs. Telehealth has normalized remote care. Patient portals are widely available. And yet, engagement remains a persistent challenge.

In recent national surveys examining provider perspectives and consumer preferences on digital engagement in behavioral health, one theme emerged consistently across both groups. Access to tools does not automatically translate into meaningful participation in care. Consumers described early experiences with services as administratively heavy, confusing, and impersonal. Providers acknowledged difficulty sustaining engagement during intake and the critical first weeks of treatment. Both groups highlighted the period between visits as a vulnerability point—when motivation can waver, relapse risk can rise, and connection to the care team may feel distant.

These findings suggest that the next phase of behavioral health innovation must focus less on expanding access and more on redesigning the consumer experience itself.

The Consumer Journey: Where Engagement Breaks Down

From the consumer's perspective, the behavioral health journey often begins with urgency—crisis, distress, substance use relapse, family conflict, or psychiatric decompensation. Yet the first digital touchpoints frequently involve lengthy forms, multiple logins, consent documents, and screening tools delivered without context.

Our survey data revealed that providers see significant drop-off during intake and onboarding. Consumers reported feeling overwhelmed by information, uncertain about next steps, and unsure how to communicate questions between appointments. Traditional portals—when used—are often limited to appointment reminders or document access rather than interactive engagement.

This misalignment matters. Research consistently demonstrates that early engagement predicts retention in treatment, which in turn correlates with improved outcomes in both mental health and substance use disorder care (SAMHSA, TIP 42). Yet digital systems in many organizations were not designed to support sustained, recovery-oriented engagement. They were built for administrative efficiency.

The result is a structural gap where consumers spend most of their time outside clinical settings, but digital infrastructure does little to support continuity during those hours and days.

Between Visits: The 99% Problem

Behavioral health treatment is episodic. Recovery is continuous.

Consumers spend perhaps one hour per week in formal sessions. The remaining time, what might be called the "99% problem," is when coping strategies are tested, social stressors emerge, cravings fluctuate,

see Consumer Experience on page 44

Addiction Recovery: The Role of Peer and Alumni Support

By Taylor Rocheleau
and Tammie Rojas, MS, LPC
Enterhealth

Behavioral health care has made meaningful progress in evidence-based treatment, yet one of the most persistent challenges remains what happens after discharge. Recovery does not end when a person leaves residential care. In many ways, that is when real-world pressure begins.

The transition out of residential treatment represents a sharp shift in environment, structure, and support. Individuals move from a highly regulated, recovery-focused setting into daily life, where competing demands, stressors, and decision-making return rapidly. Even with thoughtful discharge planning, the loss of consistent structure and shared community can feel abrupt.

Peer support and structured alumni engagement are increasingly recognized as continuity tools rather than optional enhancements. As defined in national guidance, peer support is nonclinical support delivered by individuals with lived experience. Peer recovery services help people initiate and sustain recovery. When thoughtfully designed, peer and alumni programming can bridge high-risk transitions between levels of care, particularly when structure decreases and isolation can return.

Residents at Enterhealth participate in an outdoor group session focused on peer support and connection

From a clinical perspective, the period immediately following discharge is especially vulnerable because connection, accountability, and routine are no longer built in. Sustaining access to recovery-oriented community during this phase can help individuals carry forward the habits, values, and sense of belonging developed during treatment.

As Tammie Rojas, MS, LPC, notes, "Human beings want to continue the community they are a part of. Continuing the habits and values learned during residential care and having a community that understands the experience and can offer accountability can help support people through that transition."

This framing shifts the focus away from outcomes and toward continuity, emphasizing that ongoing connection matters not because treatment failed, but because recovery unfolds in real life.

The Vulnerable Transition Between Levels of Care

Residential treatment is often the beginning of recovery, not its conclusion. People enter care physically depleted, emotionally exposed, and uncertain about what lies ahead. In that environment, connection forms quickly. These bonds matter because the transition out of residential care can feel abrupt, even when discharge planning is thorough.

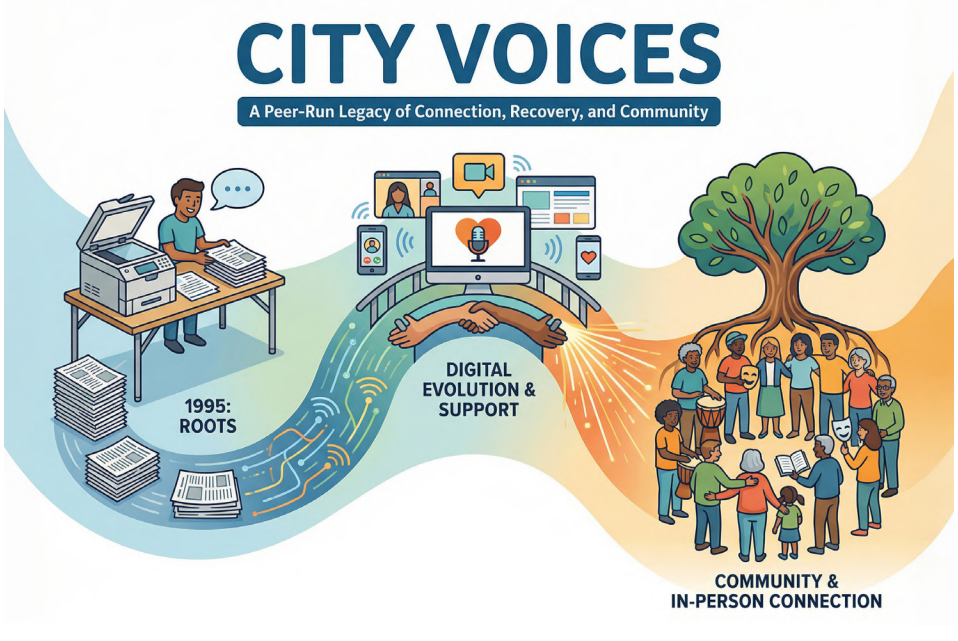
Taylor Rocheleau describes early recovery after residential treatment as fragile. "Recovery is at infancy; it needs to be sheltered and protected." Risk increases when individuals are unable to step down into an appropriate next level of care, particularly outpatient services. The reasons are often practical rather than motivational: work schedules, transportation barriers, childcare responsibilities, insurance limitations, or returning to home environments that do not support recovery.

When outpatient care is disrupted or unavailable, the clinical need does not disappear. In these moments, structured alumni engagement and peer connection can help reduce the gap, preventing isolation from turning into disengagement.

see Addiction Recovery on page 45

City Voices: A Peer-Run Legacy of Connection, Recovery, and Community

By Dan Frey
and Philip Yanos, PhD
City Voices



In 1995, a man named Ken Steele began what he described as his recovery from a "30-year schizophrenic odyssey." His story stretched across the United States — from Hawaii to New York City — through periods of homelessness, halfway houses, and profound disconnection. Everything changed when he arrived in Brooklyn and received compassionate, consistent mental health care at The Park Slope Center for Mental Health. That care sparked a desire in him to contribute something meaningful to others walking a similar path.

Ken began asking fellow patients to share their personal stories, opinion pieces, and poetry. He typed them up, photocopied them, stapled them together, and handed them out. That simple act of peer expression became the first issue of City Voices, a grassroots newspaper created by and for New Yorkers living with mental health challenges. Over time, the publication grew to reach an audience of more than 15,000 subscribers — a remarkable achievement for a peer-run project born from a folding table and a photocopier.

When Ken passed away in 2000 at the age of 52, one of us (Dan Frey, who had been working as an assistant to Ken) stepped in as editor-in-chief and continued producing the newspaper for the next 20 years. During that time, City Voices published personal narratives, news coverage, event reports, opinion essays, poetry, and reflections from across the New York mental health community. The newspaper served as a platform for people whose voices were often overlooked, offering a space where lived experience was treated as expertise (digital versions of back issues are available online at cityvoicesonline.org/newspaper).

As the world changed, so did the needs of our community. When the COVID-19 pandemic arrived, it became clear that City Voices needed to evolve beyond print media. Isolation was intensifying, and people needed connection as much as information. We transitioned to digital platforms and began expanding our mission from sharing stories to building community.

Two support groups, offered online through distance technology, emerged during this period and continue to this day. The first is a weekly spiritual discussion group, offering a space for people to explore meaning, grounding, and resilience. The second is a support group for peer specialists — professionals whose lived experience with mental health or substance use challenges allows them to build trust with clients in ways that traditional providers sometimes cannot. These groups became anchors during a time when many people felt adrift. Details on these groups can be found the City Voices website.

Of course, while distance technology can reduce barriers for connection, in person connection is still essential for all humans, especially people diagnosed with mental health conditions. When pandemic restrictions lifted, we began partnering with psychosocial clubhouse Fountain House to host monthly in-person events in a centrally located, welcoming space. These gatherings have included Social Anxiety Mixers, Drum Circles, Black History Storytelling Circles, Friendship Storytelling events, Barter Bashes, and Storytelling Masquerades. Each event is designed to reduce isolation, celebrate creativity, and strengthen community bonds. In addition, Fountain House members can participate in our weekly meditation groups, often led by experienced instructors who generously volunteer their time.

Another important initiative that was developed during the pandemic was

see City Voices on page 45

Beyond Boundaries: Oh, the Places Peer Support Can Go!

By Helen "Skip" Skipper, CPS, MA
Executive Director
NYC Justice Peer Initiative

Peer support has always been bigger than the box systems tried to paint it in. Long before it was codified, credentialed, or added into service plans, it was ordinary folk reaching for one another—standing in the front, behind and to the side of each other sharing hard-earned wisdom, offering dignity where systems offered labels, creating connection where isolation and stigma had taken hold and catching us when we fell. In behavioral health, peer support emerged from recovery, mutual aid, and consumer-survivor-led movements that insisted people are more than diagnoses, more than case files, and more than the worst moments of their lives. The field's early scholarship reflects that foundation, describing peer support as rooted in mutuality, shared responsibility, respect, and the belief that lived experience is a legitimate source of knowledge, not a bare-bones substitute for professional expertise (Mead et al., 2001; Solomon, 2004). That foundation still matters. That foundation is our bedrock where our path is engraved with the footsteps of those who started this good trouble but are no longer here. But the truth is, peer support was never meant to stay in one lane — shackled and muzzled.

Today, peer support is moving well beyond its traditional beginnings solely in behavioral health and into multiple diverse settings. Places and spaces like the criminal legal system, housing, public health, crisis response, policy, legislative advocacy, and research. I shake my head in wonderment sometimes — we are forging ahead at the speed of light! I mourn (slightly at best) that this was not prevalent as I spent 25 years moving through systems — the behavioral health system (MH and Substance Misuse), homelessness, crisis, family court... all of these systems wrapped up in a big ugly red bow of the criminal justice system — it's the kind of present or fancy gift that keeps on giving what you never wanted — everything you don't need, and absolutely nothing you do need. The expansion of peer support is not mission drift — it is putting us in places and spaces where we are so very necessary and desperately needed. It is a mission matured. It is the realization that folks do not live their lives in neat service categories, so support cannot remain siloed either. A person navigating recovery may also be leaving jail, fighting for housing, parenting through trauma, facing food insecurity, addressing physical health conditions, and trying to survive the daily weight of stigma — yeah...check all the above. And add into that potent witches' brew...struggling to achieve and maintain recovery and yes — wellness. Now there's a word I never heard as I came up through these systems — wellness. In this reality, peer support works because it meets the whole person where they are rather than a single system-defined problem. Research continues to show that peer support improves engagement, hope, empowerment, and recovery-oriented outcomes, especially for people who have been failed or stigmatized by traditional systems (Chinman et al., 2014; Davidson et al., 2012). What peers often bring that institutions cannot manufacture is credibility.

That credibility is grounded in lived experience. And let me be clear: lived experience is more than valid — for me — it is the epitome — the pinnacle. It is not anecdotal fluff. It is not charity. It is not tokenism. It is knowledge forged through surviving and navigating systems that many decision-makers only know from reports, policies, or statistics — or yes — academia. As an academic myself — I'm not shooting

see Beyond Boundaries on page 47

Strengthening Peer Services in Behavioral Health: Operational Considerations for Sustainable Integration

By Imani Brockington, BS, MA, LMFT
Behavioral Health Care Manager
Integral Health

As a Licensed Marriage and Family Therapist (LMFT) and Behavioral Health Care Manager working within integrated care systems, I regularly see how deeply relationships and social environments shape an individual's worldview, self-confidence, and sense of safety in the world. Recovery does not happen in isolation, nor does it happen solely through clinical knowledge or information gathered online. It happens in the context of connection.

Over time, both my clinical work and my systems work have reinforced something I have always believed intuitively: humans are inherently relational beings. We are born into families, shaped by attachment experiences, and regulated through connection with others. When individuals feel seen, understood, and able to show up authentically, their nervous systems respond differently. Their hope increases. Their engagement increases. Their willingness to try again increases.

In my role within collaborative and integrated care settings, I often see how engagement shifts when a patient feels emotionally safe with someone on their care team. Sometimes progress is less about the intervention itself and more about the relationship that makes the intervention possible.

Research consistently supports this truth. The quality and accessibility of social relationships are strongly associated with mental health outcomes, resilience, and even mortality risk (Umberson & Montez, 2010; Holt-Lunstad et al., 2024). Connection is foundational to healing and well-being.

What Peer Support Is and What It Is Not

Peer support is typically defined as support provided by individuals with lived experience of mental health conditions or substance use recovery who are trained to assist others navigating similar challenges (Value of Peers, Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Peer specialists may offer emotional support, advocacy, recovery coaching, and practical guidance, often helping individuals navigate systems that can otherwise feel overwhelming or impersonal.

It is important to clearly distinguish that peer support is not therapy, traditional case management, or clinical treatment. The effectiveness of peer services often lies precisely in what differentiates them from clinical roles, shared lived experience, mutuality, and authenticity. When organizations blur these boundaries, they risk undermining the unique relational value that peer specialists bring to care teams.

The Power of Shared Experience and Perceived Understanding

As clinicians, many of us have witnessed firsthand the rise of mental health advocates and social media influencers. I have noticed in sessions how quickly a patient can develop trust in online figures when they perceive and feel understood by someone who has "been there" before. Many patients spend significant time online gathering information (whether credible or not) and

see Strengthening Services on page 48

Strengthening Peer Services Through Partnership

By Jeremy Reuling, LCSW, NYCPS, CPRP
Senior Director of Special Projects
Hands Across Long Island (HALI)

The expansion of peer-delivered services is one of the most significant developments in behavioral health over the past decade. What was once a rare, little-known role has become mainstream. A 2024 report by the Peer Recovery Center of Excellence estimated that more than 100,000 individuals nationwide have been certified as peer providers in mental health or substance use dependence (SUD) services, and that number continues to grow.

Today, trained peer professionals work across crisis services, emergency departments, inpatient and outpatient programs, housing, outreach teams, community-based settings, and more. Their presence reflects a broader shift toward a recovery-oriented behavioral health system.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), peer staff foster hope, accelerate engagement and the development of trust between individuals and their treatment/support teams, and illuminate potential pathways to recovery. When well implemented, clinical providers and peer professionals complement one another, leading to a more responsive, person-centered approach to service delivery.

Despite this growth, many organizations continue to struggle with implementing peer services with fidelity. Challenges often include unclear role definitions, supervisors unfamiliar with peer practice, workplace cultures that misunderstand the peer function, and policies that were never designed with peer roles in mind. In addition, limited career pathways and advancement opportunities can contribute to turnover and workforce instability. This also affects agencies' ability to find and recruit qualified peer professionals.

While most agencies approach peer integration with good intentions, many lack the infrastructure, training, or bandwidth to fully support the role. In some cases, peer positions are added to meet funding requirements without sufficient attention to organizational readiness.

The rapid expansion of the peer workforce presents additional challenges. Many peer professionals are new to the nonprofit workplace and must navigate unfamiliar organizational cultures. In programs where only one peer role exists, staff may experience professional isolation and lack opportunities for peer-to-peer learning and solidarity.

Maintaining fidelity to peer values can also be complex. Some staff experience "peer drift," gradually taking on clinical tasks outside their scope. Others may become overly rigid in protecting role boundaries, straining team dynamics. Both patterns highlight the need for strong peer-informed supervision and organizational clarity.

While implementation challenges are real, traditional behavioral health agencies do not have to navigate them alone. Peer-run organizations represent a critical and often underutilized resource in building strong, sustainable peer services.

Led and staffed by individuals who openly disclose significant lived experience of trauma, mental health challenges, substance use, and other major life disruptions, including incarceration and housing instability, peer-run organizations bring both professional expertise and historical perspective to the field. Many were instrumental in shaping the early development of peer roles and continue to steward the values and practices that define the profession.

Beyond understanding the role conceptually, peer-run organizations have decades

see Partnership on page 36

Implementing and Sustaining Peer Support: The Recovery Workforce Learning Collaborative (RWLC)

By Maria E. Restrepo-Toro, BSN, MS
Chyrell D. Bellamy, PhD
Graziela Reis, MPH, BS
Sai Snigdha Talluri, PhD, CRC, LPC
and Megan Evans, PhD
Program for Recovery and Community Health (PRCH)
Yale School of Medicine

The integration of peer recovery support specialists represents a significant shift in behavioral health systems. Peers offer unique perspectives and authenticity that strengthen recovery-oriented systems of care (Davidson et al., 2021). Drawing on lived experience, they bring insights that support workplace transformation and engagement (Davidson et al., 2016). However, successful integration requires more than hiring peer staff; it requires intentional cultural shifts, clear role definitions, and systematic strategies for organizational transformation (Byrne et al., 2021).

Implementing Peer Supports in the Behavioral Health Workforce

People often ask: ***Why is this needed? Why a learning collaborative for peer support integration****?*

Our answer comes from decades of collective work, beginning in the early 1990s. For many years, we trained peer supporters and helped place them into traditional mental health systems. At first, there was excitement. Hope. A sense of possibility.

But too often, that hope faded.

Peer and lived experience workers often felt uncertain about their roles, and the authenticity and connection that made their work powerful did not always translate into organizational structures built around clinical hierarchies. They encountered unclear expectations, limited supervision models suited to their work, and roles that shifted unpredictably.

Organizations also struggled. The agencies that hired peers were unsure how to support or integrate them effectively. Many knew that peer support was important, sometimes required by funding or policy, but they were unsure about the why, the what, and the how. Job descriptions were vague, supervision models were poorly defined, and without intentional structures, the promise of peer support often went unrealized.

We realized we were doing a disservice to everyone.

From that realization, a new vision emerged. Early efforts to address these challenges began in Philadelphia under the leadership of former commissioner Dr. Arthur Evans, where initiatives focused on helping behavioral health organizations understand how to integrate peer support roles into traditional systems of care. Those experiences revealed many of the same barriers agencies continue to face today: a lack of role clarity, limited supervision models, and organizational cultures not yet prepared to fully embrace lived expertise. This early work was conducted in partnership with peer leaders, community advocates, and behavioral health organizations in Philadelphia who helped demonstrate the importance of organizational readiness for peer workforce integration.

Building on those lessons, in 2017, our work evolved into the first iteration of what is now known as the **Recovery Workforce**

see RWLC on page 50

Measuring What Matters in Peer Support: Using Competencies and Fidelity to Strengthen the Workforce

By Megan Evans, PhD
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Sai Snigdha Talluri, PhD, CRC
Graziela Reis, MPH, BS
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Program for Recovery and Community Health (PRCH), Yale School of Medicine

Peer support, a cornerstone of recovery-oriented behavioral healthcare, is a rapidly expanding service model nationally. Delivered by individuals with lived experience of mental health challenges, substance use, trauma, or disability, peer supporters use shared experience, mutuality, and hope to provide relational support to others undergoing similar challenges. First introduced as a service model in 1991, peer support became Medicaid-reimbursable in 2007, and programs in 48 states and the District of Columbia offer reimbursement for these services currently. Forty-nine states have peer certification processes, and over 100,000 people have been trained nationwide.

As the peer workforce continues to grow, it is important to build the infrastructure needed to support it. Because peer support is delivered in many different settings and ways, questions such as the following have emerged:

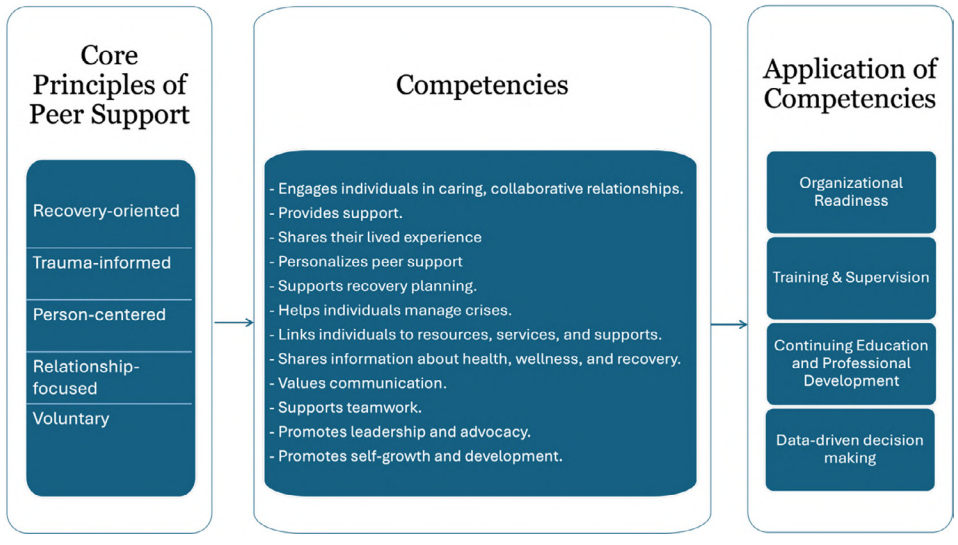

Figure 1: Application of core competencies of peer support

- How can organizations make sure peer support stays true to its core values?
- How can systems measure the impact of peer support while maintaining its relationship-based nature?
- How can we scale the workforce to meet client needs without losing the value of lived experience?

