National VA Mental Health Wellness & Recovery Webinar Series:

The Role of VA Peer Specialists in Supporting Physical Health and Wellness

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Dr. Samantha Hack: This series is made possible by the VA Office of Mental Health and Suicide Prevention, Psychosocial Rehabilitation and Recovery Section, and the VISN 5 Mental Illness Research, Education and Clinical Center [MIRECC] in partnership with the Employee Education System. The planning committee members for this Webinar series include: Daniel Bradford, Valerie Fox, Spencer Glipa, Catherine Lewis, Marty Oexner, Kathryn Peacock-Dutt, Donna Russo, Tim Smith, my co-host Ralf Schneider, and myself, Samantha Hack. Today's Webinar is entitled, "The Role of VA Peer Specialists in Supporting Physical Health and Wellness". Our presenter for today's Webinar is Dr. Anjana Muralidharan. Dr. Muralidharan is a clinical psychologist and researcher at the VISN 5 MIRECC. The focus of her research is on aging with serious mental illness, peer support, and recovery oriented and person-centered care. She is currently testing a peer delivered coaching intervention to promote participation and supervised fitness training among older adults with serious mental illness. She is avid mindfulness meditation practitioner, and a believer in the power of compassion and human connection as an ultimate source of joy and healing. At this time, I'm happy to turn the Webinar over to our presenter.

Dr. Anjana Muralidharan: Hello. Thank you Samantha. Welcome everybody. I see people are still streaming in, but I am going to get started, because I have a lot of material I want to cover. So, can everyone hear me clearly? Yes. Okay. Got some yeses. Okay, so anyway, please interrupt me if there is any issues with the sound, but I will go ahead and get started. So, yeah, my name is Dr. Anjana Muralidharan and I work at the VISN 5 MIRECC with my colleagues Ralf and Samantha. I'm so excited to be here today and talk about one of my favorite topics, which his peer support. I don't have anything to disclose. So, before I jump into the actual sort of outline of my presentation, and the meat of my presentation, I want to do a little clarification of terms of and definitions. I think people throw the term peer support around, and it's not always clear what type of peer support they're referring to or talking about. So, um, I want to start by saying that peer support has its roots in as a non-hierarchal practice of giving and receiving help in which individuals with mental health conditions support each other and um, historically speaking, this kind of support,

mutual self help and support, was actually an act of resistance as part of psychiatric survivor and ex-patient movement. Individuals who, in the mid-1900's, the 60's, 70's, objected to the paradigm of mental health care that were available at the time, that were in ways, dehumanizing and, you know, denied folks with mental health conditions certain civil rights . These individuals, you know, said, "We don't need these formal healthcare systems, we're going to build our own sense of community and support outside of these systems, and we can take care of ourselves". So, this was a very powerful, sort of active resistance out of which our modern and current paradigm of peer support has grown, and mutual self-help and mutual peer support is still alive and well out there in the community and it's a very, very important form of peer support that I think we don't always value and we sort of undervalue from within healthcare systems. So, I wanted to give a nod to this paradigm with peer support. I included a link there if you're interested in finding out what this symbol means, you can check that out. Some interesting history. So, with that, I'll move on, to say that's not the kind of peer support I'm going to be talking about in my presentation. I'm going to be focusing instead of peers providing services and supports in the context of formal community or healthcare organizations. And so I'll probably use the term peer providers a lot because they sort of mean people who are embedded in these organizations and when they work with service users there kind of is a little bit of hierarchy where one person is a helper and the other is the person being helped. So, it's not quite as mutual or reciprocal as other models of peer support. More specific than peer providers is the term Peer Specialist – these are individuals who are certified, they have specialized training to use their recovery story to support that of others. Frequently they are paid employees, and sometimes they work as volunteers. And then of course, even more specific than that are VA Peer Specialists who are Veterans and work in a VA setting. So, I'll probably be using the term peer providers quite a bit. I'll try to be specific about who I'm talking about when I'm talking about the research. So, what's the point of this presentation? Well, historically speaking, in mental health, when you have mental health peers, they're people with a mental health condition who are in recovery from the mental health condition, and they traditionally support others around mental health recovery. As they've been incorporated more and