Addressing these questions requires moving toward the **next phase of workforce development: developing a peer-informed fidelity measure** to assess whether peer support is being delivered as intended. National efforts led by the Substance Abuse and Mental Health Services Administration (SAMHSA) helped identify core competencies of peer support. These competencies guide training, certification, and role clarity while strengthening the recognition of peer work and maintaining its recovery-focused values.

Core Competencies as a Foundation for Peer Workforce Development

SAMHSA's core competencies of peer support (Figure 1) are grounded in the following values:

- Recovery-oriented
- Trauma-informed
- Person-centered
- Relationship-focused
- Voluntary

Competency frameworks can help clarify peer roles, inform training programs, and support the development of certification standards across states. They can provide a shared language that helps organizations understand what peer support is, and what it is not, providing clarity around the peer support role.

While these competencies define what peer support should look like, they do not necessarily provide tools for assessing whether those practices are being implemented in real-world settings. This gap has important implications for both workforce

see Measuring on page 52

The Power of a Peer Specialist: Sharing Lived Experience to Support Recovery

By Glenn Slaby, MBA, MFA
Certified Peer Specialist,
PROS Program
St. Vincent's Hospital Westchester

"It is people who go through suffering that have an empathy for the suffering of others." - Mary Robinson

Traveling through suffering is best shared. Learning from suffering and being able to pass on knowledge is a blessing. Working with mental health consumers, I can see myself in their struggles and doubts, and hopefully they see hope from my struggles. Can the flow of such exchanges be like a ripple in a pond reaching outward, touching unknown shores?

Being a peer is more than just exchanging ideas and skills. It can also be a bond, because we can be more than just therapist and client. Unlike working with a therapist, the walls of separation are different, and the connections are different. There is a commonality of experiences, of pain, of disappointments, hopes, and successes shared.

My successes and failures, I can pass them onward. Who could have thought I would be stronger today? After involuntarily leaving an accounting career, after being misdiagnosed for twelve years, after several inpatient stays (five in five months), I would achieve an MFA in Creative Writing. Therapy developed mental resilience to survive radiation and chemotherapy and become a peer. Accomplished through therapy and using taught skills, treatment can bring a renewed future. Guiding by example.

My Groups

Weekend Planning: Via research, contacting local communities for everything from free events to food pantries. Making sure clients have something to do and are not overwhelmed by being alone or by downtime.

What's New in the World: Discussions on issues affecting clients, new developments in the sciences, sports, nature, etc. Learning how fortunate we are (see the Village of 100). Avoid specific topics. Enhance goodwill.

Men's Group: As most of the therapists are women, a session to talk freely about any subject.

Symptoms Management: Discussing issues occurring, preventing relapses, and skills to use. Sharing ideas, experiences, and what has personally worked.

Welcoming New Clients: Making new consumers feel comfortable. Giving tours of our facilities. It can feel like entering a class in mid-semester.

Socializing: Our recreation center offers various activities, from cards to movies, with an open policy. Location of the free bookstore, where clients, staff, and all programs can take what they desire. There are no sign-out sheets. Books do not have to be returned. Also, the location of free information and resources from all levels of government and various organizations.

Filling In for Therapists: We are there, we are the backups, the reserves, continuing the care clients deserve and need. Consistency of treatment.

see Lived Experience on page 54

Centered in Lived Experiences: Peers Reshape Engagement in California's CARE Court

By Linda Boyd
and Nilsa Gallardo
Los Angeles County Department
of Mental Health CARE Program

Living with the symptoms of a serious mental illness can feel isolating and debilitating. It can also breed distrust, which makes it difficult to accept services and support. These challenges were top of mind when the CARE Act launched in Los Angeles in December 2023, establishing a civil court pathway to connect people living with eligible psychotic or mood disorders to treatment, services, and housing.

In Los Angeles County, we have found that engaging peers in this work on the front end of the civil court pathway is essential to help our clients engage in the process and significantly advances their recovery.

One of our Senior Community Health Workers, Liroy Williams, experienced childhood adversity and mental health challenges. He recently shared a story of a client with schizophrenia living in unstable housing.

"When I would go get him to take him to appointments in the community, he had all of these concerns," Williams said. "He was afraid to go outside and communicate with other people. I said, 'Is the world going to end if you go? We can't control how people think or expect them to think the way we do.' To overcome my own challenges, I've had to accept that and stay focused on what I can control."

After building trust and engagement through consistent peer support, Williams's client began regularly going to his therapy appointments on his own, and is now living in stable, independent housing and able to manage weekly activities.

In LA County, peers—both certified peer support specialists and those with lived experience in other roles—often lead the first interaction with CARE clients. They are a relational bridge to participants and a constant buffer to disengagement. They contribute to recovery plans and normalize treatment and court involvement. This partnership helps lower clients' stress response and brings compassion into what may otherwise feel like a scary legal process.

"I can never understand what [clients] are going through completely, but I can relate," said Williams. "I know what they've been through. When they ask really tough questions like, 'Why am I here?' I share my challenges. It can be a big motivator."

Unlike traditional case management, which can center on service coordination or treatment compliance, CARE begins with understanding. Peers have a unique lens into the stigma that surrounds psychotic disorders and the hesitancy some people feel about voluntary participation in a process with legal oversight. It makes peers like Reyna Leyva, a Medical Case Worker for CARE, even more effective in the field.

"I was skeptical at first about how our program would make a difference. Because I've been through the system, I know it's not easy. Now I advocate for our clients," said Leyva.

Peers' distinctive skill set is respected within our treatment teams. Our CARE teams meet daily. Everyone from clinicians and nurses to peers consult closely when there are high-acuity clients who need specialized support.

"We're able to pull in other systems experts so we can meet a person's needs," Leyva said. "For example, we had a client who had challenges with her medication. Trust is crucial for most of our client base, and we maintain it by helping them voice

see CARE Court on page 46

Substance Use Disorder: Supporting Individuals in Early Recovery Through Peer-Led Services

By Temitope Fabayo, BA, MBA-HR
DMC HomeCare

The first days and weeks of recovery from a substance use disorder are among the most precarious in any individual's health journey. Detoxification has been completed, the immediate crisis has passed, and now the real work begins: rebuilding a life without substances. Yet this is precisely when most people find themselves most alone — disconnected from family, unemployed, housing insecure, and surrounded by triggers in their physical and social environments.

It is in this gap between clinical treatment and sustainable recovery that peer-led services are proving transformative.

The Science of Shared Experience

Peer recovery support specialists (PRSS), also known as recovery coaches or peer mentors, are individuals with lived experience of substance use disorders who are trained to support others in their recovery journey. Unlike clinicians who treat from a clinical distance, peers offer something fundamentally different: the credibility of having been there.

Sarah Zemore, senior scientist at the Public Health Institute's Alcohol Research Group, puts it simply: "The findings are pretty clear that we can refer people to a range of empirically supported mutual help groups. The bottom line is that all of these groups are highly effective." Her research, examining everything from traditional 12-step programs to SMART Recovery and Women for Sobriety, found that greater involvement in mutual-help groups predicted better alcohol outcomes regardless of which specific approach individuals chose.

This finding matters because it suggests that the active ingredient may not be the specific philosophy or steps, but rather the human connection and shared experience at the core of all peer support models.

The Data Behind the Promise

The evidence base for peer-led services has strengthened considerably in recent years. A systematic review published in *Current Addiction Reports* synthesized findings from 28 multi-group studies involving 12,601 participants, concluding that "PRSS can play an important role in the SUD care continuum, particularly in helping individuals initiate and stay engaged with treatment."

Three specific studies illustrate the magnitude of this impact:

1. The West Virginia hospital study. Researchers examining more than 5,000 hospital encounters with patients experiencing opioid use disorder found that those who accepted a visit from a peer recovery coach had dramatically better outcomes than those who declined. Among patients who engaged with peer coaches, 60.8% achieved successful outcomes (initiating medications for opioid use disorder, receiving treatment referrals, or scheduling follow-up appointments), compared to just 17.1% of those who declined peer support. This difference — a success rate more than three times higher — represents hundreds of lives redirected toward recovery rather than continued use.

2. The Indiana re-entry program. For

see Peer-Led Services on page 51

Supporting Peer Mentoring as a Bridge to Campus Belonging

By Diana Damilatis-Kull, MA, LMHC
Stephanie Grindell, MA, LMHC
and Yan Mei Nie, MA, MS
Bridges to Adelphi Program
at Adelphi University

Across colleges and universities, students are experiencing increasing mental health challenges while simultaneously navigating the social, academic, and developmental demands of campus life. For many students, the transition to college represents their first time living independently, managing complex schedules, and forming new social networks. For neurodivergent students and those with social communication differences, these transitions can be particularly difficult. Navigating unfamiliar environments, interpreting social expectations, and building peer relationships may create additional stress that can impact both well-being and academic success. In response, institutions of higher education are increasingly exploring ways to provide meaningful support that fosters both inclusion and independence.

Peer mentoring programs represent a powerful and often underutilized strategy for supporting student success while promoting community inclusion and belonging. By pairing students with trained peers who can model social engagement and provide consistent support, these programs create opportunities for connection that extend beyond traditional academic accommodations.

The Bridges to Adelphi program, a campus initiative designed to support neurodivergent college students, integrates peer mentoring as a central component of its social support services. Through structured peer relationships, students are provided with consistent opportunities to practice social engagement, build friendships, and develop confidence navigating the university environment. The program emphasizes the importance of experiential learning in social contexts, recognizing that social skills and community participation are most effectively developed through meaningful interaction with others.

The Role of Peer Mentors

Peer mentors within the Bridges program are volunteer Adelphi University students who are recognized as leaders within the campus community. These mentors meet with participating students for approximately one hour per week, engaging in a range of social and campus-based activities designed to help students feel more comfortable and connected within the university setting.

Activities vary depending on student interests and may include attending campus events, exploring student clubs and organizations, studying together, walking around campus, visiting the student center, or simply practicing everyday social interactions in a relaxed and supportive environment. These shared experiences help students become more familiar with the rhythms of campus life while also creating opportunities to develop natural peer relationships.

Rather than focusing solely on formal instruction, peer mentoring emphasizes social modeling. Mentors demonstrate how to initiate conversations, navigate group settings, and participate in campus life in ways that feel authentic and accessible. Students are able to observe these interactions and gradually practice them within a supportive context. This approach allows social learning to occur organically, reducing anxiety and increasing confidence in social environments.

Through these relationships, students gain opportunities to develop authentic connections and experience the sense of

see Bridge to Belonging on page 53

The Value of Being Seen: Acknowledging the Importance of Shared Identities and Lived Experiences

By Dr. Jantra Coll, PsyD
and Damon Watson, MPH, LPC
Vibrant Emotional Health

It is a well-known fact that our traditional mental health care system has experienced a strain over the past six years. Not only are there ongoing needs for services across communities, but also an ongoing staffing crisis that impedes the successful delivery of those services. Mental health challenges from suicidality, stress, bullying, substance misuse, family planning, systems navigation, and relationship woes require innovative approaches to mental health service delivery. For many, the process of accessing a mental health service is even more challenging during their time of need, due to lengthy intake processes and changes in providers. Recent data indicate that our current national network of healthcare providers is only meeting 26% of the actual need, and an additional 6,200 providers would need to be hired to help alleviate this shortage.

Peer Specialists are uplifted as a valuable resource to support the complex needs of communities. In 2025, New York State awarded $2.75 million toward bolstering the Youth and Family Peer Advocate Workforce. Though Peer Specialists have been acknowledged as offering a unique approach to utilizing lived experience(s) to support those dealing with mental health concerns, the idea of lived experience has been an ambiguous concept. Peer lived experience has historically been linked to mental health challenges and concerns, meaning to be a successful peer, one must have had the same challenge as the specific population served. However, the understanding of shared lived experiences can be broadened to appreciate all aspects of a person that contribute to their mental health. In fact, peer work is understanding the need for genuine acknowledgement of the many facets of a person that need to be seen and understood. Those are the essential elements of any helping professional that can coalesce with the identities of our help seekers.

At Vibrant Emotional Health (Vibrant), we have prioritized peer roles across all service lines: crisis hotlines, youth education, and family and youth wellness programming. However, we emphasize the importance of all clinical professionals and leaders to consider their own identities in their work and how it is mirrored in the experience of those they support.

Consider the current state of Youth Mental Health in the United States. It is well documented that there is a current Youth Mental Health Crisis, where 40% of high school students express feelings of hopelessness, and due to several environmental and systemic barriers, youth have not engaged in therapeutic services. Innovative programs that integrate mental health with day-to-day educational support may be the key to supporting this population. The Fellowship Initiative, funded by JP Morgan Chase, models an innovative approach by offering comprehensive social and emotional wellness support to youth during formative years of their development; Vibrant integrates mental health support in all facets of their educational journeys as they apply for college. Clinical Youth Leaders, mental health professionals who share identities with the youth, are essential in this strategy. They can connect with their

see Being Seen on page 49

The Need for More Effective Approaches to Mental Health Crises

By Dr. Gene Ira Katz, DMCJ, LAC, LPC
Positive Pathways Counseling

Law enforcement officers are most often the first responders when individuals are experiencing a mental health crisis. Some research studies have estimated that at least 20% of police service calls involve a mental health or substance use crisis, and this demand has been increasing for many departments across the US. In a nationwide survey of over 2,400 senior law enforcement officials, approximately 84% reported an increase in mental health-related calls during their careers, and 63% noted that their departments now spend more time on mental illness calls than ever before.

Over the past few decades, the way that police agencies handle these encounters has come under increased scrutiny. Concerns have been raised by people diagnosed with mental illness and mental health advocacy groups, particularly regarding interactions that involve the use of force. One study estimated that one in four people with a mental health condition have been arrested at some point in their lifetime. This increase in mental health-related cases and incidents has progressively led leaders and policymakers to question the adequacy of officers' training in responding to such mental health crisis calls, and progressively more communities have been developing programs wherein police and professional mental and behavioral health clinicians have been collaborating more closely on such emergency call responses.

Policymakers have shown a keen interest in improving police responses to individuals experiencing mental health crises through numerous hearings and more robust legislation. A joint report by the Vera Institute of Justice and Bazelton Center for Mental Health Law underscores the US Departments of Justice (DOJ) and Health and Human Services (HHS) strong support for federal laws mandating that individuals with behavioral health and other disabilities are to receive a *health response*—not a *law enforcement* response—in situations where others would receive a health response. In other words, when someone is experiencing a mental/behavioral health crisis, a team of workers with mental health expertise should be dispatched, similar to how an ambulance would be sent for a physical health emergency. Failing to provide this type of response can be considered a violation of the civil rights of the individuals involved.

In addition, the DOJ and HHS assert that deploying co-responder teams, which pair officers with clinicians, can be considered a "reasonable modification" in situations where a police response is necessary. However, continual reliance on co-responder teams and other police-led approaches will tend to "perpetate the criminalization of individuals experiencing behavioral health crises." They also emphasize that ongoing federal guidance and support is available for communities that have historically depended heavily on police for mental crisis responses who want help in reducing police involvement related to such behavioral health situations.

While it may be fair to assume that of the approximately 18,000 US law enforcement agencies, few have actively followed the federal directives described above, it is also true that quite a number of communities have been successfully implementing effective models that follow the spirit, if not the exact letter, of the mandates regarding mental and behavioral health crisis incidents.

In exploring options for improving and enhancing their mental health incident responses, a number of agencies nation

see Mental Health Crises on page 55

Peering In: A Look at Mental Health Peer Providers and How They Help People Recover

By Emily Grossman, MA, CPRP
Peer Life Coach/ Keynote Speaker/ Author

I believe that recovery is possible. Not just for me, but for EVERYONE. Does this mean that everyone recovers? No, because not everyone is taught the skills to recover. Also, once a person learns the skills, they must choose to use them. My peer specialist colleagues and I can give you a flashlight so that you can see your way out of the darkness of mental illness.

Kids seem to have a sixth sense. At least that was my experience of them while teaching middle school about a decade ago. There I was, working hard, while also vigilantly trying to hide the fact that I had spent the previous decade in and out of treatment for bipolar II disorder. Yet, somehow, my students kept on coming to me with their mental health struggles. Could they somehow sense that I was more than just sympathetic -- that my empathy was that of a person who had experienced similar?

I will never clearly know the answer to this question -- but one thing did become clear: I had to help these kids, and not just in the traditional way that a teacher is allowed to help--the old guidance counselor referral -- but REALLY help. I remember my tenure year of teaching, when I sat down with another member of the staff at the school and told this person that I was resigning.

"Are you out of your mind?" my colleague said. "You have a stable job WITH a pension, and the economy is terrible. How could you give that up?"

My answer was simple: I needed to follow my heart-and my heart was with those kids-kids like me who could become anything they wanted if they were treated for their mental health struggles early. I knew this first-hand because I had lived it. After being in the psychiatric hospital at least 13 times during my college career, I graduated, gone to Columbia University to get a master's in education, and started my journey in recovery teaching the students that I loved.

Yet, because I had a huge loan out from my second degree, I couldn't afford to go back to school again for mental health, so I found an alternative: Peer Specialist training. It turned out that NJ had a program that trained people who were living in recovery from mental illness to provide mental health services to others. The concept was that a person with "lived experience" of mental illness and recovery could really help others to get well.

After the training, I went on to work as a peer specialist in community mental health centers, where I worked alongside social workers, psychiatrists, supported employment specialists, and others helping people to get well. I loved (and still love) the work. I even "hung a shingle" and began my own peer specialist practice, which still exists (shameless plug). And then, I got into training other mental health professionals and peers on how to implement services that really put the client and their recovery first (also known as Recovery-Oriented, Person-Centered services), which I still do also.

So, why do I believe in peer services so much? Well, first, I have seen first-hand how we can provide people with mental illness hope. No one can show a person that they can recover from mental illness

see Peering In on page 51

Peer Specialist, Heal Thyself: Recovery at Age 75 is Not Too Late

By Carl Alan Blumenthal, MS, MA, NYCPS (retired)

The Dream

Scene I
Psychiatrist X: We've got you covered….
Psychiatrist Y: Smothered
Psychiatrists X and Y: And if you don't perform, we'll make you permanent.
Me: Let me out of here and we'll all be free.

Scene 2
Social Worker Z: We're cancelling the group today.
Me: But I need to share my dream.

Scene 3
Me: My shrinks doubt me.
Peers A-W: You're so much better now.
Me: Then how come after 60 years of therapy, I'm standing smaller.
Peers A-W: Where would our shrinks be without us? Poorer.

On Becoming a Peer Specialist Before It's Too Late

Where would we be without labels? I'm an old, white, straight, middle-class guy, born and raised Jewish, now a liberal Protestant Quaker. (Our sect is known for its "honest to goodness," but never owned Quaker Oats.) If not for my bipolar disorder diagnosis in 1974, at age 22, I'd have lived out my life in psychiatric obscurity. While at my worst during periods of suicidal depression, alternating hypomania enabled me to bounce back, including professionally as a community organizer, urban planner, and journalist.

But it wasn't until 1999 when I heeded the plea of my mother, president of a community mental health center, to join the National Alliance on Mental Illness (NAMI Metro NYC) and tell my story publicly of how I had passed as "chronically normal" for so many years. In 2002, I cashed in my notoriety by becoming an employment specialist for Brooklyn, New York's Baltic Street Mental Health Board (now "Baltic Street Wellness Solutions"). By the time I retired from Manhattan's Fountain House in 2024, at age 73, I had worked as a peer specialist for a dozen agencies, my proudest stint being two years at NYC Well (now the 988 suicide and crisis line) during the pandemic.

Shooting for the Moon Medicinally and Falling Flat on My Face Emotionally

For years I had been reducing my dosage of the mood-stabilizer, Depakote, with the goal of eventually eliminating it. After all, in old age you need all the energy you can get. And being pre-diabetic, I was concerned about metabolic syndrome as a side effect. Cautioning against going cold turkey, my latest psychiatrist suggested I substitute Latuda, an anti-psychotic no less, to reduce that risk.