more into the healthcare system, they're increasingly being asked to support physical health and wellness among individuals with mental illness. And this is, for really good reason, because among folks with mental illness, they are really high levels of medical comorbidities, as well as health disparities around access to care and access to high quality care. So, there's a great need in this area of promoting physical health and wellness in this group and so, in a way it make sense that we're excited about peers and we're excited about having them as colleagues in our system, you know, could they help us with this very important and pressing problem. I think in our eagerness though, to incorporate peers and kind of see, you know, kind of test out and see everything that they can do. Sometimes we don't think quite carefully enough about whether this is an appropriate role for mental health peers. And also, what does it mean to be a peer if we are now focusing on a physical health outcome. So, for example, you know if we have Peer Specialists who are working with folks with mental illness on weight management, is the mental health lived experience still relevant. Is it more important that the person has experience with managing their own weight, for example. Does it matter if they're successful in managing their own weight? Um, what sort of the essential "peerness" or the characteristics that are important for the peer to have and bring forward. So that's what I'm going to dig into and talk about a little bit today. So, here's my outline. I'm gonna talk a little bit about what mental healthcare providers typically do, just in a mental health kind of setting. And then we'll talk some about the broad overview of the literature on how peer providers are supporting physical health and wellness outcomes among folks with mental illness. And then I'm going to dig into a little qualitative work to see what we know about "peerness" in these contexts and what it is that peers are doing in these health and wellness interventions, what's the peer role. We don't really know. We don't have that much information on that, but we're going to, I'm hoping, at the very least, what I talk about today will be thought provoking and spur some ideas for future research and investigation. So, we'll start with what mental healthcare peer providers typically do. So, there's been quite a bit written about this. In a general sense, peer providers are a source of social support. So, they are another person that the service user can turn to for support, including emotional support and validation, instrumental support

like goods and services, and informational support. And this social support might be particularly powerful coming from a peer because the service user perceives the peer as like themselves, have been there, and really understands and knows that they are talking about. This brings us to what peers uniquely bring to the table which is their experiential knowledge. Peers self-disclose regarding their own experiences and per social learning and social comparison theories, when a person perceives another person as like themselves, they are more likely to perceive them as credible role models, and credible role models enhances self-efficacy, which is your confidence that you can engage in certain behaviors, and it also encourages hope and upward social comparison, which is a process where you see another person who you perceive to be just like you, and you see that they've accomplished certain things and you think to yourself maybe I can do that as well. Right. So that gives folks something to strive towards and enhances motivation and hope. Another interesting construct that has been written up about, by Larry Davidson and colleagues, about the role of peers is the concept called conditional regard. So, I think this is a really interesting concept. I think it's a play on what many mental health providers on this call have probably been exposed to, the term, unconditional positive regard, right, where you always work with a patient, a service user, with warmth, with empathy in an unconditional kind of way. The concept of conditional regard is the idea of empathy paired with a very strong accountability that can be drawn from the Peer Specialist's own lived experience and credibility. So, a Peer Specialist might say to someone, "Look, I've been where you are and I know that you can do better than this because I was there." And so, they're able to maybe have even a higher level of accountability, hold people to even a higher level of accountability because of the credibility that they bring to the table. A little bit more about what Peer Specialists do uniquely. This is from a literature review from 2016 that kind of pulled together a list of things that Peer Specialists do. So, a lot of really great things right? Promoting hope, serving as a role model, sharing your story, reducing isolation, being flexible in terms of where and when they meet, engaging clients in treatment, increasing patient activation, helping link folks to resources, serving as a liaison between staff and client, helping to increase access to services, running groups, having a strength focus, being empathic, promoting empowerment, having