Unfortunately, around Easter last year, my hope for resurrection triggered what felt like a crucifixion. I fell into a depression with an agitation so great that, when I finally ran out of energy, all I could do was lie in bed for six weeks. Even though my wife, Susan, "force-fed" me, I lost 20 lbs. (down to 125). And stopping my medication didn't help. Hard to know how much this reaction to the new drug was complicated by such "losses" as retirement, a sister's death, and the completion of my "From Here to Recovery: Confessions of a Peer Counselor." (The letdown after completing a manuscript can be devastating.)

Remembering what a long and tortured process my brother's fatal anorexia had been, I finally admitted myself to the inpatient psych unit at Maimonides Medical Center, where I relearned that the quickest

see Not Too Late on page 54

The Power of Peer Support: Walking Alongside Someone Towards Recovery

By Julia Lopez
Peer Recovery Specialist
On The Road to Wellness

I remember the nights I'd cry, looking in the mirror, not recognizing the girl I was looking at. I wanted and needed a way out. With so much shame and stigma around substance use and mental health, I did not know how to ask for help. The process of calling detoxes and getting certain documents felt so hard for me to do, and scary when I was in my active use.

I often think about what I needed most, and it was not just receiving phone numbers to call. I needed guidance and connection with people who truly understood the fear, the anxiety, the exhaustion - someone who could walk alongside me with no judgment. Today, as a person in recovery and working as a peer recovery specialist, I see how these spaces create the bridge that feels safe, easy, and real between wanting help and receiving it.

I started working at On the Road to Wellness on November 3rd, 2025. Since working here, I have had so many beautiful experiences, but one in particular stays with me. A member would come in, some days feeling down and out, and other days up and restless. He started to hint about wanting to get sober but also mentioned reasons as to why he couldn't "yet": responsibilities to handle, needing an ID, only wanting to do treatment out of state, and needing to wait for the mail. These reasons were valid but also backed by fear, something I could see, feel, and relate to.

Certain tasks that may seem easy to others, such as making phone calls, paperwork, and appointments, can feel stressful and impossible for someone struggling with mental health and substance disorders. On The Road to Wellness was able to financially support him in getting his ID, and I was able to sit beside him at the DMV to support him through the process. He knew he didn't have to do this alone. He started to feel some hope. We were able to find an open bed out of state that would have taken him that day. Fear of the unknown stepped in, and he did not end up taking the bed. That is okay. We will continue to be a safe space with zero judgment or pressure for him.

On February 19th, 2026, he came in so defeated, sad, and just tired. He began to share that the night before was the anniversary of losing his child. He came in seeking support and again said he wanted to go to treatment. So, we made the calls, we got a bed, but again fear and willingness started to show up. These are the moments where peer support is so powerful. I was able to share parts of my experience, relate to how he was feeling, and normalize it. This time, he did not let fear win. He needed to keep his belongings safe, needed toiletries, and transportation. We made a plan and supported him in every way.

Ten minutes later, he agreed to do the phone screen. The open bed was ready. He packed his bag, got into an Uber, and went straight to treatment. That night, I received a message that he had arrived safely and had been admitted. In that moment, I was reminded why peer support matters. What makes the difference is having someone willing to walk alongside a person through the ups and downs, the phone calls, the paperwork, and the uncertainty of what comes next.

see The Power on page 55

The Invisible Adverse Childhood Experience (ACE): Parental Mental Illness

By Michelle D. Sherman, PhD, LP, ABPP
Board Certified Clinical Psychologist
Seeds of Hope Books

Children rely on their parents for so many things, such as learning how to tie your shoes, respect your elders, and navigate relationships with friends. Parents are often the first to celebrate their kids' joys and support them with the challenges of life. Parents teach and role model through their words as well as their behavior, demonstrating skills on how to manage strong emotions, get along with others, make healthy decisions, and solve problems.

When a parent is living with mental illness, all of these domains can be affected. Parenting is hard to begin with…but regulating emotions, solving problems, being attuned to and engaged with your child, and making healthy choices can be more difficult when managing mental illness.

Research on Parental Mental Illness

Parental mental illness is one of the ACE (Adverse Childhood Experiences) categories that has been studied for several decades. Research shows that about 1 in 5 youth lives with a parent managing a mental illness (Swedo et al., 2024). While the severity of the illness can vary considerably, about 4 to 7% of youth live with a parent with a serious mental illness (Campo et al., 2020), including schizophrenia, major depression, or bipolar disorder.

Many of these youth are resilient, drawing upon personal and community supports. Research has found these children can develop strong empathy and compassion, skills that can serve them well throughout their lives (Sabella et al., 2022).

However, research also shows that parental mental illness is a risk factor for a variety of physical and mental health problems, difficulties with social relationships, and academic challenges (Rasic et al., 2014). A recent very large meta-analysis (Uher et al., 2023) found that about half of children whose parents have major depression or bipolar disorder will develop some kind of mental illness at some point in their lives. About 20% of youth whose parent has psychosis will develop some form of mental illness. Thus, due to both nature and nurture, these young people are at increased risk.

The Youth Experience

Children whose parents manage mental illness often experience a wide range of feelings. They may be:

- Embarrassed at their parent's behavior in public
- Confused why their parent doesn't come to their school events
- Angry that their family has to manage this situation
- Scared that they will someday develop a mental illness themselves
- Sad at seeing their parent hurting
- Lonely when they feel invisible and misunderstood
- Hurt when their friends make fun of their parent

These challenging emotions can be amplified when kids feel like no one understands their experience and they don't have anyone to talk to.

see Invisible ACE on page 41

An Ecological Perspective on Policing and Behavioral Health

By Shane King, MSW, LCSW
Psychotherapist/Professor
Reflective Therapy LCSW, PLLC

The ecological model helps us understand how people's environments—from family systems to institutions like policing—shape behavioral health outcomes. Environmental determinants help explain how systemic and structural conditions contribute to mental health disparities. This article examines the ecological model's capacity to account for environmental influences on mental health and discusses its integration into the biopsychosocial paradigm.

Integrating the Ecological Model

The ecological framework investigates the interactions between systems and the development of individuals, families, and groups within their environments. It examines immediate contexts, such as a person's childhood home, alongside other influential systems that shape thoughts and behaviors in that environment. This model emphasizes core principles, including the relationship between environment and individual development, as well as the connection between the life course and the biopsychosocial framework.

Rationale for the Ecological Model

The ecological model provides a scholarly framework for analyzing systemic oppression through an anti-oppressive lens, offering context for the lived experiences of those from marginalized communities and for understanding human interactions within environmental settings at the individual, interpersonal, institutional, and structural levels. It emphasizes that human lives are shaped by lived relationships; however, the intersection of human identity in marginalized communities within institutional environments often reveals disparities. These environments tend to devalue humanity, enforce conformity, and restrict autonomy, identity, or safety among marginalized groups. When critical elements are missing, clinicians must intervene to deliver services and resources that support adaptation. Sometimes, this involves changing the environment, such as helping individuals returning from incarceration.

Ecological Factors in Policing Behavioral Health Crises

Banaji et al. (2021) explore how dehumanizing stereotypes related to marginalized groups influence policing behavior, leading to aggression and discrimination. These examples show that systemic oppression within the environment exists both between people and within organizations. The disparity in police shootings contributes to historical and generational trauma among marginalized communities. Police violence highlights the importance of critically evaluating law enforcement practices in marginalized communities. Ecological approaches support collaborative responses to behavioral health crises. Programs like Crisis Intervention Teams (CIT) foster partnerships between law enforcement, mental health professionals, and community groups to better address psychological distress, aiming to reduce escalation and improve access to care. Applying the ecological model through an anti-oppressive lens aligns with ethical principles and highlights the importance of assessing environmental risks that influence individual and family development.

Bio-Psycho-Social in Behavioral Health

The bio-psycho-social model explains

see Policing on page 49

Healing, Growth, and Purpose: Becoming a Peer Specialist

By Patricia Masi
Peer Specialist

On January 14, 1980 (my birthday) I sat at a drafting board at Island Drafting and Technical Institute in Amityville, New York, beginning my journey as a mechanical draftsperson. One thousand hours later, I earned my certification and was placed through the school's employment services at an engineering firm in Freeport, where I worked for four years. At the same time, I was pursuing my Associate's Degree in Advertising Art & Design at SUNY Farmingdale.

During my time at the Freeport firm, I learned to draw topographical maps, much of which supported the telecommunications industry. I spent countless hours drafting roadways, learning where to place conduit and how to develop the plans, profiles, and details that brought projects to life.

As the years passed, hand drafting gradually gave way to CADD. As an artist, however, I found computer-aided design to feel cold and impersonal. Eventually, I transitioned away from drafting and into a role as an Office Administrator. Over time, my attention to detail led me to specialize in assembling proposals. I worked for years under tight deadlines, coordinating documents from architects, engineers, surveyors, and subconsultants; typing, printing, and learning new design programs, priding myself on never missing a deadline. But that pace came at a cost.

Patricia Masi at an art show in Babylon, NY, with her painting *Eiffel Tower*, 12" × 24", acrylic on canvas.

After the birth of my son in 1988, while balancing part-time work in an architecture and engineering office while also working from home, I began experiencing what I would later understand as postpartum depression, along with panic disorder, anxiety, and agoraphobia. At the time, I didn't yet have the language for what I was going through. In 1990, the diagnosis finally came, months after I had reached a point where even leaving my home felt impossible.

For the next 18 to 24 months, I faced daily challenges, trying to "climb out of a paper bag" while simultaneously "breathing into one," overwhelmed by anxiety and relentless pressure. Difficult circumstances at home eventually led me to seek counseling, a decision that changed the course of my life and ultimately led to my divorce.

Through it all, I continued working while co-parenting my son with my ex-husband. I completed my Associate's Degree in Advertising Art & Design and later took on two additional jobs to make ends meet. Determined to keep growing, I returned to college and earned my Bachelor's Degree in Business, Management, and Economics at the age of 50. My son went on to build an international life, studying International Relations in the United States, having lived in Moscow, Russia, and eventually settling in Paris, France, where he currently resides.

In 1998, 2006, and 2016, I faced three separate diagnoses of early-stage breast cancer, ultimately undergoing a double mastectomy followed by multiple reconstructive surgeries. During that time, I was also illegally terminated from my job. After five months of unemployment, I secured a local position, though at a significant pay cut. Then COVID hit, and once again I found myself out of work. During that period, the Department of Labor offered a course to become an Addiction Recovery Coach, and I chose to pursue it. My instructor encouraged me to continue my education through the Academy of Peer

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support communities, and assist individuals as they transition from structured treatment back into their communities.

A recent OASAS survey found that 85 percent of providers report using peer services, reflecting the growing recognition that recovery-oriented systems of care benefit from integrating lived experience into service delivery.

Supporting Engagement Before and After Treatment

Peer services also play an important role in supporting individuals both before and after formal treatment episodes. OASAS guidance highlights the importance of preadmission services that help stabilize individuals as they begin the treatment process. Early peer engagement can reduce barriers to care and improve treatment initiation and retention.

Peers are increasingly deployed in settings where individuals may first encounter the behavioral health system, including emergency departments, courts, jails, prisons, and harm reduction programs. In these environments, peer professionals can help individuals navigate complex systems and facilitate connections to treatment and recovery supports.

OASAS regulations also allow outpatient programs to deliver services in community settings outside the clinic, enabling individuals to receive support in environments where they may feel more comfortable. Through collaboration with the New York State Department of Health and the Centers for Medicare & Medicaid Services, OASAS secured federal approval for Medicaid reimbursement of certain off-site services — allowing both peer and clinical supports to be delivered where people live and work.

Peer services are also central to continuing care, an important component of the

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Part 822 regulatory framework. Continuing care enables individuals to remain connected to outpatient treatment long term. Through peer support and related services, individuals can maintain connections to care during periods of stress, return to use, or major life transitions — recognizing that recovery is often long-term and non-linear.

Building and Supporting the Peer Workforce

As peer services expand across the system, workforce development and effective supervision are critical to sustaining their impact.

New York State has placed increasing emphasis on strengthening peer supervision. The InUnity Alliance New York Certification Board has developed a Peer Supervision Professional Certification to ensure supervisors have the skills and competencies needed to effectively support peer staff. Clear supervision structures help maintain the integrity of the peer role while promoting professional growth and accountability.

Equally important is helping clinical staff and administrators understand the distinct role of peer professionals. Peers are not substitutes for clinicians; rather, they provide complementary support rooted in lived experience, empowerment, and recovery coaching.

OASAS continues to expand the peer workforce by supporting training, professional development, and leadership opportunities. Through initiatives such as the Addiction Professionals Scholarship Program and the OASAS Leadership Academy, the agency is investing in the next generation of recovery professionals. To date, OASAS has awarded more than 150 scholarships to support individuals pursuing the Certified Recovery Peer Advocate credential.

In alignment with Governor Hochul's priorities, OASAS is also working to develop specialized training and certification pathways for peers supporting individuals affected by gambling harms. Additional initiatives are underway to expand recovery support services, including peer services, that address the unique cultural and developmental needs of young adults.

To further strengthen the field, OASAS and the recovery community have established peer and peer supervisor learning collaboratives. These collaboratives provide opportunities for shared learning, mentorship, and systems improvement across the state, while also helping organizations meaningfully integrate peers into their programs.

OASAS is also collaborating with the Office of Mental Health to convene peer professionals working across behavioral health systems. A statewide conference dedicated to peer professionals is currently in development and will further support knowledge exchange and workforce growth.

Strengthening Recovery-Oriented Systems of Care

The expansion of peer services represents an important evolution in how addiction treatment systems support recovery. By integrating lived experience alongside clinical care, programs can create environments that are more engaging, responsive, and person-centered.

Across New York State, peer professionals are helping individuals build hope, strengthen resilience, and sustain recovery over time. As OASAS continues to advance peer integration across the behavioral health system, the role of lived experience remains clear: people in recovery are not only beneficiaries of care - they are essential partners in helping others achieve it.

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disconnected from hope and opportunity. They help people begin to see that change is possible, even in the midst of difficult circumstances.

Together, these peer-led services help bridge individuals from long-term hospitalization, incarceration, or crisis into community life with dignity, support, and connection.

The Power of Community-Based Peer Support

Community-based peer services are especially important for people rebuilding confidence after repeated crises, hospitalization, or prolonged disconnection. In these settings, recovery is not just discussed—it is practiced. People learn to reconnect with others, strengthen communication, set boundaries, develop coping skills, and navigate everyday challenges with greater confidence.

When individuals experience consistent connection, they are more likely to stay engaged, ask for help earlier, and sustain progress over time. Peer services also function as an early intervention strategy. Welcoming spaces and trusted relationships can help people recognize warning signs and seek support before a situation escalates. This timely support can reduce avoidable emergency department visits and inpatient stays while helping individuals remain connected to housing, employment, education, and family responsibilities (Davidson et al., 2012).

To be most effective, peer roles must be supported with training, reflective supervision, and meaningful integration with care teams. Peers should be included in discharge planning, warm handoffs, and community follow-up so that transitions do not become gaps in support. When peer services are properly integrated, people experience continuity rather than feeling as though they must start over every time they encounter a new part of the system.

Why Peer Services Matter Now

Peer support should be viewed as core behavioral health infrastructure, not an optional add-on. It complements clinical care, strengthens engagement, and helps prevent crises by keeping people connected to supportive relationships and practical recovery tools. It also advances equity by reaching individuals who may avoid traditional settings because of stigma, past negative experiences, or cultural barriers.

At its core, peer support reflects a simple but powerful truth: people heal in connection with others. That is why peer services are so essential to a system that seeks not only to treat symptoms, but to support whole-person recovery.

A Path Forward

To fully realize the impact of peer services, we must continue investing in sustainable peer roles, strong supervision, and meaningful integration across settings. We must also recognize that recovery-oriented systems are strongest when lived experience is not just included, but valued.

At MHANC, our purpose is to serve as the path to mental wellness and recovery by transforming our community's experience with trauma. Peer services are a critical part of that mission. When peer support is resourced and respected, it helps people reconnect, heal, and thrive—and strengthens communities by transforming how we understand trauma, recovery, and hope.

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indicators of distress. These may include noticeable shifts in behavior, increased irritability, withdrawal, changes in performance, conflict, or increased absences. This step is not about diagnosing. It is about noticing and taking concern seriously.

A - Approach with Care. Learn how to begin a supportive conversation in a way that reduces defensiveness and stigma. This includes choosing the right time and place, using respectful language, listening without judgment, and communicating care rather than criticism. In practice, this means focusing on what you have observed and asking open, supportive questions.

F - Find Support. Identify pathways to help that match both the workplace and the individual's needs. Support may include internal resources, external options such as EAPs or community-based services, or immediate safety supports when warranted. A key principle is knowing what is available before an urgent situation occurs.

E - Engage and Encourage. Follow-through matters. This step emphasizes ongoing support, encouragement, and appropriate check-ins. It reinforces that reaching out for help is not a one-time event and that recovery and stability often

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require more than a single conversation.

What SAFE Changes in Workplace Culture

It works because it is both practical and relational. SAFE focuses on human connection rather than rigid policy. It does not begin with policy; it begins with people. It helps workplaces strengthen what behavioral health has long recognized as essential: connection, empathy, boundaries, and clear pathways to support.

The World Health Organization emphasizes that psychologically safe workplaces rely on supportive communication, early recognition of distress, and clear pathways to help - all core elements of the SAFE model (World Health Organization, 2022).

When staff share a common framework, important shifts can occur. Employees are more willing to speak up early when something feels off. Conversations become more respectful and less reactive. Workplaces become better equipped to connect individuals to help before problems escalate.

SAFE also reinforces an important distinction: supportive workplaces are not workplaces without challenges. They are workplaces that respond to challenges with clarity, compassion, and responsibility.

The Role of Behavioral Health Organizations

Behavioral health providers have a unique opportunity to help communities extend support beyond clinical settings. Although workplaces are not designed to provide treatment, they can serve as protective environments where individuals feel seen, supported, and connected to the help they need.

In that sense, SAFE reflects a broader principle: mental health is not only a clinical concern; it is a community concern. Models that translate behavioral health values into everyday environments strengthen prevention, reduce stigma, and expand access to early support.

A Path Forward

Workplaces do not need to become clinical. They need to become capable - capable of recognizing concern, approaching people with care, and connecting individuals to support without shame. With shared language, clear steps, and a culture that values dignity, organizations can move from awareness to action and help create safer, healthier communities for everyone.

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of practical experience delivering community-based services. They understand what has worked, what has not, and how to implement peer services in ways that remain faithful to core peer values.

Perhaps most importantly, their commitment to peer services is deeply personal. Peer-delivered services emerged in response to system failures that directly affected and sometimes harmed many of the individuals who built these models. That history continues to inform today's peer leaders, driving efforts to create behavioral health systems that are more responsive, compassionate, and recovery oriented. At HALI, a peer-run organization serving Long Island for nearly four decades, we have seen firsthand how partnering with traditional providers strengthens workforce development and improves outcomes.

Peer-run organizations can support traditional behavioral health agencies in multiple ways. From strengthening workforce infrastructure to partnering directly in service delivery, the following strategies illustrate practical approaches that have been used successfully to enhance peer workforce development and implementation fidelity. These approaches are not exhaustive, but they illustrate how peer-run organizations can serve not only as service providers, but as workforce and systems partners.

Peer Recruitment Support: Peer-run organizations can help traditional agencies refine recruitment strategies to better attract qualified peer professionals. This may include reviewing job descriptions and other recruiting material to ensure alignment with peer role standards, strengthening onboarding practices, and advising on outreach methods that reach appropriate candidate pools. Because peer-run organizations are often deeply connected to peer networks and training communities, they

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can also serve as a direct pipeline for identifying strong candidates.

Supervision Support: Agencies that lack supervisors experienced or knowledgeable in peer practices may benefit from external supportive supervision. One effective model is co-supervision, in which a supervisor from a peer-run organization provides guidance to both the peer professional and their non-peer manager.

Meetings with managers often focus on education regarding peer values, role definition and standards, and effective team collaboration. Sessions with peer staff emphasize skill development, role clarity, self-advocacy, and strategies to prevent "peer drift." When needed, joint meetings can facilitate shared problem-solving and strengthen team alignment.

Reflective Practice for Peer Staff: Reflective practice, sometimes described as group supervision, provides peer professionals with a structured space to share experiences, process challenges, and learn from one another. It functions as "peer support for peer supporters," helping staff maintain role fidelity, strengthen skills, and reduce professional isolation. Peer-run organizations are well positioned to facilitate these sessions and can help agencies build internal capacity to sustain reflective practice over time.

Training for Non-peer Staff: A common barrier to successful peer service implementation is lack of understanding among non-peer team members. Targeted training can help clarify the peer role, strengthen collaboration, and reduce misconceptions that undermine integration. Since peer-run organizations have a deep and nuanced understanding of peer roles and often have multiple staff who are experienced in training on that topic, they are well positioned to educate staff and boards on how to meaningfully incorporate peer professionals into multidisciplinary teams.

Partnering in Direct Services: In certain circumstances, an organization may wish to offer peer services but lacks the time, resources, or infrastructure to hire, train, and supervise staff independently. In these situations, a peer-run organization can operate as a subcontractor, placing experienced peer professionals to fill roles in the programs that need them. Under this model, peer staff receive task supervision from the onsite manager but continue to be paid by and receive supportive supervision from the peer-run organization. Clear communication between agencies is key for these arrangements to succeed.