a trusting and friendly relationship and teaching skills. And then the last thing on here is helping their clinical team be recovery oriented and focus on recovery. So, this is a lot, right? This is a lot of really valuable things that peers are bringing. And so, it's really important to think about, okay, given that this is what peers can bring to the table, how can this, how is this working when we shift the target outcome to physical health and wellness? So, I'll review some of the literature in this area now. As a caveat, most studies of peer providers delivering health and wellness interventions for individuals with mental health conditions are small, single group, pre-post studies. There are some pilots, RCTs with a couple of, you know, with two groups. But most of them are small. There are a very few randomized controlled trials, and so I'm going to try cover the RCTs today, and I'll cover some of the smaller studies, but it won't be an inclusive review because this is a growing area and there's a lot of new and exciting work out there that I couldn't possibly cover in one presentation. So, the intervention target that I'll discuss include medical illness self-management, getting connected to healthcare, health lifestyle interventions like weight management, and smoking cessation. One thing I won't really touch on very much is this growing literature around incorporating a technology component to peer support. So, there's this really cool, cutting edge kind of area called digital peer support where, you know, there's evidence to support the idea that peers can help service users engage with technology to support their recovery. And so, there's, you know, generally a lack of large trials to establish clear efficacy of this, but it's becoming increasingly clear that this is something that is feasible and that people like. So, if folks are interested in this area of work, I suggest you see a recent systematic review written by a colleague of mine, Karen Fortuna, that I was a co-author on, and it's listed in the reference section. But yeah, some of these, this is for peer support across the board, but some of the studies look at supporting physical health and wellness outcomes by connecting service users to like mHealth and apps like that, that support health. Okay, so let's start with medical illness self-management. This is where we have the strongest support in terms of the research evidence. So, medical illness self-management, as a model, promotes proactive health behaviors among individuals with chronic health conditions. And it's based on the idea that across various chronic health conditions, there are

common tasks that everyone has to engage in. So whether you have diabetes, whether you have heart disease, whether you have arthritis, you do need to think about managing your medicine, making good use of your healthcare, staying physically active, eating a healthy diet and managing your stress. So, medical illness self-management focuses on teaching key self-management skills to support this broad self-management of chronic health conditions. The most well studied self-management intervention is Chronic Disease Self-Management. The Chronic Disease Self-Management program, or CDSMP, this is a group-based intervention delivered by individuals with chronic health conditions. So, it is a peer delivered intervention, but it's not in the mental health world, it's among folks with chronic medical conditions. It has been adapted for individuals with mental illness. There are two versions, that both have good research evidence behind them. One is the Health and Recovery Peer Program and the other is Living Well. Just to orient you, so I have a lot of slides, and they unfortunately have a lot of text on them, so to help orient you to the main points on these slides, I've done a little formatting, so, when you see the text that is italicized and underlined, that explains who the peers were and what "peerness" was in those particular interventions. And then the bold text are the things that were positive outcomes. I'm hoping that will help orient folks to the slides, which have a lot of information on them. Okay, so yeah, so both of these interventions are group-based interventions, co-facilitated, well, the Health and Recovery Peer Program is co-facilitated by two peers who have comorbid mental health and chronic medical conditions, where as Living Well has the option to be facilitated by two peers, or by a peer and non-peer provider. In both cases, "peerness" is defined as somebody who has both a mental health and a chronic medical condition. And there are positive outcomes in both of these studies for self-management behaviors, self-efficacy and quality of life, testing in large randomized controlled trials [inaudible 18:06]. I'm going to talk more about Living Well later, because that was actually a study that we did here at our MIRECC and we've done some interesting qualitative analysis of the data, that I think will be, you know interesting to kind of dig into around the question of "peerness" and what the peer role is. Um, I can say now that the, the, this was a VA study, we tested it in our RCT in VA and the participants really connected with the peer

facilitators, around many different aspects of identity. Especially Veteran identity, so that was a major reason or way that people felt connected to the peer providers, as well as other aspects of identity like mental health and medical issues. That was medical illness self-management, I want to talk a little about connecting to healthcare now. So, there's a handful of studies looking at if mental health peers can help individuals with mental illness connect to healthcare. We know that there are, like I said, there are health disparities among folks with mental illness. They tend to have poor access to healthcare, you know, less likely to get good preventive primary care. So, in a study where individuals were admitted to the psychiatric ER, were randomized to receive a primary care navigator, or usual care for one year. They were also offered the opportunity to connect with a mental health peer. So, the peers in this study were individuals with a mental health condition who worked at peer run organization and had formal training as peers. So, the randomization component was not around the peers for this study, so it's not actually a randomized control trial for this research question. However, it was found that the participants who were connected to mental health peers, were more likely to follow through with primary care. So, it's not as strong as if it was a randomized trial around the peer, but it still provides a little bit of evidence that peer support can be helpful with this construct. Another study is the Bridge intervention. So, this was a randomized controlled trial that, in which services users were randomized to either the Peer Navigator intervention or a waitlist control. And the Peer Navigator intervention is a six month intervention that consisted of coaching, motivational interviewing, goals setting, patient activation, the peers actually attended medical appointments with the participants and helped them advocate for themselves, they reviewed what the doctor said after the medical appointment, and then there was a kind of fading out of support over time, over the six months. And so, the Peer Navigator intervention was associated with improvements in access and use of primary care, as well as other health outcomes at six months. So, it's cool, it's pretty promising. What's really interesting about this study is that the peers were either people who have lived experience of their own of mental illness or had a loved one with this experience. So, in this case the "peerness" is experience navigating the healthcare system either for yourself or on behalf of someone with a

mental health condition. So, it's just an interesting definition of "peerness" and individuals all got a training and received ongoing supervision and feedback. So, you can see already just in this handful of studies that "peerness" is defined totally differently depending on the context, and there's a lot of variability and how people are trained and things like that . Very important to keep an eye on those things. Last set of studies in the connecting to healthcare category is the Peer Navigator Program that came out of Pat Corrigan's work. So, this was based on community-based participatory research, so the folks who were sort of the targets of intervention were very involved in the actual development of the intervention. This program was tested in two randomized control trials, two different versions – one version was for homeless African Americans with serious mental illness, and the other was for Latinx individuals with serious mental illness. And, of course, the peers were, you know, matched on all those different characteristics respectively, so racial identity, ethnic identity, language, and experience of homelessness. Great, so, this is an example where there's so many intercepting identities along which the peers are connecting to people, but it's unclear, you know, which aspect of identity is really doing the heavy lifting and even in Pat Corrigan's paper he talks about how, you know, we're just really not sure about which of these is most important, or even if they can be parsed out in that way, right, because, you now, our identifies are intersect, so… . I think again, it's just really important to, that when we think of peer, even within mental health it can mean so many different things. So anyway, in this study the, the, in both RCT's, the Peer Navigator Program was connected to, associated with increase scheduling and attendance of healthcare appointments compared to usual care. So, you know, some decent evidence that having a mental health peer can help you make better use of primary care and preventive care. So, I'm gonna talk a little bit about healthy lifestyle interventions now. So, these are the types of interventions that are focused on diet, exercise, and weight management. So, I want to talk about the webMOVE Study. So, this is a study that some of us at the VISN 5 MIRECC were involved in, along with collaborators of ours out in California. This is a little bit complicated so I will talk you through it. Probably folks on the call are familiar with the VA Move Weight Management Intervention. Our center took that intervention and created a manualized version,

specifically for folks with mental illness. And then, that version was adapted further to become a computerized version that was delivered as computerized modules. So that's WebMOVE, these computerized modules with education and opportunities for monitoring and goal setting around weight management that are delivered on a computer. webMOVE was supplemented with weekly phone calls from a peer coach to promote engagement. So, they'd call every week and say, "Hey, you know, did you do your module, did you have any questions, did you set your goal, how did it go", that kind of thing. And in this case, peers were Veterans with mental health condition. This was a three-arm study, so webMOVE was compared to an in-person version of MOVE as well as the usual care, and it was a large trial with 276 Veterans who were randomized to one of those three conditions. I mean, you can see the outcomes there that webMOVE was associated with in terms of decreases in weight, increases in weight related self-esteem, and increases in physical activity. So, again, some evidence to show that peer coaching and in this case, interacting with a tech delivered intervention, can have positive impacts, albeit modest, but positive impacts on healthy lifestyles. We did some qualitative work around the participant's perceptions of the peer coaches and what they said, and generally the participants remarks about the peer coaches were really positive, but they involved the program in general, so they were happy about peer coaches helping them review content, remind them of their goals, and offering accountability, motivation and support, and only secondary to that was things around specific recommendations for physical activity, tech support, etc. So, connecting to folks more around, broadly helping them engage in the program as opposed to specific lifestyle recommendations. Okay, the other intervention I want to briefly mention is an intervention called Peer-led Group Lifestyle Balance (PGLB). So, this is a peer delivered healthy lifestyle program that was delivered in supportive housing, which I think is a really cool model, right, like bringing it to folks right where they live. So, the paper I cited here is the protocol paper, so they talk about the methods, but I have not been able to find the results, I do not think they are yet published, though I look forward to seeing them because I think that it would be really interesting. But the reason I share it is that this group has done some really cool qualitative work around how this intervention is working. So, I'm going to