Program Design: As the evidence base for peer-delivered services has continued to grow, many behavioral health organizations have shown interest in adding them as a service option. However, they often are unsure where to begin or what elements are necessary to build an effective peer service model. Peer-run organizations are in an ideal position to assist in designing programs that maintain fidelity to peer values and practices. This may include helping to establish overall program structures, developing policies and procedures, defining staff roles, or planning supervisory frameworks.

Organizational Culture Development: A critical yet often overlooked element of successful peer service implementation is ensuring that an organization's culture is prepared to incorporate them. Peer-run organizations understand the nuances of what a "peer-ready culture" looks like, including a person-centered orientation, belief that recovery is possible, trauma-informed practices, and a strong commitment to staff wellness. An agency may engage a peer-run organization to assess its readiness by reviewing policies, procedures, and program materials, as well as exploring staff attitudes and beliefs through qualitative discussions. When organizational culture becomes more welcoming and aligned with peer values, the benefits extend beyond peer staff to the entire workforce.

While the challenges of expanding peer services in behavioral health services are significant, they are not insurmountable, and the potential benefits are enormous. When traditional behavioral health agencies approach implementation with intention, care, and attention to detail, the entire system of care, especially those who participate in services, will benefit from it. Peer-run organizations, beyond the highly beneficial direct services they provide, are invaluable community partners who can play a key role in helping traditional providers realize that vision.

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heard, it's fuel to drive success and to drive recovery.

Family Peer Support fosters family driven care, bridges families with providers, and naturally supports positive successful engagement and trust. When trust is mutual, families feel less judged and stigmatized. Facing her challenges, my daughter experienced judgment - judgment from her peers, her teachers, even members of our family. As her parent, I too faced the same judgment. The shame was at times debilitating. Through support from my Family Peer Advocate, the stigma we experienced started to lift. Family Peer Support provided me with validation, allowing for an empowering journey toward my daughter's recovery. Having faced adversity and stigma, I have highly regarded those that share their lived experiences to support and guide those in need which also led me to become a credentialed Family Peer Advocate in support of other parents.

The web that is the children's mental health system challenges parents when they do not need additional challenges in life. A system designed to support emotional health, well-being and provide preventative support is often accessed not for prevention but rather when crisis strikes. Due to the stigma that accompanies mental health, families do not readily seek support services until they are in a crisis situation. Families enter the system already overwhelmed and at a disadvantage for navigating and understanding it. This is not due to lack of services or providers but more so because there is no guide or handbook. You may have case managers, therapists, crisis support, school counselors, all working toward a shared goal of successful interventions, all sharing their expertise and guidance. For a parent, that is equivalent to being in a room where everyone is loudly shouting suggestions at the same time - overwhelming, difficult to process and intimidating. In those moments, families can lose their sense of self and lose their voice.

Family Peer Support enhances the children's mental health system in many different valuable ways. I have witnessed and experienced this at varying levels, from working with small grassroots agencies in creating Family Support Programs to amplifying family voice at the state level.

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Family Peer Advocates have become partners in program and service development, as well as development of policy and regulation guidance. Services and supports designed for families and children should be driven by the very same people accessing and utilizing them. Family Peer Support not only creates bridges between providers and families but also between families and system development.

Gaining momentum for its importance in elevating family driven care, Family Peer Support has evolved and is present in the various tiers of the mental health system - from community-based service supports, in-patient treatment facilities, residential treatment to crisis intervention. Similar to my experience, the literature shows that Family Peer Support Services can be a welcome addition to traditional mental health programs (Hoagwood et al., 2010; National Federation for Families, n.d.; Radigan et al., 2014). Parents and other caregivers can benefit from connecting and speaking with someone who has been in their shoes. They are more likely to feel heard, understood, and feel less alone and judged. Through these services, parents and caregivers can feel more empowered and have increased confidence in managing challenges and participating in services. Family Peer Advocates can also engage parents and caregivers in parenting skills, managing behaviors, and navigating services. The support and services received means that families may be more likely to stay engaged and involved in the services they and their child receive as it helps to reduce barriers.

Family Peer Support Services can be very successful when well-designed and thoughtfully implemented in mental health programs. Successful implementation of Family Peer Support Services involves:

1. Leadership and program staff learning about Family Peer Support prior to implementation;

2. Having a clear vision for how Family Peer Support can help families as its own service distinct from clinical work;

3. Crafting job descriptions that align with Family Peer Advocate credential requirements and practice principles;

4. Communicating to existing staff the value of Family Peer Support and how multidisciplinary teams can work together for a family;

5. Creating workflows that include participation by all staff, including peers, as equal partners;

6. Ensuring the Family Peer Advocate receives supervision in line with peer practices and principles (which is different than clinical supervision); and

7. Supporting staff in continuous professional development and networking with other peers (Mirbahaeddin & Chreim, 2022).

There are a variety of resources that exist in which agency and program leaders can learn more about the implementation of Family Peer Support, such as by connecting with Families Together in NYS, FREDLA, National Federation of Families, Strong Families and Communities Training Center, or accessing resources at PeerTAC or CTAC. Agencies and programs can further extend their support for families by ensuring that more family voice and feedback inform services and supports family driven care. Family peer support does not replace clinical treatment but instead complements clinical care and ensures that the family is at the center. No parent should have to face the children's mental health system alone. With the support of family peer advocates, families gain the encouragement, knowledge and confidence to advocate for their children. Services are family driven, making resilience and recovery possible.

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most of which rely heavily on Medicaid to sustain their operations, are subject to other constraints that militate against the better angels of the recovery movement. These include but are by no means limited to institutional hierarchies; adherence to innumerable regulatory standards; and the sharp delineation of roles and responsibilities between "peers" and "professionals." Practitioners of peer support who wish to apply it in a manner consistent with its theoretical, philosophical, and historical underpinnings must proceed with caution lest they be utterly coopted by the deeply entrenched systems that promise merely to "integrate" them.

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potential consequences for their lives, loved ones, and communities should not be underestimated. Vulnerability can show up in peer workers' own recovery journey and the possibility of encountering triggers which lead to relapse (Barker et al. 2018). Although surveys show a willingness among peer workers to have some clinical responsibilities like administering Narcan to reverse an opioid overdose, peer responders reported concerns about legal repercussions, including fears of being charged with causing death if the naloxone administration was unsuccessful or resulted in harm (Wright et al. 2006). Peer workers may also have a harder time establishing boundaries in their work, leaving them vulnerable to emotionally overextending themselves (Miler et al. 2020 p. 11). Overall, peer workers emphasize the need to know themselves, their limitations, and receive proper training in order to mitigate risk while working in such unpredictable environments (Barker et al. 2018).

Responsibility

Because peer workers frequently serve as a primary line of connection between clients and providers, they often feel overwhelmed managing both the formal responsibilities they are assigned and the more messy, dangerous realities of the work that is being done. In several studies, this showed up in situations where peer workers administering harm reduction supplies felt like they had to take on larger roles than they felt comfortable doing, such as administering naloxone as mentioned above, or even helping physically disabled individuals inject drugs in order to prevent them from using more dangerous methods (Wright et al. 2006, Dechman 2015). Although these issues will certainly vary across organizations who may encourage different kinds of interactions and levels of involvement in outreach work, it is clear that peer specialists often feel responsible, or are implicitly expected, to take on responsibilities that are not necessarily explicitly outlined in their job description or training.

Although confident about his role and abilities doing outreach runs, Lavaughn also identified overwhelming responsibility as a systemic issue within the peer support field. Lavaughn identified one of the struggles he sees in peer support as safety: "Safety would be my biggest concern. If they want to know what peer navigators need, we need a safety…handbook training—just make sure that we're safe because we're the ones out here in this. If something happens, we got to deal with it." While Lavaughn acknowledges that this is an area where he can provide expertise, it can be difficult in the fast-paced environment of a run to provide adequate training for students and other participants who come from varying backgrounds: "Maybe not everyone has an instinct of how to stay safe in this. When you grew up like me, you learn to watch those surroundings without even knowing that you're doing it. I'm accustomed to it already."

Lavaughn identified safety behaviors that people might not instinctually do—such as staying together in a group, checking over your shoulder, and consistently scanning your surroundings—as knowledge that cannot be easily condensed into an online training module. Through this observation, Lavaughn is drawing on a

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common theme throughout the challenges faced by peer support workers in this sphere: times when peer navigators feel pressure to take on responsibilities because of their rapport with the community being served. In order to ensure that peer workers are able to care for themselves, continue to grow in their roles, and avoid the common issues of burnout, behavioral healthcare providers, particularly those in the realm of homelessness and substance abuse, should consider working with peer specialists to develop clarity around responsibilities, as well as safety training.

Compensation

Peer workers have reported across several studies that they felt that their contributions were not recognized because of their 'peer' status (Miler et al. 2020, Charron et al. 2018). This reflects the larger disagreement around the occupational status of peer workers, which mainly ranges from volunteer to low-wage employee. Research shows that more often than not, peer workers face poor employment conditions, low wages, and few benefits or opportunities for growth (Chapman et al. 2018). Access to resources among organizations that incorporate peer support in housing and substance use services such as street medicine is certainly a limitation to fairly compensating both peer and non-peer workers, and much of the work is done on a volunteer basis (Miler et al. 2020). However, it is essential that organizations and providers are sensitive to the fact that peer work can be uniquely situated to be exploitative. In a field which aims to respect the expertise, autonomy, and humanity of clients and workers alike, it is deeply concerning that peer workers' labor is devalued in comparison to non-peer workers.

Peer workers being afforded a professional role with growth opportunities is not unheard of, however. Hope can be found in Lavaughn's experience at ReVive, where his supervisor instilled confidence in him and encouraged him to keep moving up in the field of social work when hiring him for the peer worker position: "The same thing that [my case worker] put inside of me, [my supervisor] did the same thing. She told me that I can go as far as I want with this. [She told me] you are a real people person, you know how to communicate with people." Lavaughn's next goal is to go to school and become a case worker at the organization he works for currently, which has received overwhelming support from his coworkers: "They tell me I could bring people in today…that a case worker is not out of my range."

Looking Forward

Miler et al. provides a framework for implementing peer services that largely aligns with the challenges described thus far, including a clear role description, transparency around compensation so peer workers can make informed decisions about their commitment, emotional support services, career development opportunities, workplace recognition of the value of peer work, and workplace accommodations. It should be acknowledged that providing the necessary support for peer roles is heavily resource dependent and is intertwined with field-wide issues of overworking, stress, and burnout. However, in order for peer support within street medicine to continue to grow and achieve its potential as a radical, alternative form of care for hard-to-reach populations, it is essential for behavioral health professionals to reckon with both the very real challenges and possibilities of the peer support position.

Key Takeaways

- Peer workers are uniquely positioned to meaningfully engage with clients in the field of street medicine, often acting as a point of trustworthy connection between the unhoused community and medical and social work providers.
- It is important to recognize that peer workers are in a position of increased vulnerability to risk, including risk of personal setbacks, legal repercussions, and emotional burnout.
- Peer specialists may feel implicitly expected to take on responsibilities that are not in their job description or training, including ensuring the physical safety of the outreach team.
- Research shows that peer work is often devalued in comparison to non-peer workers, with the role often being low-wage with little opportunity for professional growth.
- In order to mitigate these challenges, street medicine providers should work with peer specialists to develop more in-depth training, clarity around responsibilities, and overall craft a peer support role which offers opportunities for fair compensation and career development.

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Mental Health IOPs from page 15

- Identifying community support resources
- Sharing personal experience of maintaining progress after discharge
- Encouraging proactive follow-up care

This support helps participants view recovery not as something that ends when treatment ends, but as a process they can continue in their everyday lives.

The Impact on Empowerment and Identity

One of the most powerful aspects of peer support is how it helps individuals see themselves differently.

Mental health challenges can lead people to define themselves solely by their struggles, seeing themselves as anxious, depressed, broken, or failing. Peers offer a different narrative. They demonstrate that recovery is attainable, that setbacks can be overcome, and that growth continues over time. Seeing someone further along in their recovery expands what feels achievable. This shift fosters empowerment, giving participants a sense of control and hope. Over time, participants begin to internalize not only the new coping skills but also a renewed belief in their own resilience.

Tasha R. Kalhorn, PsyD

A Complement to Clinical Excellence

Family Care Center's mental health IOP provides structured, evidence-based care in a small group format. Sessions are led by experienced behavioral health professionals and are designed to provide personalized support within a welcoming and collaborative therapeutic environment.

Program focuses on:

- Changing unhelpful thought patterns
- Symptom stabilization
- Trauma recovery
- Resilience building
- Developing practical skills for long-term recovery and wellness

Treatment approaches may include:

- Dialectical Behavior Therapy (DBT)
- Crisis stabilization strategies
- Symptom management
- Resilience training

Participants also receive support addressing factors that influence emotional health, including sleep, nutrition, pain, and substance use. Psychiatric services, along with close collaboration with primary care and mental health providers, strengthen continuity and coordination of care.

This structured, team-based approach leads to real results. Family Care Center IOP patients have reported major improvements in conditions like depression, anxiety, PTSD, and suicidal thoughts. Some of the outcomes are:

- 96% reporting reduced depression
- 82% reporting relief from anxiety
- 81% reporting fewer PTSD symptoms

In this clinically focused setting, peer support adds real value alongside professional treatment. Clinicians handle assessment, therapy, and medication management, while peers help participants use new skills, understand that recovery challenges are normal, and stay engaged.

Recovery is Relational

In the end, mental health recovery and wellness are not just about reducing symptoms. It is also about connection, confidence, and believing that change can last.

Peer support can make IOP more effective because it focuses on the human side of healing:

- "You're not the only one."
- "It makes sense that this is hard."
- "Here's how I got through something similar."

When these messages are shared honestly, they can be the difference between just understanding and actually taking action, between simply showing up and truly engaging, and between coping for now and building lasting strength.

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New York State from page 10

importance is the support provided to individuals around living a life in which they feel satisfied, connected and engaged. While support is always available if needed, many individuals connected with peer support workers go on to enjoy recovery and do not require a lifetime of services.

Peer advocates work in every setting our agency touches. One example is Assata, who was featured in an OMH Recovery Story last year. Assata had been hospitalized on and off over a period of years. But thanks in part to connections made at Albany Community Support Center at Capital District Psychiatric Center, Assata was able to thrive in the community starting in 2018 — including becoming a peer advocate worker herself. "The peer advocate group was the best group. They had me host it one day, and it was so much fun. I didn't really expect to be a peer advocate, but it's a very good job, especially for me because I like to talk," Assata said with a laugh.

The Intensive and Sustained Engagement Team or 'INSET' program is another great example of how peers can help individuals connect with care. These multidisciplinary teams engage people living with mental illness who have not had success with more traditional forms of care. The program is voluntary and provides an avenue for participants to access community resources in a non-restrictive manner. Teams are led by certified peer specialists, who bring special insight into building connections within the community. New York has four INSET teams operating in communities around the state, each helping about 60 individuals per month. A fifth specialized team on Long Island is now helping people who have been involved in the criminal justice system or are transitioning back into the community from prison or jail. And a sixth team was recently awarded and is expected to begin work in the Capital Region this summer.

Prior to engaging with INSET, one participant spent approximately 75 percent of the year in inpatient psychiatric settings. Other days were spent in shelters or overnight in the emergency department due to a lack of housing. Upon engaging this individual, INSET assisted them in finding housing. Thanks to this support, they have not returned to the hospital and express a general sense of happiness.

"I would not be alive today if not for the incredible support of New York State's INSET program," another participant said. "My peer specialist didn't expect me to trust him right away, but he earned that trust through his consistent and compassionate support."

A third participant added, "Being with INSET has helped me tremendously. I went from four hospitalizations a year to currently none for over a year. Before INSET, I couldn't maintain that type of stability. I am grateful for them. They're my buddies, my peers."

Clubhouses are another model supported by OMH that incorporate individuals with lived experience into helping others on their recovery journey. This member-driven, evidence-based approach provides structure and support for adults so they may address their social, educational, and vocational needs through community integration.

Clubhouse members express autonomy and choice and can participate whenever they want for as long as they want. In this non-hierarchical environment, they work together with staff — including many who have lived experience — on daily operations that help promote a sense of shared ownership and teamwork. By joining a Clubhouse, members can take steps to avoid hospitalizations and readmissions in a setting where they are treated as valued participants, not patients or clients.

Soon, even more New Yorkers will be able to take advantage of this model. This year, we are making $6.6 million available to establish eight additional Clubhouses statewide, offering social support, employment resources, and life skills training in a safe environment.

We are also growing New York's youth and family peer advocate workforce. Last year, OMH awarded more than $2.7 million to 10 community-based organizations to identify, train, and credential individuals with lived experience or family caregivers for those living with mental illness or behavioral health issues to become youth and family peer advocates. These youth and family advocates are in a unique position to help, with experience navigating the mental health system and the deeper empathy that often comes with it.

Peer support is a crucial resource for individuals, particularly those who haven't benefitted from traditional mental health services for various reasons. Peer support workers are a crucial part of most services funded by our agency, offering non-clinical and non-hierarchical support. We must continue to ensure the quality of this model so individuals can rely on self-empowerment to recover and thrive in their community.

Dr. Ann M. Sullivan is Commissioner of the New York State Office of Mental Health. OMH Chief Advocacy Officer Liz Breier, OMH Office of Advocacy and Peer Support Services Deputy Director Em Wasserman, and OMH Assistant Public Information Director Ian Pickus contributed to this report.

Overcoming Barriers from page 18

within multidisciplinary teams (Vandewalle et al., 2016). Because peer workers rely on lived experience rather than traditional clinical training, their expertise is sometimes viewed as less legitimate within medicalized systems. This dynamic can limit peers' ability to contribute meaningfully to care planning and decision-making.

Education and leadership engagement are essential to addressing this challenge. When healthcare leaders and clinical staff understand how peer support complements clinical care, rather than replacing it, teams are more likely to integrate peers effectively (Shepardson, 2021). Training programs that clarify the philosophy and function of peer roles can help shift organizational culture toward a more recovery-oriented model of care (Ibrahim et al., 2019).

Operational barriers also remain significant. Peer specialists often report unclear job responsibilities, limited supervision, and insufficient opportunities for professional development. Without clear role definitions, both peers and clinical staff may struggle to understand where peer services begin and end within the care continuum (Shepardson, 2021). Research suggests that clearer role delineation improves job satisfaction, strengthens team collaboration, and reduces turnover among peer workers (Njuguna et al., 2025).

Supervision is another critical component of successful peer integration. Because peer specialists frequently support individuals navigating complex and emotionally challenging circumstances, access to structured supervision and mentorship is essential for sustaining workforce wellbeing. Without adequate support structures, peer workers may rely on informal supports outside the workplace, which can increase the risk of burnout.

Funding and reimbursement mechanisms present additional barriers. Medicaid remains the largest payer of behavioral health services in the United States and serves as the primary funding source for many peer support programs. Since Georgia first introduced Medicaid reimbursement for peer specialist services in 2001, dozens of states and the District of Columbia have implemented similar reimbursement models (KFF, 2022).

While Medicaid reimbursement has expanded access to peer services, it has also introduced administrative challenges for peer-run organizations. A national survey of peer organizations found that many were hesitant to pursue Medicaid reimbursement due to concerns about administrative burden, compliance requirements, and the potential tension between recovery-oriented values and medicalized reimbursement structures (Ostrow et al., 2023). Smaller organizations may lack the financial infrastructure needed to manage billing systems, audits, and performance reporting requirements.

Maggie G. Mortali, MPH

Jennifer Da Silva, MPA

As behavioral health systems continue to evolve, the integration of peer support will remain an essential component of building more responsive, person-centered care models. Addressing structural barriers, such as workforce support, leadership education, and sustainable financing, can help ensure that peer specialists are positioned to contribute fully to multidisciplinary care teams.

Peer support is not a substitute for clinical care. Rather, it represents a complementary form of expertise that strengthens recovery outcomes and deepens engagement with services. When clinicians and peer specialists work in partnership, behavioral health systems can move closer to delivering the kind of comprehensive, recovery-oriented care that individuals and families deserve.

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Peer Specialist from page 34

Services in order to earn my certification as a New York Certified Peer Specialist.

When the world began to reopen, I secured a position at a local mental health clinic on Long Island. Although I had not yet completed my studies, my supervisor, a physician's assistant, supported me in finishing my coursework while working as a Peer Bridger.

I began meeting with clients weekly and launched a painting workshop that met twice a week. Diagnoses were left at the door. Week after week, clients returned, sharing openly, supporting one another, and creating meaningful artwork. Over time, the group became a safe haven: a space for connection, expression, and healing through creativity.

When that grant ended, I transitioned into a CORE Educator role under a new program, helping clients in their homes and in the community work toward their educational and employment goals. I later spent nearly a year doing street outreach with the homeless with another agency. Ultimately, I realized how much I missed working directly with clients in a mental health setting.

For the last nearly two years, I have worked at another mental health clinic on Long Island, where I see multiple clients each day and co-facilitate three art groups, two for adults and one for children. I have also successfully launched two art shows, bringing pride, joy, and a sense of accomplishment to both the clinic and its participants.

My most difficult moments ultimately guided me to where I belong, using my experience, strength, and hope to support my clients each day. The path to peer support has been long and winding, but incredibly rewarding, allowing me to do what I truly love.

I am honored and privileged to meet with clients sharing their most vulnerable stories, yet, through art, we create, and unleash, only what the power of art can do: provide limitless opportunities to express oneself without even uttering a word. **#yougottahaveart**

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- Reducing response strain on other emergency responders.

This model aligns strongly with Florida's CORE vision and broader statewide peer support initiatives, offering an effective approach for other jurisdictions seeking to improve crisis outcomes in communities heavily affected by opioid use and behavioral health emergencies.

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Invisible ACE from page 33

How These Children Are Often Invisible

Sadly, all too often these children are invisible and fall through the cracks. There are many reasons for this state of affairs, including:

- Families' fear of child protective services involvement
- Families being focused on the ill parent, leaving less time and energy for the kids
- Lack of community supports for these kids
- The siloed mental health care system where adult and child providers don't consistently collaborate
- Children sometimes pretending they're "fine" to avoid burdening the stressed family system

Interestingly, children whose parents manage other issues are more recognized and supported. A simple online search quickly reveals inviting resources, camps, support groups, and more for children managing parental cancer, dementia, and incarceration. Similarly, parental addiction (a commonly overlapping issue with other mental illnesses) has considerable supports, including a formal organization (National Association for Children of Addiction), free support groups (Alateen), children's programs in some treatment centers (e.g., Hazelden's Betty Ford programs), and many excellent books and resources. In comparison, I'm unaware of any formal programs, groups, or organizations in the United States specifically for youth whose parents manage mental illness; similarly, there are relatively few books and resources for these kids.

In addition, children of parents managing mental illness have formal legal rights in some countries. For example, Norway requires mental health staff to register the children in the health record, identify the children's needs, educate parents, and connect families with other services. Similarly,

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the United Kingdom requires certain steps when a parent is involuntarily admitted to an inpatient psychiatric unit. Staff must identify the parent's children, provide the kids with support, and provide appropriate referrals. Laws such as these in Norway and the United Kingdom can be exemplars for the United States to help identify and support these children.

A New Resource for Teens

In collaboration with my mother, an advocate and teacher, we have been working to raise awareness of these youth for 20 years, and are passionate about making them "visible" in our country. One component of our work is writing books for families, and we recently released the second edition of our interactive book for teens: "I'm not alone: A teen's guide to living with a parent who has a mental illness or history of trauma" (2024, Seeds of Hope Books). Focusing specifically on parental depression, bipolar disorder, schizophrenia, and post-traumatic stress disorder (PTSD), it provides essential information, skills for effective coping, and empowering messages from teens who have "been there." Throughout the book, readers reflect on their feelings and consider scenarios that may resonate with their experience. It's a practical, hopeful book that strives to connect with readers so they feel informed, empowered, and not alone. Sample chapters and many free online resources are available on our website: www.seedsofhopebooks.com.

What Can We Do to SEE These Youth?

First, we need to recognize these young people, in our schools, healthcare settings, community activities, and neighborhoods. Remember, there are about 18 million kids navigating parental mental illness in our country. As noted above, there are many reasons these children and families may not choose to disclose the precise nature of what's going on, but you might sense they're struggling. Simply invite the child to join your family for an outing, or offer to drop off a meal. Sometimes it's just the little things that can make a big difference.

Secondly, we need to create resources for youth-serving professionals. The science of prevention identifies skills that can be helpful for building resilience in children. Connecting kids with other supportive adults and youth, encouraging regular exercise and healthy eating, recommending kids avoid substances and excessive social media use, and instilling hope can be extremely valuable approaches.

Third, it's imperative for mental health providers who work with adult clients to routinely, respectfully, and directly ask about their experience as parents and how their children are doing. Appreciating the potential for embarrassment and fear of being seen as an ineffective parent, it's essential to take a strengths-based, affirming approach. Validate that parenting is hard, and explore how you might be able to help them as a parent and support their children. Learn who in your community has expertise in supporting kids managing parental mental illness, and collaborate in serving the entire family.

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related to peer support is needed for all staff; engaging HR staff is important in this effort (Byrne et al., 2022) since many institutions rely on HR to respond to reports of discrimination and workplace conflicts. Lack of clarity around their role can cause peers to feel stigmatized and excluded from their workplace team (Shaw et al., 2026). Therefore, leadership must be involved in these trainings to not only learn what policies are needed to clarify peer roles, but also to show all staff their leadership's commitment to helping peers succeed.

4. Add checks and balances to power structure and diffuse highly dependent relationships. This step will be difficult because those in power may feel threatened and become defensive at the prospect of upsetting the status quo and their positions in the power structure (Mental Health Commission of Canada, 2023). Peer supervisors need organizational support and require authority to effectively do their jobs (Gillard et al., 2024). Peer specialists need to be included in decision-making processes related to their work and to be a respected part of the team with which they work. The organization's leadership, board of directors, and advisory board must include individuals with lived experience of MI/SUD so discussions of policies and resource allocation always include those voices and perspectives.

5. Respond well to victim disclosures (& create a trauma-informed reporting policy). A common response when someone who has perpetrated harm in a workplace is confronted with their actions is a term Freyd (1997) coined called DARVO: Deny, Attack, Reverse Victim and Offender. An example of this would be if a peer overheard colleagues speaking about the role of peer support specialists negatively and offensively and, when confronting those colleagues with the harmful nature of those comments, the colleagues do not take responsibility or apologize. They then start referring to that peer as "crazy" or "just a junkie" when discussing them with colleagues as a way of diminishing the credibility of the peer. If an organization does not have a trauma-informed reporting policy (a clearly defined policy that the peer could follow to report this experience without the fear of being retaliated against) for this type of situation, the peer will likely suffer further harm (Harsey et al., 2017) .

6. Bear witness, be accountable, apologize. This means acknowledging the harms you (as a colleague or institution) perpetrate or witness, apologizing for those harms, and transparently defining what steps will be taken to repair those harms and keep them from happening again.

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7. Cherish the whistleblowers; cherish the truth tellers. Thanking peers (and other colleagues) who call out harms directed at peer support specialists and shutting down any attempts at DARVO by the perpetrators of the harm is important. Reward those who speak out.

8. Conduct scientifically sound anonymous surveys. Consider including the Institutional Courage Questionnaire (ICQ)-Individual and ICQ-Climate for Employees (Smidt, Adams-Clark, & Freyd, 2023) in ongoing quality assurance efforts and allow all employees to complete them anonymously. These short yes/no questionnaires assess how well institutions respond to harassment of employees. Some examples: *Responding adequately to the experience, if reported? Handled your case well, if disciplinary action was requested? Not covering up the experience? Your employer created an environment where this type of experience was safe to discuss?*

9. Regularly engage in self-study. Once an organization has decided on the best evaluation tools, commit to implementing them on at least an annual basis. When I work with healthcare organizations, I encourage them to embed them in their quality improvement process.

10. Be transparent about data and policy. This requires leadership to share the outcomes from anonymous staff surveys and other quality assurance measures. Share these outcomes with staff, service recipients, and the community.

11. Use the organization to address the societal problem. Examples of this step can be found in the current Office of Addiction Services and Supports (OASAS) Strategic Plan Objective: *Goal 4: Reduce racism and stigma surrounding addiction*, and the Office of Mental Health's (OMH, 2024) funding of projects that specifically work to address intersectional stigmatization.

12. Commit ongoing resources to 1-11. Commit organizational resources to all previous steps. Fund trainings, devote staff time, and consider linking promotions and departmental funding to staff who perform well on outcome measures related to the *Steps of Institutional Courage.*

Wall et al. (2022) include this quote in their research on experiences and challenges of peer support workers: "Courage was considered an important personal quality for building genuine relationships. The peer supporters described it took courage to be present and harbor the patients' narratives, and never to abdicate from standing up for the patients' perspective." I encourage institutions who employ peers to honor that courage by committing to the difficult task of implementing the *Steps of Institutional Courage* in their workplace.

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Leadership Style from page 24

in a clear, respectful, and open way establish a climate of trust and respect. Employees are appreciated and informed, they trust the leader more, and they establish a culture that trusts others. Communicating clearly and consistently about expectations, changes, challenges, and successes helps employees understand the way things are done. Lack of communication or poor communication by a leader creates confusion, mistrust, conflict, and poor morale. For instance, in a human service organization where employees need to establish trusting relationships with clients to achieve results, leaders who do not communicate clearly and consistently establish a culture of mistrust and suspicion. Employees feel disconnected and unsupported. Communication does not involve only the message conveyed but also the manner and tone. For example, is the communication method participative or authoritative? Is the attitude encouraging and supportive, dictatorial or punitive? The way a leader communicates influences the way employees feel about themselves and their organization. It influences whether employees feel connected to the organization.

Decision-Making and Priorities as Cultural Drivers

What leaders value and prioritize greatly influences an organization's culture. What a leader decides to reward or not establishes the priorities of an organization. For example, if a leader consistently rewards teamwork and joint effort but ignores individual contributions, a culture which values teamwork and joint effort will be established. If a leader consistently focuses on speed and output while ignoring the need for planning and process, a culture that favors speed and output over planning and process will be established. The way a leader makes decisions also influences the culture. For example, leaders who consistently make participative decisions establish a culture of participation and involvement. Employees feel empowered and valued. Leaders who consistently make autocratic decisions establish a culture of control and mistrust. Employees feel disconnected and unsupported.

People, Practices, and Cultural Support

People-related practices - such as hiring, promotion, reward, and recognition - influence an organization's culture (Acheampong, 2025). Leaders who establish hiring practices that ensure people who share the organization's values are hired create a culture that supports those values. Leaders who promote people not only based on what they know and can do, but also on how they do it, establish a culture that supports the values of the organization. Leaders who reward and recognize employees who consistently act in line with the organization's values establish a culture that supports those values. For example, if an organization's values are respect for clients, respect for each other, and teamwork, and a leader rewards employees who consistently demonstrate those values, a culture that supports them will be established. On the other hand, if a leader ignores poor behavior and rewards results no matter how they are achieved, a culture that ignores values will be established.

Isaac Mawuko Adusu, DHA, MSNPM

Emotional Intelligence and Its Cultural Effect

A leader's emotional intelligence strongly influences an organization's culture (Mishra et al., 2024). Leaders with high emotional intelligence foster cultures that promote psychological safety, trust, and equity. Employees feel safe to take risks, they feel trusted to make decisions, and they feel the organization is fair and just. Leaders with high emotional intelligence are aware of their own emotions and those of others and consistently act in ways that support the health of everyone. They establish a climate of trust and respect. For example, a leader who consistently provides timely, honest feedback establishes a climate of trust and respect. A leader who consistently reacts badly when an employee makes a mistake establishes a culture of mistrust and suspicion.

Leadership and Culture Change

Culture change is perhaps the most difficult thing leaders can do (Muls et al., 2015, pp. 633-638). Many leaders fail to change their organizations' cultures because it is a long-term process that demands sustained effort and commitment. Many leaders lack the patience and persistence to see the process through. Furthermore, many leaders do not model the way, thereby failing to gain trust and confidence with employees. Leaders who consistently model the way establish a culture that trusts and has confidence in them. When such leaders establish a new way of doing things, employees are more likely to follow. Employees trust the process and the leader and consistently support it. When a leader consistently and persistently communicates a new vision and way of doing things and models that way, employees begin to see a different way and establish a new one. Employees begin to consistently support the new way because they trust and have confidence in the leader and the process. For example, when leaders consistently communicate the need for employees to support each other consistently and persistently to establish a new service, employees begin to see that the way to establish the new service is to support each other in the same way. Employees begin to establish a culture of teamwork and cooperation to establish a new service. When employees consistently support each other in establishing new services, a culture of cooperation and teamwork is fostered.

Leadership Style and Inclusion, Diversity, and Equity

A leader's leadership style strongly affects whether an organization supports and promotes inclusion, diversity, and equity (Tsai, 2024). When a leader consistently models inclusion and honors diversity, a culture that supports inclusion, diversity, and equity is established. Employees feel included, valued, and supported to contribute. When a leader consistently ignores diversity, equity, and inclusion, a culture that does the same is established. Employees do not feel included, valued, or supported in contributing. For example, when a leader consistently makes sure that all employees' voices are heard, values variety of thought and approach, and consistently challenges discrimination and inequity, a culture that supports inclusion, diversity, and equity is established. When a leader consistently ignores employees' voices, variety of thoughts and approach, and discrimination and inequity, a culture that ignores inclusion, diversity, and equity is established.

Long-Term Corporate Impact of Leadership

The long-term impact of leadership on an organization's success is perhaps the most important influence leaders have (Zakliki & Christodoulou, 1996, pp. 30-47). An organization's success is long-term because it is consistently influenced by how things are done. The way things are done consistently influences whether an organization consistently establishes and supports a positive, productive, and performance-oriented culture. When leaders consistently establish and support a positive, productive, and performance-oriented culture, employees are consistently positive, productive, and performance-oriented. The culture consistently attracts and retains talented employees who consistently support a positive, productive, and performance-oriented culture. Employees consistently support innovation, risk-taking, inclusion, diversity, and equity. Employees consistently support and establish quality and distinction and consistently strive to improve and excel. Employees consistently feel positive about what they do and how they do it and consistently feel that what they do is important and makes a difference. Employees consistently feel that they matter and are valued, and that they can consistently contribute to the best of their ability.

Conclusion

In conclusion, leadership style strongly influences an organization's culture. It influences the way employees consistently feel about what they do and how they do it. It influences whether the organization consistently achieves positive results and makes a difference in clients' lives or consistently achieves negative results and does not. It influences whether the organization consistently flourishes and prospers or consistently does not. Leaders who consistently model the way and establish a positive, productive, and performance-oriented culture consistently achieve positive results and make a difference in the lives of clients. Leaders who consistently do not model the way and consistently do not establish a positive, productive, and performance-oriented culture consistently achieve negative results and do not make a difference in the lives of clients. Leaders either consistently flourish and prosper, or consistently do not, depending on how they consistently influence their organization's culture.

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Consumer Experience from page 25

and motivation shifts.

In our survey, providers acknowledged that between-visit engagement is difficult to monitor. Consumers expressed interest in tools that would allow them to check in, track goals, communicate securely, and access recovery resources without waiting for the next appointment.

This is not a request for automation. It is a request for connection.

Peer services illustrate this dynamic clearly. Individuals with lived experience often provide crucial support during transitions—after hospitalization, during early recovery from substance use, or when navigating new diagnoses. But from the consumer's standpoint, peer support is not a separate programmatic silo. It is part of a broader recovery ecosystem.

Digital platforms that fail to integrate these elements into one cohesive experience risk reinforcing fragmentation.

Reframing Digital Engagement as Partnership

If we begin with the consumer experience rather than organizational workflows, a different design philosophy emerges.

Instead of static portals, behavioral health systems can envision collaborative consumer engagement hubs—integrated digital environments that support:

- Recovery-aligned onboarding that introduces services clearly and reduces information overload
- Secure, two-way communication with members of the care team
- Structured mood check-ins and goal tracking that reinforce progress
- Embedded safety planning and harm reduction tools
- Access to peer supports and lived experience guidance
- Navigation assistance for housing, food, transportation, and other social needs

This model shifts digital engagement from passive access to active collaboration.

Importantly, such platforms must reflect recovery-oriented principles articulated by the Substance Abuse and Mental Health Services Administration (SAMHSA), including person-centeredness, empowerment, and strengths-based care. Consumers consistently report that feeling heard and understood matters as much as the clinical intervention itself.

When digital systems reinforce these principles, they extend the therapeutic alliance rather than merely documenting it.

The Role of Peer Services Within a Consumer-Centered |Engagement Hub

In a consumer-centered digital ecosystem, peer services become more accessible and visible—not as add-ons, but as integrated supports.

Jorge R. Petit, MD

Matt Kudish, LMSW, MPA

For example:

- A consumer completing a digital check-in that indicates increased anxiety or relapse risk could receive an outreach message from a peer specialist.
- Onboarding materials could include a brief introduction to peer services, demystifying the role early in the journey.
- Recovery milestones tracked digitally could be reinforced by peer encouragement.
- Post-hospital follow-up could include coordinated outreach that blends clinical and peer engagement.

Research on peer support has demonstrated improvements in hope, empowerment, and engagement among individuals with serious mental illness and substance use disorders (Chinman et al., 2014; Solomon, 2004).[1] However, operational barriers—including documentation workflows and siloed communication systems—can limit the scalability of peer services.

When digital infrastructure integrates peer communication within the broader care team workflow, it enhances coordination while preserving role clarity. From the consumer's perspective, the experience feels cohesive rather than segmented.

Measuring Engagement Meaningfully

As CCBHC expansion continues nationally and value-based payment models evolve, organizations face increasing expectations to demonstrate measurable outcomes, such as follow-up after hospitalization, retention in substance use treatment, and crisis response effectiveness.

Traditional engagement metrics—appointment attendance, portal logins—capture only part of the picture.

A consumer-centered engagement hub offers the opportunity to measure more nuanced indicators:

- Completion rates for digital onboarding
- Response patterns to structured check-ins
- Engagement frequency during the first 30 days of treatment
- Utilization of safety planning tools
- Interaction with peer services within digital workflows

Such data can inform early identification of disengagement risk, allowing proactive outreach rather than reactive response.

Crucially, these metrics should serve improvement, not surveillance. Transparency with consumers about how data is used is essential to maintaining trust.

Equity and Accessibility

Digital innovation must also address disparities in access and usability. Survey respondents noted differences in digital literacy, language accessibility, and device availability.

A next-generation consumer engagement strategy must therefore include:

- Mobile-first design
- Multilingual interfaces
- Clear, plain-language communication
- Accommodation for varying literacy levels
- Optional hybrid models that blend digital and in-person support

Peer services are particularly valuable in bridging digital divides. Individuals with lived experience can guide consumers in navigating platforms, troubleshooting barriers, and integrating tools into everyday life.

Technology alone does not solve inequity, but thoughtfully designed digital infrastructure can reduce friction and expand access when paired with relational support.

Moving Beyond the Traditional Portal

Across the behavioral health field, organizations are recognizing that legacy patient portals are insufficient for the complexity of recovery journeys. In response, some behavioral health technology leaders are developing next-generation consumer engagement hubs within their electronic health record ecosystems.

These platforms aim to integrate communication, structured engagement tools, peer support options, safety planning, and measurable analytics into a unified digital experience. Rather than layering features onto outdated systems, the goal is to design around how consumers move through care.

Such efforts reflect a broader shift from transactional access toward recovery-centered partnership.

Conclusion: Designing for the Recovery Experience

Behavioral health systems have invested heavily in expanding services. The next investment must be in experience.

Our survey findings underscore that consumers want more than appointments and reminders. They want clarity during intake, connection between visits, accessible peer support, and tools that reinforce recovery goals in real time.

A consumer-centered engagement hub—integrated within clinical workflows and oriented around lived experience—offers a pathway toward that vision. By embedding peer services within a broader collaborative digital environment, organizations can enhance continuity, strengthen retention, and align technology with recovery principles.

Ultimately, digital transformation in behavioral health should not be about sophistication. It should be about support.

When technology reflects the realities of the recovery journey—its nonlinear progress, its vulnerable transitions, its need for human connection—it becomes more than infrastructure. It becomes a bridge between visits, between people, and between access and engagement.

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Footnotes

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Why Peer Networks Work

Clinical care provides stabilization, skill development, and individualized treatment planning. Peer connection offers something distinct: lived-experience credibility, belonging, and relational accountability that does not feel like surveillance.

Rocheleau recalls a moment that illustrates this dynamic. A resident who did not want to engage or speak one day was later found in the gym with peers. When asked what had changed, the resident replied, "They just got me up, so I did."

The moment reflects a core tenet of peer support: social reinforcement grounded in shared experience rather than instruction or oversight.

A growing body of evidence and clinical experience suggests that peer support in addiction treatment is associated with improved engagement and recovery-related outcomes, while also acknowledging variability in program design and implementation. This balanced view matters. It positions peer services as a serious continuity strategy without overstating certainty or replacing clinical care.

Addiction and mental health conditions are deeply isolating. "That's why so much treatment happens in groups," Rojas explains. "People need to know they are not alone."

Alumni engagement builds on that foundation by extending connection beyond discharge, helping individuals remain anchored to a recovery-oriented community when formal structure decreases.

Alumni Engagement as Structured Continuity

Alumni programming occupies the space between formal treatment and independence. When done well, it offers structure without pressure, an open pathway back to support and a consistent way to stay connected.

Current alumni engagement efforts described by Rocheleau include quarterly alumni gatherings, recurring check-in opportunities, and resource navigation when outpatient care is not feasible. Alumni are also connected to broader sober communities, including activity-based recovery organizations that emphasize community connection as a protective factor against isolation.