share that towards the end of the presentation, so I wanted to prep you all for it now. So, basically this is a group, a peer-led group, delivered in supportive housing and the peers – um, this is one study where the peers are actually trained as Peer Specialists. Very few studies actually specify that. So, I think that's important to know. So, these are people who have completed a Peer Specialist training program. Okay, um, lastly, I'll talk about smoking cessation. So, as I've gone through each of these categories, right from medical illness self-management on down, the evidence has gotten weaker and weaker from what we know in the literature. In the area of smoking cessation, what we've got are uncontrolled studies. So, I'll just share them because I think it's an interesting example of "peerness". So, for example, in one study that involved peer to peer tobacco education and advocacy, peers were nonsmoking individuals with mental health conditions who had one-on-one sessions, brief, with folks providing information about tobacco and, you know, talking to folks about whether they want to quit and how they want to quit. Among 102 people, there was a decrease in the number of cigarettes they smoked at one-month follow-up. So, generally with these studies we don't see significance around actually quitting. Some people will quit, but it's not a significant number, so, but they do see a decrease in the number of cigarettes smoked. Another study, which was a large study done in Australia, it was a multifaceted smoking cessation program that was implemented at community mental health centers all across, I think southern Australia. It included, you know, access to a quit line, it included access to nicotine replacement therapy, a lot of different components, but it also included a 10-week peer and non-peer co-facilitated smoking cessation group. And, interestingly in this case, folks had mental health conditions and quit experience, so they had to have been successfully quit smoking, and be comfortable nonsmokers. So, again another sort of very specific aspect that folks were looking for. Again, this was associated with a decrease in the number of cigarettes smoked at the end of the program of around 844 folks. Okay, and then one last study I'll share about smoking cessation is a small study. It's carried out by some of my colleagues here at the MIRECC and at our academic affiliate, where peers were individuals with mental health conditions and quit experience, and they were trained to provide a smoking cessation group, as well as individual

coaching to smokers with mental illness. So, this was a small study, just 30 folks. There was a decrease in the number of cigarettes smoked. The reason I share it is that the group published some interesting qualitative data around the experiences of the peer mentors and what they shared is that more salient than mental illness, or psychiatric illness experience, smoking and quitting smoking was more a focus of self-disclosure in this. Yeah. So, as you can see from this brief sort of review, what is "peerness" in these contexts that really seems to differ right? So in the smoking cessation studies, it seems like at least with that last one, but, you know, the ability to quit to smoking, the fact that you were a former smoker, and now you've stopped is very important. Um, in our VA studies, Veteran identity always comes up as a major component, as well as experience navigating the VA healthcare system, right? Because that's a whole lived experience and wisdom in itself. In connecting to healthcare world of stuff, it's often a person in recovery from mental illness who have experience navigating the healthcare system as a person with a mental health condition, but it can also be a loved one and it really seems like it might depend on the context of the intervention, right? Like, um, with some of Pat Corrigan's work, they are kind of carrying out these studies in communities that have certain racial or ethnic identities that are really important. So, I just think it's a really fascinating question that, you know, we need to be keeping our eye on as we continue to do work in this area. So, I'm gonna try to dig into this question a little bit more with the time I have left, sharing some of the qualitative research that we've done and then some qualitative research from another group as well. So, let's talk about the peer role right…, what the peer even doing in these health and wellness interventions, and is it similar or different from what they're doing in mental health, when the outcome is focused on mental health. So as a reminder, Living Well is an illness self-management intervention for folks with serious mental illness. We tested here at the VA with the Veterans in a large RCT with good outcomes and the groups were co-facilitated by a peer and non-peer. And the peers were folks with medical and mental health conditions, Veterans. So, we did qualitative interviews with 15 participants in Living Well and we asked them about a whole bunch of different things related to their experience with Living Well. The analyses I'm going to talk to you a little bit about today are focused on what

were their perceptions of the peer co-facilitation model in terms of having both the peer and non-peer be involved, and how that worked. And then I'll talk just a little bit about how they reported that Living Well led to processes of change and changed behaviors for themselves. Um, so, let's first talk about peer and non-peer co-facilitation. So, this is a figure that we came up with. Um, so I'll talk us through it. I want to start with Box 1, Group Atmosphere, right there in the middle. So, this was the most salient theme that came up. People spoke very, very positively about the group atmosphere. The participants said that it was warm, supportive, kind, folks were caring and it felt like an atmosphere where everyone was equal, on an equal playing field and no one was better than anyone else, very non-hierarchical, and also interactive and participatory, where everyone spoke up, everyone shared their experiences and everybody got to share. This was very important. Then I will bring your attention to Box 2 on the left, Diverse and Complimentary Perspectives. So, what people said about the peer and non-peer co-facilitation model was they really appreciated the complimentary perspectives of these two facilitators. They said it was great to have the peer with their kind of been there kind of experience, or lived experience, their wisdom, sharing their own anecdotes, etc. It was also great to have the non-peer facilitators, which in our case was typically a master's level person with a background in psychology, bring what they termed as sort of their book smarts, as well as kind of a diverse or different perspective on the same topics. So, they really, the folks really appreciated having both, and a very important reason why having both worked was because of how well they worked as a team. So, people really talked about that, the facilitation between the peer and the non-peer was really seamless. They worked together in a very collegial way, very respectful. It didn't seem like one person was really in charge, and the other was like supporting them, but really the two worked together very well on goal splitting. And so that those two things, the fact that they work well together and brought complimentary perspectives, significantly contributed to the positive group atmosphere. Okay, so I think that's very important, and I will talk about that more later. But I also want to draw your attention to box 6, at the bottom, Self-Disclosure. So, participants talked about how peer self-disclosure was really important in getting the other participants to self-disclose and share their experiences.

And I'll share some quotes that say it better than I ever could. But that that was a very important part of facilitating a positive group atmosphere that was interactive. And then both self-disclosure and the group atmosphere contributed to an atmosphere that was conducive to social learning which is a really important part of health behavior change models, though, you know in groups, one of the active ingredients was that you hear from other people, and you hear their ideas and you brainstorm with them and you get, you know, that helps you figure out how you want to move forward with your health and wellness, or whatever the topic of the group is. And so you can see here that a major thing, that peers are bringing to the table, in group-based health and wellness intervention is promoting and enhancing this process of social learning by self-disclosing, by bringing their lived experience, they're contributing to group cohesion, which helps to promote an atmosphere of social learning. Really, really valuable and it's very key and it fits right in with health behavior change models. So, I will share some quotes now. So, "you had peer on one side, you had non-peer on the other side, so those were two different perspectives than what they're gonna throw out there to you. What non-peer might not understand, peer would – you know, especially with the mental health issue, I mean, unless you've been there and done that, you don't have a clue." "You got to have a peer facilitator to help egg the group a long and get participation out of the group members." "I've learned over the years that a lot of times the people who are supposed to be teaching you about stuff don't have a clue. Peer brought some very, very, very personal anecdotes to the class, which she didn't have to and that really made the group a more cohesive group because she ripped a veil, for lack of a better word, she ripped a veil and allowed us to kind of open ourselves up because she put her stuff on the table too." "Peer helped by the things he would say about himself and his problems – he had back problems and he some mental problems, he had stuff, would instantly group us all together as a group." And then finally, "you know some people go in there, the group, with a little lack of confidence and self-esteem, and you know they're a little bit reserved, so when you have a peer like that they're discussing things, and it kind of opens them up a little bit more. Peer would, every, every discussion that was started, the first example was always peer. He gave us his example to relate to whatever we were talking

about, whether it was physical or eating better or whatever, and then they started around the table, so I think that helped out a lot." You can see how powerful this is, right, this peer self-disclosure and how much it contributed to the group atmosphere. You can also see that people talked about the peer sharing both medical and mental health examples. Based on this analysis, we came up with some recommendations for peer and non-peer co-facilitated groups. I just want to draw your attention to a couple of them. So, #3, fostering a respectful collegial relationship between the peer and non-peer facilitator. I feel like that's really important. I think what we saw in our analysis is kind of a parallel process, where there's this really great respectful and collegial relationship between the peer and non-peer, and that served as a signal to the rest of the group members that, hey, like this is the space where we all on equal footing, we are all equal, all of our opinions and our perspectives are valued. And I think that was really powerful. So, in order to foster that relationship, I think 4, 5 and 6 kind of help, maybe as concrete things to help foster that. So, you now, one is setting aside time to really talk about what's my role and what's your role, right. Um, it could be, as per #5, that the non-peer is more focused on tasks – keeping the group on task, covering the material, etc. That sort of seemed to be what participants were saying was helpful from the non-peer facilitator and the peer facilitator might be much more focused on process, so eliciting participation. And lastly, explicitly creating space for peer self-disclosure, both structure on spontaneous during the group session is really, really important. I think we often, you know, give these manuals or we give intervention to peers and we say "hey man, you know, self-disclose, you know how to do that, like do your thing." Um, but I do think working collaboratively with peers we can say "hey, where in this session would you like to self-disclose" and then, in a more structured way. And then also, I know spontaneous self-disclosure as it comes up it feels right to you, is really important, so how can we make sure to make space for that, like how will I know that you want to or, you now, that kind of thing. I think it's really important to consider. I'll talk briefly about out processes of change findings. So, this is a separate qualitative analysis we did with the same interviews. So we wanted to see what people said were the most important active ingredients of Living Well that led to, you know, behavior change, and so in this Living Well