Taylor Rocheleau

Rocheleau also frames recovery as a progression from sobriety to recovery to healing, where purpose and connection help sustain momentum beyond initial stabilization.

From a clinical standpoint, alumni engagement is not designed to replace therapy or medication management when indicated. Its role is to extend continuity, reinforce recovery capital, and create earlier opportunities to re-engage with care if needed.

Addressing Gaps When Outpatient Isn't Possible

A persistent challenge in behavioral health is that clinically recommended next steps are not always realistic. When outpatient care is unavailable or inaccessible, the question becomes how to reduce risk while respecting autonomy and dignity.

Tammie Rojas, MS, LPC

In these situations, alumni engagement can function as a protective layer. It does not serve as crisis care. It does not substitute for clinical intervention. But it can keep a line of connection intact, especially when the alternative is a sudden drop from intensive structure to unstructured daily life.

Importantly, this framing avoids positioning relapse as inevitable. Instead, it emphasizes vulnerability, connection, and early support as strengths rather than signs of failure.

Boundaries and Sustainability

As peer services expand, their credibility depends on clear boundaries. Peer and alumni roles derive strength from lived experience and consistent outreach, while clinical teams remain responsible for assessment, treatment planning, and risk management.

Peer support can be beneficial, but it can also become counterproductive if boundaries blur. Co-dependence, emotional overextension, or disengagement from one's own recovery due to relationships with peers can undermine sustainability. A clear role definition protects both clients and staff.

As Rojas explains, "Clinicians give patients the tools to make decisions during critical periods of their lives. Peer support provides community, but professional guidance remains essential, especially when someone is struggling with depression, anxiety, or functional impairment."

Like any program, peer and alumni engagement presents implementation challenges, including staffing, training, burnout risk, and funding sustainability. Programs that succeed tend to evolve by learning what does not work and refining structures accordingly.

Where Peer and Alumni Services Are Headed

Looking ahead, alumni engagement is likely to become more distributed and intentional, less tied to a single campus and more embedded in community life. Emerging models include alumni-led meetups, candid panels where current clients can ask questions, short skill-refresh retreats, and hybrid in-person and virtual options.

At a system level, the field continues to examine funding models, training standards, and credentialing frameworks that support sustainable peer services without diluting their core value.

Peer and alumni engagement are not replacements for evidence-based clinical care; they are extensions of it. Peer support offers ways to carry connection, accountability, and recovery identity into daily life after discharge.

As behavioral health systems continue to evolve toward long-term recovery ecosystems, the most important question may not be what happens during treatment, but what happens next and who stays connected. Sustaining human connection beyond discharge may be one of the most underutilized advantages in behavioral health care.

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CompanionConnections (originally called The Friendship Squad) a one-to-one companionship program for people experiencing loneliness and isolation. The need for this kind of connection is profound. According to the U.S. Surgeon General's 2023 advisory, the United States is facing an epidemic of loneliness and social disconnection, with significant consequences for both physical and mental health. For people in mental health recovery, the impact can be even more acute. Many individuals face stigma, fractured support networks, or long periods of isolation that make it difficult to rebuild community. Companion Connections participants commit to connecting at least once a week — by phone, text, or distance technology — for six months. Over the past four years, we have watched many of these companionships grow into lasting relationships that continue well beyond the program's formal structure. Although our focus is on people in mental health recovery, we do not turn away others who may benefit — including seniors who are often deeply affected by isolation. The online component of Companion Connections has also allowed City Voices to extend its reach beyond New York City. More than 120 people have participated in Companion Connections so far.

Dan Frey

Concurrently with the development of the above services, in 2023 City Voices officially became a non-profit organization with a board (with professor and mental health advocate Philip Yanos joining on as recording secretary), allowing it to fundraise, support part-time staff, and apply for grant support. A recent grant from the Dammann Fund, will allow for the expansion of the Companion Connections program.

Philip Yanos, PhD

City Voices has changed dramatically since Ken Steele first stapled together those early pages, but the heart of the work remains the same: people with lived experience of mental health conditions supporting one another through shared experience, creativity, and connection. Peer-run organizations like ours may be small and non-traditional, but they can have a meaningful impact on the lives of individuals who often fall through the cracks of larger systems.

City Voices demonstrates what is possible when people with lived experience come together to build something for their own community and shows that peer-run initiatives can come in all shapes and sizes. Peer-run initiatives are uniquely positioned to foster trust, reduce isolation, and create spaces where people feel seen and valued. City Voices is just one example of what can grow from that foundation.

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their preferences. By advocating for her, we collaborated with the medical team to take a different approach, and that adjustment led to her remaining in treatment."

LA County was one of the first counties to implement CARE, and now it is live in all 58 California counties. First responders, behavioral health clinicians—including nurse practitioners and physician assistants—community outreach teams, or family members can initiate CARE Court petitions. Once the court accepts a petition, the county behavioral health agency department assumes responsibility for the case.

While CARE continues to grow to scale across the state, the LA County program has grown dramatically. As of March 1, 2026, this program filed 850 petitions, received 272 referrals, 183 Public Guardian requests for stepdown from conservatorship to CARE, and 826 orders from the Mental Health Court.

Monthly petitions continue to increase in 2026, and LA County's plan is to maintain this momentum in keeping with state goals. Staff recruitment and retention have been key to providing both the increase in petitions as well as providing the intensive field-based services geared toward assisting clients in achieving their recovery. This growth underscores LA County's strong uptake of CARE services as the program continues to gain awareness, and our work to build a strong person-centered, peer-forward approach will provide a strong foundation to receive this increased engagement.

Linda Boyd

Nilsa Gallardo

Embedding peers at the outset and throughout CARE has changed our approach from one building toward treatment *compliance*, to one that prioritizes treatment *engagement*. For complex, high-acuity populations, that's not a small shift in the dynamics of systems of care. It's transformative. And peers have been key to making that happen.

"Trust is a big deal with clients," said Williams. "It's more than what you say or share, it's how you carry yourself. I know they're thinking about how I make them feel safe, am I consistent, will I call if I'm going to be late. I think I care about trust with clients more than anything."

To learn about the CARE Act and how it works, visit www.care-act.org.

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many years, began to deteriorate after his housing became insecure. This began, for him, a spiral in functioning resulting in his becoming homeless and eventually relapsed with substances. At around the same time, other outreach peers began to exhibit concerning behavior around functioning and their own increased substance use.

While research supports the efficacy of peer services, (Bassuk, et al., 2016), there is no denying the vulnerability that working with one's own issues may bring to an individual. To provide support to the agency's peers, a Peer Supervision and Support Work Group was established. It was co-chaired by a mental health professional and a Certified Peer Recovery Advocate. The goal of supporting peers was expanded to vocational support after it was noted that outreach peers may be put in a bind in which they are fearful of losing a stream of income when that income is contingent on their connections with people using substances. This could potentially have the iatrogenic effect of concretizing an outreach peer's presence with "people, places, and things" that are potentially harmful for them. In addition, trained peers, who (often) are in substance use recovery, are still exposed to harm reduction practices that could be triggering (such as clean syringe distribution). The committee developed a protocol that included the following:

Enhanced Orientation at Hire - Designed to normalize problems that might arise in the course of their work.

Life Skills Group - Designed to help support healthy living and wellness skills that may have not been learned during their period of substance use or psychiatric illness.

Vocational Enhancement Group - Designed to teach soft skills (such as conflict resolution, "managing up" and understanding one's professional role).

Enhanced Orientation

The first recommendation of the workgroup is an Enhanced Peer Orientation upon hire. This peer directed and led orientation is designed to clarify (in writing) what the specific goals and tasks are for each person as they begin their role in the agency, introduce the topic of managing work related triggers, identifying supports both inside and outside the agency to deal with difficult periods at work, understanding that supervision is for vocational support and growth, and understanding our/their role as agency representatives. In addition, the Enhanced Orientation would include a quarterly check-in with peers to assess if there are aspects of the work that cause them distress and if they have current supports. Outreach peers would be asked about current use of substances (responding to this inquiry would be completely voluntary, as it is understood in this role, at a harm reduction program, that their use of substances remains their choice). It was agreed by the workgroup that increased use of substances (and therefore health risks) could be an iatrogenic problem of participating in the Outreach Peer program while continuing to use drugs.

Life Skills Group

The second recommendation is to provide a Life Skills Group. It has been noted that those with significant lived experience, around both substances and/or mental illness, may have missed certain developmental experiences (such as managing money, planning meals, basics of keeping a home clean). This group is designed to provide a supportive, non-judgmental space for people to learn skills, including low-cost community activities, healthy eating, and healthier coping skills. It is recommended by the work group that group participation come with a stipend or gift card (such as a grocery or laundromat card) to provide an incentive for attendance as potential participants may not know, without attending, what benefits this group could provide for them.

Vocational Enhancement Group

The third recommendation is a Vocational Enhancement Group. A possible problem identified by the workgroup is that peers without formal training (particularly those participating in the syringe exchange program), might not see a pathway for further vocational growth. The concern is that while appreciating the opportunity to receive a stipend, as well as the esteem they get from supporting the agency's goals, they may not experience themselves as capable of more. Since the syringe exchange program utilizes peers who are currently using substances to reach their community, this could have the unintended consequence of preventing a peer from moving towards other healthy activities, as doing so might result in losing their assignment with the agency. While fully respecting all peers' right to choose their level of involvement with substances, the Vocational Enhancement Group would help each person evaluate vocational goals and possibilities. In addition, topics of the group might include what it means to be a professional, dealing with conflict at work, and utilizing pre-existing skills (even if they are "street skills"). It was also recommended that group attendance be encouraged with a small stipend or gift card for the same reasons cited above.

By providing concrete support around issues of competency and functioning, in a supportive and non-stigmatizing manner, the hope is that peers will experience growth in functioning in all aspects of their lives. Evidence has shown that peer workers can enhance recovery and services (Bassuk, et, al., 2016; Davidson, et al., 2012) for those in crisis. The goal of targeted vocational and emotional support is to strengthen the recovery of those who are working to make this happen.

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myself in the foot — I'm just being authentic and real. I consider myself armed and truly dangerous because I have intimate knowledge of both sides of the coin. In my own public testimony, I described this as the move from "lived experience to lived expertise" (Skipper, 2024). That phrase matters because it names a transformation too often overlooked. Lived experience is the raw knowledge earned through surviving these traumatizing systems of care. Lived expertise is what happens when that knowledge is sharpened through reflection, practice, analysis, service, research, and leadership. It is not simply "having a story." It is knowing how to use that story responsibly and strategically to support others, reshape systems, and inform policy.

That idea is also reflected in my published scholarship. In recent peer-reviewed work on peer support and reentry, my coauthor and I argue that peer support is effective precisely because people with lived experience can provide "unique and practical support" that traditional models often miss, especially where trauma, criminal legal involvement, and structural barriers intersect (Skipper & Ortiz, 2024, p. 542). That distinction matters because the people most impacted by system failures are often those least likely to trust systems that have repeatedly harmed, dismissed, or criminalized them. A peer can enter that space differently. A peer is often understood first as someone who has walked a similar road and learned how to keep going despite and also just because (only a peer will understand this last part!).

This is especially clear in the criminal legal system. Justice-involved individuals frequently return home carrying trauma, disrupted care, family strain, housing instability, untreated behavioral health needs, and the deep shame from being impacted. Traditional reentry structures often expect compliance before connection. Peer support reverses that logic. It begins with relationship and community building. It begins with trust and mutuality. It begins with the simple but radical message: I know something about this road, and you do not have to walk it alone. Research on credible messengers and justice-impacted peer roles underscores this point, showing that individuals with lived experience of criminalization bring forms of trust, legitimacy, and practical guidance that are deeply meaningful to the communities they serve (Urban Institute, 2022). This is not a soft extra or an "add-on." It is often the very thing that makes engagement possible.

The same is true in crisis response and public health. Public systems are increasingly being forced to confront what peers have known all along: health, safety, and

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recovery are deeply interconnected. Mental health crises do not occur in a vacuum. Neither do overdose, community violence, homelessness, or the despair that grows when people are cut off from care and connection. Public health frameworks now emphasize social determinants and structural drivers, but peers have been translating those realities on the ground for years. We know what it means when a person misses an appointment because they have no MetroCard, no child care, no safe place to sleep, or no reason to believe anyone in the room actually sees them or even hears them. Peer support bridges those gaps because it translates both ways: it helps people navigate systems, and it helps systems understand the people they were supposedly designed to serve.

Housing is another place where peer support has become indispensable. Recovery cannot stabilize where housing is unstable. Hope is hard to hold onto when a person is facing eviction, shelter conditions, unsafe placements, or the crushing uncertainty of not knowing where they will sleep tomorrow. In housing settings, peers help reduce isolation, strengthen problem-solving, and reinforce self-determination. They do not exist to enforce compliance. They exist to help people build lives that can hold fast. In reentry and supportive housing, that distinction is crucial because too many systems still confuse surveillance with support.

Policy and legislative advocacy may seem further removed from traditional peer roles, but this is exactly where peer leadership belongs. Systems have long been designed around people without meaningfully including the people most affected by them. Peers change that. Nothing about us — without us! They bring grounded lived knowledge into conversations about diversion, treatment access, Medicaid reimbursement, workforce development, crisis services, jail policy, and community investment. They do more than tell personal stories. They expose the distance between policy language and lived reality. They ask sharper questions. Who was this policy built for? Who does it leave out? What does "access" mean if the front door is technically open but still impossible to enter? It's not okay when you open the door and let us in without giving us the supports to stay in! When peer workers step into policy spaces, they bring insight that is both experiential, analytical and crucial. The hard questions are asked and answered by their testimony. That is lived expertise in action.

What excites me most about this moment is not simply that peer support is expanding. It is that the peer workforce is forcing a larger reckoning with what counts as expertise. For too long, expertise has been defined as something that comes only through formal training and education — far removed from lived struggle. But surviving incarceration, navigating recovery, rebuilding after crisis, advocating through systems that were not built for you, and learning how to transform pain into purpose also generate advanced knowledge. That knowledge deserves recognition, compensation, infrastructure, and leadership pathways. My own professional life—and the lives of so many peers I work beside—makes the case that lived experience is not adjacent to system transformation. It is central.

At the same time, expansion brings risk. As peer roles become more formalized, institutions may try to absorb peers without honoring peer values. They may want the labor without the philosophy, the optics without the power shift, the relatability without the critique. The literature is clear that peer support is strongest when it remains anchored in mutuality, clear role definition, adequate support, and organizational cultures that genuinely value lived experience rather than treating it as symbolic (Repper & Carter, 2011; Solomon, 2004). Professionalization strengthens the field through training, supervision, certification, and sustainability. But if we professionalize the soul out of peer support, we lose the very thing that makes it transformative and alive.

So yes, peer support began in behavioral health. But it didn't stop there, and it should never. It belongs in hospitals, jails, courts, reentry programs, housing settings, schools, violence interruption efforts, community health work, policy tables, and research teams. It belongs anywhere people are being asked to heal, rebuild, navigate harm, or imagine a future larger than what systems have told them is possible.

When I say, "Oh the places peer support can go," I am not talking about trendiness or a basic elevation for expansion's sake. I am talking about what became possible when we finally recognized lived experience as valid, lived expertise as real, and peer leadership as essential. If behavioral health—and all the systems surrounding it—are serious about recovery, justice, and human dignity, then peers cannot remain on the margins. Trust, we are not asking for permission to matter. We already do!

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then bring those insights back into the clinical space. While this information-seeking can sometimes stem from curiosity or even doom scrolling, I often believe it reflects a deeper need: the desire to feel seen, understood, and validated when those needs are not being fully met within their real-life relationships.

For many individuals today, social media has become a substitute environment for connection. When someone hears a story that mirrors their own experience or encounters language that finally puts words to what they are feeling, it can create a sense of emotional resonance and safety. The nervous system often responds to perceived understanding before it evaluates credibility. In other words, people may experience relief simply because they feel seen; regardless of whether the information itself is clinically accurate.

I have also observed similar dynamics within healthcare settings. Patients who have previously felt dismissed or misunderstood by providers often approach treatment with guardedness. When someone with lived experience enters the care environment, that guardedness can soften. The interaction communicates, sometimes without words, "You are not alone."

As behavioral health continues moving toward person-centered and trauma-informed care models, peer support can be understood as a bridge between clinical systems and human experience. This represents both a major opportunity and a significant implementation challenge. The opportunity lies in improving engagement, trust, and outcomes. The challenge lies in integrating non-clinical roles into traditional clinical environments without unintentionally diluting what makes them effective.

A Growing Demand for Authenticity in Care

There is also a broader cultural shift occurring within healthcare. Many individuals today are seeking authenticity, transparency, and relatability in their treatment relationships. Patients increasingly want to feel humanized; not reduced to diagnoses, modalities, symptom scores, or treatment plans. Peer support often meets this need in ways traditional clinical models sometimes struggle to achieve.

For many individuals, interacting with someone who embodies recovery provides tangible hope; lived proof that change is possible. This sense of possibility can be particularly powerful for individuals who have experienced repeated treatment failures or stigma within healthcare systems.

The research reflects what many clinicians observe in practice. Peer services have been associated with improved engagement, self-efficacy, hope, and satisfaction with care, particularly among individuals with serious mental illness (Davidson et al., 2012; Chinman et al., 2014). Some studies also suggest reductions in hospital utilization and improvements in recovery outcomes (Repper & Carter, 2011). From both a clinical and operational standpoint, these findings are difficult to ignore.

Benefits of Peer Integration

When implemented thoughtfully, peer services offer meaningful advantages across behavioral health systems.

1. **Improve Engagement and Retention**: Individuals who may feel hesitant or mistrustful toward traditional providers often connect more easily with peers. In collaborative care environments, where engagement directly impacts treatment outcomes, this can be particularly valuable.

2. **Measurement-Based Care Engagement:** Peer specialists can also improve engagement with measurement-based care by helping patients understand the purpose of symptom tracking and reinforcing how progress monitoring connects to their personal recovery goals.

3. **Workforce Expansion:** Behavioral health clinician shortages are a national challenge, and peer roles provide a complementary workforce that extends capacity without requiring advanced licensure.

4. **Cultural and Community Alignment**: Shared socioeconomic, cultural, or lived experiences can improve trust and relevance of care.

5. **Reduced Utilization:** There is growing evidence that peer services may reduce high-cost utilization, including emergency department visits and hospitalizations (Chinman et al., 2014).

Risks and Implementation Challenges

Despite the many benefits, peer programs face predictable risks when integration is not approached thoughtfully. These challenges are not inherent flaws in peer support itself, but rather reflections of how systems are designed, implemented, and supported. Without intentional structure, organizations may inadvertently undermine the very value peer roles are meant to bring.

1. **Role Confusion:** Without clear boundaries, peers may be asked to perform clinical tasks outside their scope, or conversely, may feel undervalued within care teams. Both scenarios can erode role clarity and effectiveness.

2. **Tokenization:** Some organizations include peer roles primarily to meet funding, accreditation, or regulatory requirements without meaningfully integrating them into workflows or decision-making structures. When peers are present but not empowered, their impact is limited.

3. **Burnout:** Drawing on personal recovery experiences can be deeply meaningful, but it can also be emotionally taxing. Without appropriate supervision, support, and workload balance, peer specialists may face increased risk of burnout or compassion fatigue.

4. **Identification and Projection:** Because peer specialists share lived experience, there may be moments when they unintentionally project their own recovery narrative onto the individual they are supporting. Without proper training and supervision, this can influence decision-making or create unrealistic expectations about recovery timelines. This is a relational dynamic that requires thoughtful support structures.

I have also observed how easily systems can unintentionally medicalize peer roles through excessive documentation requirements, productivity pressures, or hierarchical team dynamics. When this happens, authenticity erodes; peers may begin to feel more like junior clinicians than individuals offering lived-experience support.

These challenges highlight the need for thoughtful operational design rather than assuming peer roles will naturally integrate into existing structures.

Operational Considerations for Sustainable Integration

From a systems perspective, sustainable peer programs share several key characteristics.

Role Clarity: Clear role definitions protect peers, organizations, and patients. Job descriptions, workflows, and expectations should emphasize collaboration while preserving the distinction between peer support and clinical treatment.

Training and Onboarding: Certification alone is rarely sufficient. Organizations should provide onboarding that addresses documentation practices, communication norms, ethical boundaries, crisis protocols, and the appropriate use of lived experience.

Supervision Structures: Supervision is one of the most critical components of peer integration. Dual supervision models that include both administrative guidance and recovery-oriented support can help peers maintain role identity while navigating workplace demands.

Team Integration and Culture: Peers should be included in interdisciplinary teams while maintaining their unique perspective. Cross-training clinicians about peer roles can reduce stigma and improve collaboration.

Documentation and Metrics: Metrics should reflect recovery-oriented outcomes such as engagement, goal attainment, self-efficacy, and quality of life; not solely symptom reduction.

Career Pathways and Compensation: Retention improves when peers have opportunities for advancement. Career ladders, leadership roles, and equitable compensation signal respect for lived-experience expertise.