box, the two bullets, actually the three bullets – I'll draw your attention to the last three bullets. So, the first is learning from others, which is basically the same as social earning, which I already talked about, which the peers were like key to making that happen. The third bullet is real world practice, so um, the structure of Living Well was that folks would assign, I'm sorry, would set goals in one group, go practice the goals and then come back the next group and talk about how it went. And people really appreciated that opportunity for real world practice, they said that that was a very important active ingredient of the group. And then, the last bullet, that I'll highlight, is the kind support and a push to go further. So this was a, it was something that all the participants talked about where a blend of being really caring, nonjudgmental, respectful, but also holding you accountable that you set a goal last week so what did you do this week… It was really, really important. And I actually think it sort of maps on a little to the conditional regard construct that I talked about earlier, where peers are able to hold people at a certain level of accountability because of their own experiences. So, you can see that these active ingredients from Living Well, that the peer involvement really enhances them in a lot of ways. So, you might say, well okay, that's one study, that's 15 people, you know, who cares. I was really delighted to find some qualitative work from this group that is conducting the Peer Group Lifestyle Balance Study that really very closely mirrored a lot of our findings. I don't know if anyone from this group is on the call, but, you know, call me, send me an E-mail – this work is so interesting, and I'd love to figure out how we could collaborate. So, they did qualitative interviews with 28 participants in this Peer Group Lifestyle Balance which, as a reminder, the peer led group lifestyle intervention delivered in supportive housing and they, again, they compared, just like we did, perspectives of the peers who led the group with their participant perspectives of non-peer providers that they also had, and they found that peers were more process oriented, emphasizing hope and change and relating through self-disclosure and shared experience, where as non-peer providers were more task oriented, they emphasized consequences of non-action, like, if you don't start eating better, if you don't start, you know, exercising, these are the bad things that could happen. And that they related more through shared treatment goals. So, participants appreciated the contributions

of each, and so this is really important, right? Like when we're trying to focus on health and wellness in this group, we can all be person-centered, we can all be, we can all empower people, but we might have slightly different roles because of, you know, what our discipline is, right? Okay. Um, so some other really cool qualitative work that came out of this was they also wanted to explore a little bit how it was that peers contributed to the intervention. So they did qualitative interviews, but they also did this really card sort exercise, where they provided participants with 15 statements and said can you pick the top three statements that describe the Peer Specialist that you work with. The first choices that were most often selected were Peer Specialists were someone I felt comfortable with, who provided me with encouragement and support and that helped me feel hopeful. And then the most common second choices was the Peer Specialist knew what they were talking about in terms of a healthy lifestyle, understood what I was going through, shared their story, and put things in words I was able to understand. So, I felt like this is so powerful and it really helps us understand, you know, what are the main things that people are connecting to the peers around in these healthy lifestyle interventions. And so, another thing that came out of that qualitative analysis was this really beautiful figure that I feel kind of jealous of. I think it's a really lovely figure and captures a lot. It is not my work, so I'm going to do my best to talk through it. But, as I said, if there are folks from this group on the call, give me a call. So, interestingly what they found in their qualitative analysis was that the shared experience of SMI, serious mental illness, which you see all the way on the left, was sort of foundational at the beginning to help with building rapport and engagement in the first place. So, you know, your credible because you've been through mental health issues and you, you're figuring it out, and in that way you can connect with people on the front end, so they start feeling engaged and like they can trust you. Then, a little bit later, a shared experience of the healthy lifestyle became more salient, you know, now that I trust you, that we're sort of similar on this foundational way, I feel like you're a credible role model around other aspects of healthy lifestyle as well. So, people shared about, you know, diets, physical activity and all these other things. If you look at the other three circles that sort of surrounding that middle triangle, there's a lot of overlap with what we found in our work,