Looking Ahead

Peer services are likely to expand across a wide range of settings, including primary care, emergency departments, digital platforms, and community-based programs. As behavioral health becomes more integrated within broader healthcare systems, peer specialists have the potential to serve as relational anchors, helping patients navigate both medical and behavioral health experiences while strengthening engagement across the continuum of care. Their presence can be particularly valuable in complex systems where individuals often feel overwhelmed, disconnected, or uncertain about how to access support.

The emergence of health technology also introduces additional opportunities for growth. Virtual peer support, digital recovery communities, and hybrid care models can extend access while maintaining relational connection, particularly for individuals facing geographic, transportation, or stigma-related barriers to care.

At the same time, scaling peer programs without losing authenticity will remain a central tension. The more systems attempt to standardize peer work through rigid workflows, productivity metrics, or clinical frameworks, the greater the risk of weakening the relational qualities that drive its effectiveness. Preserving the human elements of connection, mutuality, and lived experience will be essential as peer services continue to expand.

Conclusion

Many individuals feel disconnected from healthcare systems, the presence of someone who has walked a similar path offers a sense of belonging and possibility.

Sustainable integration requires intentional design, cultural humility, and leadership commitment to preserving humanity at the center of patient care. When peer roles are supported thoughtfully, they strengthen engagement, trust, and recovery itself.

As behavioral health systems continue to evolve, the question is not whether peer services should be included, but how they can be integrated without losing the authenticity that makes them effective.

Peer support works because humans heal in relationships and systems must be designed to protect that relational integrity.

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how biological, economic, social, demographic, and cultural factors influence life transitions and key events (Gitterman & Germain, 2008). It clarifies the cause-and-effect link between environmental conditions and behavioral health. Engaging clients helps identify variables affecting decision-making and internal or external stressors, especially when environmental resources are lacking. Surroundings significantly impact psychological, emotional, and physical well-being. Natural and human-made environments—such as parks, oceans, transportation, and housing—are crucial for resilience and health. While some overcome adversity, others internalize stress, leading to issues like substance abuse or poor health. Understanding these challenges is vital for social workers, as they can trigger mental and physical health problems. Assessing both internal and external factors is key to addressing environmental risks systematically. Factors such as race, religion, age, gender, and emotional states shape how individuals

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interact with their environment. Clinicians must recognize how environmental influences impact diagnoses and symptoms. This perspective underscores the importance of incorporating environmental influences into a comprehensive biopsychosocial assessment.

Conclusion

The ecological framework emphasizes supporting vulnerable populations by assessing their strengths, stressors, resources, and environmental impacts on their life trajectories. This comprehensive approach provides detailed insights into how environmental factors influence individual and group development, making it essential in social work. Consequently, careful application of the ecological model is essential when conducting a bio-psycho-social assessment with clients, ensuring that health determinants influenced by the environment are accurately identified. Thus, the traditional bio-psycho-social format should be expanded to include more detailed information about the individual's and family's environment, capturing protective and risk factors that contribute to inequality. This allows clinicians to more effectively link clients with resources beyond their immediate environment. At the micro level, this involves changing bio-psycho-social factors within organizations and offering training to foster a comprehensive understanding. Integrating ecological assessment into behavioral health practice can help clinicians better understand how policing, community stressors, and institutional policies shape mental health outcomes.

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own experiences, utilize this knowledge to bridge mistrust, and find the opportunity to integrate tools for overcoming inevitable challenges that youth face growing up.

Damon Watson, Program Director for Vibrant Emotional Health's Social Emotional Wellness arm of The Fellowship Initiative offers a layered perspective to how having a shared experience can benefit those who are often overlooked by a traditional mental health system of care.

"I have the honor of leading The Fellowship Initiative (TFI) at Vibrant, where we support young Black and Brown masculine individuals on their social and emotional wellness journeys. Every day, I sit at the intersection of clinical care, leadership, and lived experience. I'm also a Black, masculine-bodied therapist. And that identity isn't separate from my work. It's foundational to it - a vital part of its fabric. Before I became a therapist and before I entered leadership, I was a country boy who came of age in rural Virginia. I was raised around strong women and feminine energy. My sense of self was formed largely through the intentional care work of my grandmother, mother, and aunts. My grandma, in particular, taught me care, compassion, and accountability long before I had language for emotional wellness. Women like her often carried families, communities, and traditions on their backs, teaching us all strategies for being well in environments that weren't always designed to protect and prioritize our wellness. But outside of those spaces, the message for boys like me was different: be tough, be silent, handle it on your own. Without question, these conventions of normal masculinity not only influenced me but also policed how I could show up in the world. And today, I see that same tension molding the young men I serve.

In behavioral health, we talk a lot about evidence-based practices, treatment fidelity, and outcomes, all of which are needed. However, one of the most powerful tools I bring into the room cannot be measured on a fidelity scale: shared identity, which refers to the common lived experiences and cultural backgrounds of provider and client that inform mutual understanding and build trust.

Early in this role, someone told me the most powerful thing I could do was 'simply show up.' I've come to understand the truth about that. When young Black and Brown masculine bodies see me, not simply as a therapist, but as a leader, something changes. That wall slowly comes down. Guarded postures soften. The initial belief of 'he doesn't see me' starts to evaporate.

My upbringing taught me early on how culture shapes survival. I understand code-switching because I've lived it. I did not know it had a name back then. And yet, I performed it often. I understand hypervigilance because I've felt it. I understand the pressure to perform strength because I've carried it. So, when a fellow tells me he can't afford to be seen as 'soft,' I don't hear resistance. I hear strategy. I hear protection. I hear a young person navigating systems that haven't always been safe.

Growing up surrounded by strong women taught me that care and even softness are strengths. Yet society often teaches Black boys the opposite: that masculinity requires emotional suppression. In my role as a therapist-leader, I don't just talk about emotional wellness; I model it. I name emotions. I set boundaries. I place importance on well-being. I'm honest about the fact that I'm still learning the art of balance myself.

The young Black and Brown bodies that TFI serve are watching us. They're learning that strength can include vulnerability; that accountability can live alongside compassion; that asking for help is not synonymous with weakness; that modeling is prevention work. When we normalize lived experiences and amplify naming emotions, crises become less inevitable."

Damon's reflection and leadership are essential in the behavioral health workforce. As we experience a staffing crisis, and look at innovative ways to fill that gap, we should remember that there are those with valuable lived experiences and shared identities that also need to be recognized. Fewer than 5% of psychologists in the United States identify as Black. (American Psychological Association, 2022). A comprehensive approach should therefore include both workforce diversity and system-wide improvements (Sanford 2020). Uplifting the identities of all mental health professionals will lead to effectiveness and more healthy outcomes.

Systems must invest in:

- Organizational cultures that acknowledge lived experience as an evidence-based practice
- Pipelines for clinicians of color and those facing inequitable access to career advancement in the field
- Leadership pathways for culturally grounded providers
- Metrics that measure trust and engagement, not just service volume

Damon's experiences as a leader and therapist highlight what might be a simple approach to helping advance what peer work could mean:

"I often think about that country boy from Buckingham, Virginia, raised by powerful women, navigating expectations of masculinity, searching for places where he could be both strong and soft. I became the therapist I needed when I was younger. I became the leader I wish I had seen.

Behavioral health care works best when those we serve feel noticed, heard, and understood. Shared identity doesn't replace clinical skill; it strengthens connection, deepens trust, and accelerates healing. Sometimes the most powerful intervention isn't a technique. It's a recognition. Perhaps recognition is a technique. Because when young people see themselves mirrored in the people who hold space for them, they begin to believe that healing belongs to them, too."

Dr. Jantra Coll, PsyD, is the Vice President of Community Programs, and Damon Watson, MPH, LPC, is the Program Director of the Fellowship Initiative, both at Vibrant Emotional Health.

Resources

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Learning Collaborative (RWLC). Central to this vision from the outset was the principle of **co-creation**. Peer and lived experience leaders have been essential partners in the design and delivery of the collaborative. They help shape the curriculum, co-facilitate training, provide technical assistance to agencies, and continuously refine materials to ensure they remain grounded in the realities of peer work.

What is the Recovery Workforce Learning Collaborative?

RWLC is a team-science approach to building organizational capacity through mutual learning among agencies committed to implementing peer support and recovery support initiatives with lived experience leaders. It invites agencies to engage fully, honor the strengths they already carry, and dream boldly about the future they want to create for their communities.

Learning collaboratives are designed to bring together diverse stakeholders to address shared challenges and develop practical solutions through collective learning. As Berwick (1998) underscored, collaborative learning facilitates the rapid dissemination and adoption of best practices within and across organizations. In healthcare contexts, learning collaboratives enable participants to share insights, develop new skills, and implement evidence-based strategies that improve service delivery and outcomes (Mittman, 2004).

The RWLC is a 12-month initiative that combines in-person and virtual learning sessions with customized consultation and technical assistance. Its goal is to help behavioral health agencies establish the organizational culture and administrative infrastructure needed to hire, retain, supervise, and effectively support the peer recovery and lived experience workforce.

The RWLC toolkit modules include:

- Module 1: Preparing the Organizational Culture
- Module 2: Role Clarity, Recruiting, and Hiring
- Module 3: Supervising, Retaining, and Advancing Peer Recovery Workers

The RWLC creates space for agencies to learn not only from facilitators and guest speakers but also from one another. Participants exchange experiences, share strategies, and collectively problem-solve. Peer leaders are embedded throughout the process, helping to reframe discussions, challenge assumptions, and model authentic integration.

Across three cohorts in Connecticut, 30 behavioral health agencies have participated in the RWLC. A parallel effort in Victoria, Australia, involving 21 agencies across two culturally adapted cohorts will be described in future work. Lessons from these agencies continue to inform and refine the collaborative model.

Grounded in Appreciative Inquiry

"We want to work towards earning the trust of individuals in our programs, so they see that we are not clinical staff but caring people with much in common."

The RWLC is grounded in appreciative inquiry, an asset-based approach to change that focuses on identifying and building upon strengths within an organization (Cooperrider & Srivastava, 1987; Hawkins & Bellamy, 2011). Rather than beginning solely with problems, appreciative inquiry asks what is working well and how those strengths can be expanded.

Traditional approaches to organizational change often emphasize identifying root causes of problems. Appreciative inquiry instead focuses on possibilities and positive potential, encouraging organizations to identify what is true, good, and possible within their systems.

Within the RWLC, this perspective encourages agencies to build on existing assets as they integrate peer recovery workers and lived expertise into behavioral health services. It also shapes how peer leaders are engaged. Their lived expertise is recognized not as a challenge to be managed, but as a valuable resource for improving systems of care.

Using the RWLC Toolkit

The RWLC toolkit was developed in 2017 in response to concerns agencies and peers raised about hiring and supporting peer recovery workers. These concerns are often centered on role clarity, supervision, organizational readiness, and onboarding processes and sustainability.

The toolkit encourages agencies to address these questions **before hiring peer staff**, rather than waiting until challenges emerge. Early preparation helps organizations reduce resistance, clarify expectations, and establish supportive environments for peers.

The toolkit themes:

- Communicating the value of peer support early to support culture change
- Developing participatory leadership pathways and co-supervision models
- Preventing burnout and tokenism while supporting career advancement
- Promoting culturally responsive supervision and equitable hiring practices
- Supporting workers who may have non-traditional or interrupted employment histories

Importantly, the toolkit is a **living document**, continuously revised by peer leaders and participating agencies based on lessons learned from each cohort.

What We Have Heard from Participants

"The learning collaborative strengthens our commitment to inclusivity, recovery-oriented care, and cultural humility."

"Peer support staff also want opportunities for advancement."

These reflections highlight a consistent theme: the collaborative works because it values the expertise of everyone involved.

Agencies are not passive recipients of training. They actively contribute to the collaborative's collective knowledge. When one agency develops an effective supervision model, others learn from it. When another improves its hiring process, those lessons spread.

Peer leaders play a vital role in this exchange. Their leadership ensures that lived expertise informs discussions, training materials, and consultation activities. Learning flows in multiple directions: agencies learn from peers, peers learn from agencies, and the collaborative evolves continuously.

This is the essence of **mutual learning**.

Conclusion: The Power of the RWLC Model

Promoting peer support and lived experience workforce development requires intentional infrastructure development that aligns with competency frameworks while remaining grounded in recovery-oriented values. The collaborative approach developed through the RWLC, combined with evidence-based implementation frameworks and a practical toolkit, provides behavioral health agencies with guidance for cultural transformation while honoring the contributions of peer support workers.

The RWLC demonstrates that meaningful change happens when organizations, peer leaders, and communities **learn together**.

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individuals leaving incarceration — a population at extraordinary risk of fatal overdose — peer support appears particularly vital. A randomized clinical trial of the SUPPORT program in Indiana followed 100 individuals returning to the community from prison. Among those assigned to peer recovery coaches, alcohol and illicit substance use decreased from 30% at baseline to just 16% after six months. In stark contrast, participants receiving treatment as usual saw their substance use increase from 26% to 41% over the same period. The peer-supported group not only fared better; they moved in the opposite direction of the control group.

3. The Kentucky Medicaid analysis. Perhaps the most policy-relevant finding comes from an analysis of Kentucky Medicaid claims data examining peer support following emergency department visits. Beneficiaries who received peer support services were significantly more likely to engage in substance use disorder treatment across all six months of follow-up. The odds of treatment engagement for those receiving peer support ranged from 1.63 to 3.84 times higher than for those without such support, even after adjusting for age, sex, geographic location, and health conditions. For individuals with multiple health conditions — the norm rather than the exception in this population — the effect was even more pronounced.

What Peers Actually Do

Dr. Peter Treitler, a person in long-term recovery and researcher at Boston University, describes peer support as operating on multiple levels simultaneously. In his study of New Jersey's Intensive Recovery Treatment Support program for individuals leaving incarceration, participants described receiving help with goal setting, encouragement, feedback for self-monitoring, and emotional support — especially during moments of vulnerability and risk for relapse.

But peers also connect individuals to tangible resources: treatment services, recovery programs, housing support, and even basic needs like clothing and cell phones. For someone emerging from active use or incarceration, these concrete supports are not incidental to recovery — they are its foundation.

Treitler's research found that individuals with opioid use disorder who participated in peer-supported re-entry programs were "much more likely to engage in treatment within six months of release compared to those who did not, and were also more likely to be enrolled in Medicaid." In this sense, peers function as both motivators and system navigators, helping individuals access the healthcare and social services to which they are entitled but often cannot navigate alone.

Temitope Fabayo, BA, MBA-HR

Not Just Any Support:
The Therapeutic Relationship Matters

A study examining the mechanisms of peer-based recovery support services across 58 sites in the northeastern United States found that the quality of the relationship between peer and participant significantly predicted outcomes. While the study did not find straightforward mediation effects, it did demonstrate that "receiving more services at Time 1 significantly predicted better PRS relationship/helpfulness at Time 2." In other words, engagement begets engagement — the more contact individuals have with peers, the stronger the therapeutic alliance becomes, potentially creating a virtuous cycle of recovery support.

Challenges and Caveats

The evidence for peer services is not uniformly positive. A pilot randomized trial in Philadelphia's drug court found mixed results: while participants linked to peer recovery specialists showed reductions in rearrests and improved court engagement, there was no impact on substance use recurrence or treatment engagement. Similarly, some studies have failed to find effects on certain outcomes, suggesting that peer support may work better in some contexts and populations than others.

The systematic review in *Current Addiction Reports* noted that study quality remains variable, with approximately one-third of studies rated "weak" due to selection bias, confounding, or other methodological limitations. This is not unusual for an emerging field, but it underscores the need for continued rigorous research.

There are also implementation challenges. Funding for peer services remains precarious, largely dependent on time-limited federal and state grants. While some states have established Medicaid reimbursement for peer services, rates are often too low to support program sustainability, or billing is restricted to specific settings.

The Policy Imperative

Despite these caveats, the weight of evidence now supports expanding access to peer-led services. The consistency of findings across populations — from emergency department patients to returning citizens, from rural West Virginia to urban Philadelphia — suggests that peer support addresses a fundamental need that clinical treatment alone cannot fill.

For individuals in early recovery, the first months are a period of extreme vulnerability. The brain is still recalibrating its reward circuitry. Cravings are intense. Social networks have been decimated. Practical needs are overwhelming. In this context, a peer who has navigated the same challenges offers something no clinician can: embodied proof that recovery is possible.

As Zemore notes, the changing understanding of addiction as a complex, multilayered condition rather than a moral failing has opened space for diverse approaches to treatment and support. Peer-led services represent a logical extension of this insight: if addiction is fundamentally a disorder of disconnection, then connection may be its most potent antidote.

Conclusion

In West Virginia, the impact of the IMPACT WV program has been rigorously evaluated, revealing significant outcomes in how rural communities address substance use disorders. A study published in the peer-reviewed journal Digital Health evaluated the program's training portal, which educates service providers working with families affected by substance use. The research found that pre- and post-assessment results showed **significant knowledge improvements in key areas**, including neonatal abstinence syndrome and substance use, with completion rates for core modules reaching as high as 73% among rural service providers. The program's patient navigation model, which begins in the birthing hospital, has been identified as the most effective approach for supporting families, coordinating care that addresses housing, utilities, transportation, and recovery support across nine northern counties with the highest rates of neonatal abstinence syndrome. The outcome is a coordinated, two-generational approach that strengthens services for vulnerable families in rural settings.

And should you walk this road again, please understand that it is not only your story that you are walking. It is a breathing, living source of hope to someone who is still searching their way. Being a peer coach in your society is something you should consider, as it may be just what someone needs. And should you find a person who has been through recovery and come out the other end, encourage them to share what they have learned. Their experience can spread outward to affect people, build up their families, and remind the world that change can happen.

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like a person who's been there. Second, peers know HOW to recover. Don't get me wrong, recovery looks different for each person, but there are common themes and threads that run across every recovery story. We didn't learn from a textbook how to help people recover. We learned how to help people by recovering ourselves. We've walked the walk, tried all different types of treatments, and we have seen first-hand what is effective. Third, we can be your biggest advocates. We know what the mental health system can be like: how at its worst it can be shaming, stigmatizing, and taking away people's freedom. We know this because we've lived through it. And we don't want you to live through the same pain. So, we'll fight for you like no one else.

I believe that recovery is possible. Not just for me, but for EVERYONE. Does this mean that everyone recovers? No, because not everyone is taught the skills to recover. Also, once a person learns the skills, they must choose to use them. My peer specialist colleagues and I can give you a flashlight so that you can see your way out of the darkness of mental illness. You make the choice about whether to turn the flashlight on. I can tell you that life can be beautiful in the light of recovery. Won't you join me here?

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sustainability and research.

Why Measurement Matters for Peer Support

The peer movement began as a response to traditional systems of care and was grounded in values such as empowerment, mutuality, and social justice. These principles are not always captured by traditional clinical measures. Behavioral health systems often rely on data to inform funding decisions, program development, and service evaluation. Many studies of peer services focus on broad outcomes such as hospitalization rates, symptom reduction, or service utilization. While these outcomes are important, they do not necessarily make clear what exactly is being evaluated or the ways in which peer support was delivered. Because of this, researchers and policymakers have struggled to determine when peer support is being delivered with fidelity to its core principles.

This creates what some describe as a "black box" problem for peer support research. If we cannot measure how peer support is delivered in practice, it becomes difficult to evaluate what makes it effective, or to ensure that programs maintain the integrity of the peer role as they grow.

To address this gap, researchers at the Yale Program for Recovery and Community Health have begun work to develop a competency-based fidelity measurement tool that focuses on assessing the defining elements of peer support and how they are delivered in research and practice. Below we discuss four ways this type of tool could benefit behavioral health organizations.

1. Assesses Organizational Readiness

One promising approach to using a competency framework is as a tool to assess organizational readiness and guide efforts to prepare the organizational culture for the integration of peer support workers. At this stage, organizations can review whether their policies, practices, and culture align with recovery-oriented peer values before introducing peer roles.

2. Guides Training and Supervision

Competency frameworks are currently used to guide certification requirements but can also serve as a valuable tool for training and supervision within organizations that employ peer workers. When used thoughtfully, competency-based approaches can help ensure that peer workers receive professional support while preserving the relational and recovery-oriented foundations of peer work.

Training programs that align with peer support competencies provide a structured way to introduce the values and practice of peer work. Instead of focusing only on job tasks, competency-based training highlights the values and relationship skills that make peer support different from traditional clinical roles. These include practices such as using lived experience intentionally, fostering mutuality, promoting hope, supporting self-determination, and helping individuals navigate complex behavioral health and social service systems.

Supervision represents another critical area where competency frameworks can strengthen peer workforce infrastructure. Traditional clinical supervision models are not always well suited to the unique nature of peer work. Peer support emphasizes shared experience, empowerment, and mutual learning, principles that may be misunderstood if supervision is grounded exclusively in hierarchical clinical models.

Competency-based supervision offers a more supportive alternative. Supervisors can use competency frameworks to guide reflective discussions about how peer workers are applying the principles of peer support in their daily practice. Conversations may focus on how peer workers use lived experience appropriately, maintain ethical boundaries while preserving mutuality, or support individuals in identifying and pursuing personal meaningful recovery goals. Overall, competency-based training and supervision help ensure that peer workforce development remains aligned with the foundational values of recovery, empowerment, and lived experience leadership. By grounding training and supervision in these principles, organizations can support peer workers while strengthening the integrity of peer support within behavioral health systems.

3. Structures Continuing Education and Professional Development Opportunities

As peer workers gain experience, organizations can use competencies to identify areas for skill development, such as facilitating peer groups, supporting individuals from diverse cultural backgrounds, practicing trauma-informed engagement, or participating in program evaluation and quality improvement efforts. In this way, competencies help create clearer professional development pathways for peer workers while aligning continuing education with the changing needs of the workforce.

4. Increases Data-Driven Decision-Making

As peer support programs expand across behavioral health systems, organizations are increasingly asked to demonstrate the effectiveness and impact of peer services. Competency-based fidelity measurement is the first step toward making data-driven decisions. Instead of immediately focusing on outcomes, fidelity approaches examine whether peer support services are being delivered in ways that reflect the core principles and practices that define peer work. By assessing whether these elements are present in service delivery, organizations can better understand how peer support is being implemented and identify areas for improvement. Then, when going on to measure outcomes, organizations better understand the extent to which peer support programming was implemented as intended.

Fidelity data can help organizations strengthen workforce development strategies. For example, if assessments show challenges related to role clarity, boundary navigation, or integration within interdisciplinary teams, organizations can respond by refining training programs or supervision models. In this way, fidelity measurement supports continuous quality improvement rather than simply monitoring performance.

Competency-based fidelity measures can also help demonstrate the impact of peer support to policymakers, funders, and health systems. As behavioral health systems increasingly rely on data to guide funding and program decisions, having tools that capture the unique elements of peer support can help demonstrate the value of lived experience-based services.

When implemented thoughtfully, fidelity measurement can strengthen the peer workforce by giving organizations useful insights while protecting the relational and recovery-oriented principles that make peer support unique.

Conclusion: Looking Ahead- Building a Balanced Infrastructure for Peer Support

Competency frameworks provide important guidance for training, supervision, and quality improvement. Measurement tools, including emerging competency-based fidelity measures that build on previous work in the field, can help ensure that peer support is delivered in ways that reflect its core principles.

At the same time, these tools must be implemented carefully. If competencies and measurement strategies are applied without attention to mutuality, equity, and lived experience leadership, peer support could become a checklist of tasks instead of a relationship-based practice. Tools must go beyond a simple checklist of "did they do the step?" to also measure the skills, accuracy, and approach used by peers to ensure the service is delivered in a way that supports the intended outcomes. Any peer support fidelity measure needs to consider both the *what* of peer support (e.g., tasks and activities) as well as the *how* (e.g., relational aspects).

The most promising path forward is a community-engaged approach: developing competency and measurement tools through partnering with peer support and lived experience leaders across the country. As the workforce expands, evaluation efforts must keep pace. The sustainability of this emerging workforce depends upon it.

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belonging that is essential for both academic persistence and emotional well-being. For many participants, peer mentoring provides a bridge between structured support services and independent engagement in the broader campus community.

Recruitment and Training of Peer Mentors

To ensure the quality and safety of the program, peer mentors are carefully recruited and selected from the Adelphi University student body. Mentors are often students who have demonstrated leadership, compassion, and a commitment to creating inclusive communities on campus. Because mentors work closely with fellow students in supportive roles, they also undergo a university background screening process prior to beginning their work in the program.

Once selected, peer mentors participate in a one-day training program designed to prepare them for their role. The training provides an introduction to neurodiversity and emphasizes the importance of creating supportive, respectful relationships that promote student autonomy. Training topics typically include:

- Understanding neurodiversity and inclusive communication
- Building supportive peer relationships
- Recognizing appropriate boundaries and maintaining professionalism
- Strategies for facilitating social engagement in natural settings
- Identifying situations in which additional support from program staff may be needed

The training equips mentors with practical tools that help them navigate common situations that may arise during mentoring sessions. At the same time, the program emphasizes qualities such as patience, empathy, and flexibility, recognizing that each mentoring relationship develops in its own unique way.

Ongoing Supervision and Support

Peer mentors receive ongoing supervision throughout the semester, ensuring both accountability and continued skill development. After each meeting with their mentee, mentors complete weekly supervision reports that briefly describe the activities completed, interactions observed, and any challenges or questions that may have arisen.

These reports are reviewed by program staff and discussed during regular supervision meetings. Supervision provides mentors with an opportunity to reflect on their experiences, receive guidance, and discuss strategies for supporting their mentees effectively. These conversations also allow program staff to monitor student progress and provide additional support when needed.

Ongoing supervision is an essential component of the program, as it ensures that mentors feel supported in their roles while maintaining the overall quality and consistency of the peer mentoring experience. In addition, mentors often report that supervision meetings serve as valuable opportunities for professional development, helping them strengthen skills related to communication, leadership, and collaboration.

Reciprocal Benefits of Peer Mentoring

While peer mentoring provides meaningful support for participating students, the benefits extend to mentors as well. Many peer mentors report that the experience deepens their understanding of neurodiversity and broadens their perspective on the variety of ways students experience campus life. Through mentoring, students often develop stronger communication skills, increased empathy, and a greater sense of responsibility toward building inclusive communities.

For many mentors, the experience also strengthens their identity as leaders on campus. Mentoring relationships often evolve into genuine friendships that extend beyond scheduled meetings and contribute to a more connected campus environment.

In some cases, students who initially participated in the Bridges program as mentees later become peer mentors themselves. These students bring a particularly valuable perspective to the mentoring process, as they understand firsthand the challenges and successes associated with navigating the college environment. Some former mentees go on to mentor undergraduate students at Adelphi as well as local high school students who are preparing for the transition to college. This progression highlights the transformative potential of peer mentorship: students who once received support become leaders who guide others.

Building Inclusive Campus Communities

Peer support programs like Bridges demonstrate that meaningful inclusion requires more than accommodations; it requires opportunities for authentic connection. When students have access to supportive peer relationships, they are more likely to feel comfortable participating in campus activities, developing friendships, and engaging fully in their academic experiences.

By fostering relationships between students, peer mentoring programs help break down stigma, promote understanding, and create campus cultures where differences are recognized as strengths rather than barriers. These programs also reinforce the idea that building inclusive communities is a shared responsibility among all members of the campus environment.

In behavioral health systems, peer support has long been recognized as an effective intervention for promoting recovery, empowerment, and community integration. Universities can learn from these models by integrating peer mentorship into student support services, particularly for populations who may experience social barriers within traditional campus structures. As colleges and universities continue to prioritize student well-being, peer mentoring programs represent a practical, scalable, and human-centered approach to strengthening community and supporting mental health. By investing in peer support, institutions not only provide assistance to individual students but also cultivate a culture of compassion, leadership, and belonging across the campus. When students support one another, they do more than build friendships, they build bridges.

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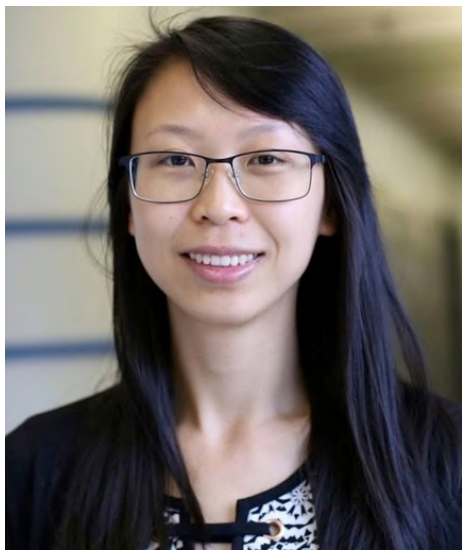

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Peers and Bridging Generational and Cultural Differences

With my peer clients, in groups or individually, there can be a generational gap that is an asset for all. Being in my late 60s, by explaining the benefits of today's treatments, medications, and skills mostly unavailable a generation ago, younger clients realize how much has been overcome and the progress to come, gaining appreciation and gratitude for being here in this place and time. Every generation has shown a decrease in stigma and improvements in diagnosis, therapy, medications, employment opportunities, and more.

Through their eyes, I hope they see, learn, and respect what I try to offer. Their acceptance and resilience strengthen my own resolve. Their skills and the generational and cultural differences they bring, I apply to my own growth and lifestyle. Technology is one obvious example. The confidence and trust consumers have in my efforts help overcome a strong sense of insecurity from years of feeling different.

In discussions, while having any illness is difficult, younger generations have a greater understanding of the benefits and opportunities available, and they are learning and adapting to specific situations and life choices. From relationships and friendships to careers and goals, a renewed quality of life can be more focused. While misdirection will always occur, their future choices and options are clearer. Everyone has limited control over life's circumstances; peers can assist those struggling

Glenn Slaby, MBA, MFA

with neurodivergent issues. Information is knowledge, and knowledge brings greater control and awareness.

Together with older clients, we share ways and ideas to climb new mountains from prior setbacks, be it prior careers, relationships, or financial hardships. There is a commonality of experiences not always available with some professionals.

I wish and hope one day peers can reach more people in our general community. Too many are not aware of how difficult it is to change the brain's neural pathways, to manage medications, and to conform daily. The human brain is so delicate and fragile. Those who do not understand can make growth, life, and recovery more difficult. There are even some who do not believe in their own fallibility, causing real challenges for everyone.

To help non-consumers understand, I use the example of trying to use your non-dominant hand in activities, just a few muscles, just a small part of the brain. Let others see how difficult it is to be constantly mindful.

Teaching Daily Life Skills

Nutrition is an important part of well-being and balance. Our society is filled with unhealthy choices from foods to entertainment. Too many are intentionally addictive. It is difficult to block their visual and sensory media dominance. Cultural differences, especially in foods, have also enlightened me to healthier lifestyles.

Peering helps everyone deal with the difficulties and complexities of medications, relationships, issues with sleep, family, jobs, and daily life skills. Sharing experiences, a wall therapists cannot breach, peering is a display of successful living with mental illness. We can also share outside our community a greater understanding of the complexities of mental health issues. And our skills can be shared with others. Too many go through life without basic life supports. I had too many employees in the business world without the basic skills consumers learn here.

Many are surprised when I tell them about my cancer (now four years in remission) and how the tools learned through mental illness helped with the anxiety, the pain, and the unknown. Tools some other cancer patients did not have. And to accept, to seek, and to find the silver linings hidden in pain. It is difficult, but by peering, hope and strength are reinforced in both me and the client.

As a former accountant, I also assist clients with managing their own finances, budgeting, and value-focused shopping. From reading labels and creating a consistent diet to navigating digital shopping apps and understanding price, cost, and value. Daily living skills, especially simple and healthy meal preparation, are usually outside the general range of therapists, as they have more important client matters to handle.

As a peer, I research the availability of paid and volunteer jobs. A volunteer job led me to a part-time paid position at the local public library. From there, we established a free bookstore, receiving donations from numerous sources. I also make available free materials (accessible in the bookstore), from food pantries, free local activities, free self-help courses, and available public information on health, consumer protection, budgeting, and finance.

"Compassion is ethical intelligence: it is the capacity to make connections and the consequent urge to act to relieve the suffering of others." - Will Tuttle

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way out was to "fake it til you make it." Notwithstanding the genuine care of the staff, I went through the motions with all the therapy, from talking to music, art, and drama. Given how weak I felt from weight loss and muscular atrophy, gaining discharge in just 10 days was a minor miracle. However, to achieve a quick escape, I abandoned "peer solidarity" for fear of sinking into other patients' deep doo-doo. Even after returning home, it took me months to realize that isolation was not a winning strategy.

From Here to Recovery with and Without Peer Support

The price of my freedom was appointments with my social worker and psychiatrist every week or two, although I had little to say to them. Because regaining my strength was uppermost in my mind, I walked the two miles to and from the hospital, plus treks up and down a hill in my Prospect Park neighborhood. (I felt like Sisyphus, who the Greek gods condemned to roll a boulder against gravity for eternity.)

Then, returning to Quaker church, I cooked for social hour after Sunday worship, a "saving grace" you might say, but without socializing. Even if many congregants had "held me in the Light" during my absence, I didn't know how to make small talk about something as deep as suicidal depression. I also prepared meals for our immigrant rights group because I wasn't up to advocating at Federal Plaza's detention center.

"Saved by Imagination: How Reading and Writing Restored my Mental Health" is one of my unpublished books. If writing was the last thing on my mind after the literary "epitaph" of "Confessions of a Peer Counselor," I could at least escape through fiction. Because what's a good story without characters who talk easily to each other, I shared with my psychiatrist the revelation that, if I didn't open to others, I would bore myself to death.

She referred me first to an interpersonal skills group, motivating me to reconnect with people I had ghosted, then one with a concern for grief (because the tongue is a vital organ to lose). My attendance was sporadic as I took two steps back before each step forward. Whereas, when I was a peer specialist, compassion for peers' predicaments was rule #1, I struggled to treat myself similarly.

For a few weeks I participated in an employment support group at my church, hoping to revive the ambition of parlaying my end-of-life midwife certification into a food service for families whose loved ones were dying. Once again, I abandoned my fellow sufferers because their lamentable job searches reminded me too much of my own.

Instead, I became a member of the culinary unit at Brooklyn's Venture House. Unfortunately, the kitchen in their temporary storefront was so small that staff supervision left little room for members' initiative. So, after studying for and passing the test to recertify my food handler's license from the city's health department, I returned to Fountain House, this time as part of their kitchen unit. With its commercial size, from which up to a hundred people are fed every meal, I was part of a dozen staff and members who accept individual responsibility while acting cooperatively.

A similar model exists for the volunteers of Good Neighbors of (Prospect) Park Slope. Although not officially a naturally occurring retirement community (NORC), our goal is a myriad of ways to maintain well-being by socializing. After participating in the aging transitions and conversational French groups online, I proposed writing book reviews together. To practice, I critiqued Alice Munro's *The Lives of Girls and Women* (1972) and M. John Harrison's *Empty Space: A Haunting* (2012), proving that I not only still had the gift of gab but also a steady enough hand to type my thoughts on paper.

Then, I shared my dark night of the soul during a discussion of our spiritual journeys at a Concern for Quaker Living meeting. That's when I had the idea for this essay. Quakers have a history of speaking truth to power, but if you don't have the power to listen for the still small voice within before translating it into words, you will be mired in stereotypes, like the ones in the dream with which I prefaced "Peer Specialist, Heal Thyself." The lesson is that what's good for the goose (peer) is good for the gander (peer specialist), otherwise known as the mutuality of intentional peer support. (If only I had applied such a maxim sooner.)

Never Too Late for Afterthoughts

One irony is that five years ago I helped create the New York Academy of Peer Services' specialization in older adult behavioral health. If I had followed my own advice in the five courses and two-page job description for helping our elders age well despite psychiatric diagnoses, I wouldn't have the pleasure of admitting I made a big boo-boo. Here I am a year later informing Jesus that I bore my cross just for him. Will he jeer me or cheer me?

Another irony is that, although I'm back on Depakote, I've maintained my weight around 130 lbs., to go with a height of 5' 5", resulting in a normal (no longer pre-diabetic) blood glucose level. How long I can keep up my slimmed-down Mediterranean diet is anyone's guess. I invite you to play the betting markets and, if you win, share your winnings with me like a good peer specialist—intentionally!

Finally, I and Susan, who retired as a horticultural therapist at 75, and is now 81, had a lawyer draft our health care proxies, HIPAA permissions, and living wills for end-of-life decision-making, documents that everyone should have. We also made burial arrangements. But I neglected to create a psychiatric advance directive (PAD) in case of another crisis. So, please do as I now say by using this handy guide to avoid meeting your maker prematurely: FREE Webinar - Peer Perspectives on Psychiatric Advance Directives (PADs).

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wide have adopted specialized approaches, often through directives from their local governments, such as **Crisis Intervention Teams (CITs),** involving specially trained law enforcement officers who respond to mental health crisis calls, in coordination with mental health providers, and **Co-Responder Teams (CRTs),** where law enforcement officers are paired with trained clinicians to jointly respond to emergency calls involving a mental health crisis.

While these approaches may fall somewhat short of the mandates described by the DOJ and HHS, the above models are arguably preferable to having only officers respond to such events with little or no specialized training in handling a mental/behavioral health crisis.

A third model seems closer to meeting the federal guidelines: **Mobile Crisis Teams (MCTs),** wherein community-based mental health professionals respond to such crises, with police being involved only when necessary. The Vera Institute and Bazelon Institute support this approach, where "jurisdictions should not assume that the proper response to a crisis is always to send law enforcement." They advocate for law enforcement and 911 dispatch to divert calls to unarmed, properly trained behavioral health responders "whenever appropriate."

According to the Congressional Research Service, CITs, CRTs, and MCTs may each improve certain outcomes, such as enhancing police officers' perceptions of and responses to people with mental/behavioral disorders, and helping to connect individuals with mental health services. However, it is less certain whether these improvements will lead to tangible benefits in the long run for those with mental health needs, such as fewer arrests and reduced use of force overall.

One of the more forward-thinking communities to address these issues is Ithaca, NY, a city of some 31,000 residents in the Finger Lakes region, home to Cornell University. In the wake of a tragic mental health response several years ago that resulted in the death of a beloved local police officer,

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the city sought to reform how such events were handled. There were several different models attempted, and after struggling for some years with how to form a workable policy, a forward-thinking mayor, along with the city's Common Council, developed the CARE (Crisis Alternative Response and Engagement) team approach, which had professional clinicians *leading* the response to mental health incidents, backed up by trained officers. Although a change of administration and police leadership led to a less robust program, in December 2023, the Re-imagining Public Safety initiative was introduced in Ithaca, and thereafter the Common Council passed a resolution to replicate the CARE Team response program.

In the Ithaca Police Department (IPD), mental and behavioral health clinicians collaborate with officers by responding to calls involving individuals who may be in dangerous situations due to their mental state. CARE services may include de-escalating situations and providing support after a crisis that may have involved violence or potential injury.

Harmony Ayers-Friedlander, the Deputy Commissioner for Mental Health Services of Tompkins County Whole Health, in Ithaca, explained that the CARE team was established based on research and data on the effectiveness of co-response teams. Friedlander noted that such research has also helped address the issue of people unnecessarily going to emergency departments for mental health crises.

Colorado Springs, CO, a community of just under a half-million, famous for being where the US Air Force Academy is located — as well as the US Space Force and Focus on the Family — may stand to represent the model closest to meeting the federal guidelines for handling such critical incidents.

In Colorado Springs, the Community Response Team (CRT) is indispensable for managing mental health emergencies. When residents contact 911 or the state crisis line for a mental/behavioral health crisis, a team consisting of a Colorado Springs Fire Department paramedic, a Colorado Springs Police officer, and a mental health technician from Diversus Health responds. The CRT was established in 2012 to improve support for individuals experiencing behavioral health crises. This followed almost a decade of exploring and developing new models of handling such events, first initiated by Chief Fletcher Howard before the turn of the century.

One reason they believe their CRT has been so successful is that the clinician and the fire department personnel take the lead in such events, both of whom seem less frightening and authoritative to a distressed individual than a law enforcement officer.

Whichever appropriate approach the local legislature and police agency may adopt, it is well past time to leave such critical mental and behavioral events to be handled by officers with little or no training, and whose job it is to enforce the law, not to treat individuals with mental health issues.

One final word: law enforcement agency personnel across the US generally hold that there is a condition known as *Excited Delirium* which can 'take over' an individual going through a mental or behavioral health crisis, typified by extraordinary strength and almost superhuman capabilities. This is a myth. There is no such thing as Excited Delirium — it has never been recognized by the American Psychiatric Association, or any other legitimate professional organization. This misconception is peculiar to police professionals. Unfortunately, tragedy has followed from this myth, especially in situations where first responders call for medical assistance due to expected superhuman behaviors showing up in a mental or behavioral health crisis, and particularly in the unnecessary use of chemical sedatives, such as Ketamine, which has led to needless tragedy and death, underscoring the need for police agencies everywhere to collaborate with professionals better prepared to deal with such incidents.

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This is not just work for me. It's my purpose - being able to meet people where they are at, using my lived experience with service and walking beside them as they move forward.

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supervision and training reinforce organizational commitment and enhance retention. Advancement should occur within the peer framework, preserving peer identity rather than requiring transition into non-peer roles.

Success can be evaluated through multiple measures: streamlined hiring processes, stronger stakeholder perception of peer value, improved interdisciplinary collaboration, higher job satisfaction, and increased retention among peer professionals.

Conclusion

Peer professionals offer transformative potential for large public behavioral health systems. Within NYC Health + Hospitals, their lived experience strengthens engagement, promotes equity, and advances recovery-oriented, community-based care.

Realizing this potential requires thoughtful attention to hiring processes, organizational culture, professional development, and career advancement. By continuing to address systemic and administrative barriers while investing in sustained support, NYC Health + Hospitals is building the infrastructure to fully integrate peer providers and establish itself as a leader in peer services, enhancing person-centered care and improving outcomes at scale.

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