so um, for example, the top circle, feeling comfortable, that seems to map on a lot to what we found around a group atmosphere that's warm, where everybody is equal, nonjudgmental, right? Friendly, it's genuine. So that was really interesting to see. If you move down to the support and encouragement circle, um, again, also seems to map on to our warm group atmosphere where people were caring, you know, consistent, supportive and providing that kind support like we talked about as well. And then the hope and motivation bubble, this is also very interesting, seems to map on to our construct around a push to go further, right? That accountability as well as real world practice, so being able to set goals, try them, normalizing slips – this is very, very important so, you know, it's totally okay if you don't, you know do the whole goal that you set out to do, that's normal and that happens to everybody and it's not a linear process of change and recovery. It's a very, very important thing that peers bring to the table because, again, they can share their own experiences around slips. So, you know, that's, that's it, that's what we've got in terms of how it is that peers are contributing to health and wellness intervention. So, I'll give a little summary now and then I'll stop, and we'll have some time for questions – not as much time as I hoped but that's all right. So, from what we know it seems like the peer role in health and wellness overlaps with the peer role in mental health quite a bit in terms of providing social support, hope, motivation, self-efficacy; in terms of providing respectful, friendly, and non-hierarchical relationships, and what I italicized is it seems like, what's really important about what peers do, is they can skillfully self-disclose across a variety of experiences, right? So, I don't, I don't think that the literature supports the idea that, you know, a person who is gonna provide support around weight management, for example, is someone who has lost ton of weight. Right? I think it's more around a person who knows how to draw from their own experience and self-disclose in a way where the other person will feel engaged and motivated. This is a very important skill that our peers know how to do, but we don't know how to do. This is an opportunity for us to learn from them about how to do this in a skillful way and I really think that this needs more exploration in the research. I'm getting some folks that agree with me in the chat, which I appreciate. So, what about "peerness". So, it could be that a shared experience of mental illness is foundational at the

beginning – we really don't know we don't have enough work on this. It may be that specific experience about health behaviors may come into play later. But more, more work is needed, and it might depend on context. So, I'm gonna see, I'm sure there are Peer Specialists on the call, but as a non-peer person I'm going to speak to the non-peers in the audience for a second. What can we do to further this work? I think, number one we need to include peer providers as collaborators in our research because they have the best understanding of what they do and what they bring to the table, especially around self-disclosure. And then, when we're designing interventions to be delivered by peers, or thinking about having a peer deliver a particular intervention in your clinic, you have to think carefully about how to make space for the valuable lived experience that they bring to the table. So, does this engage this deep wisdom that peers have about mental health recovery, or is this just like something we're asking them to do because they have availability? Right? Um, I want to bring up Whole Health groups really briefly, because Whole Health I think is a great intervention in the, you know, taking charge of my life and health group is a great group, but it can be delivered by anyone. It is not designed for peers, to be delivered by peers, to my understanding, and so, there's actually not like explicit space for peers to self-disclose. I think they do it because they know how to do it and that's their skills, but, you know, we could really think thoughtfully about, you know if want peers to be delivering these groups then how do you want to bring their lived experience with them into the room and put it on the table. And I think that's something we brainstorm with peers about, you know, when and how should self-disclosure be used and how do we understand skillful self-disclosure that promotes engagement and recovery. And at the very, very basis of everything, we all need to work towards creating collegial respectful and non-hierarchal relationships with peer providers that we work with, to the extent that we can. I think we all pretend that, maybe in VA, that these, these relationships are non-hierarchal, but the truth is, that Peer Specialists don't get paid as much as other clinicians. They don't have as much power in the system, they have a lot of, you know, supervision and oversight, and I think we need to continue to work towards closing that gap and disparity so that they can really bring their wisdom to bare on this important work. Thanks to my collaborators…. Ralf

Schneider: Great, we had a couple questions earlier on Dr. Muralidharan we can touch on those, and they're about the three big different interventions, webMOVE, PGLB and Living Well. So, for webMOVE, do you recall, was that within Whole Health, or how was, or was webMOVE part of the MOVE program for that study?

Dr. Anjana Muralidharan: Yeah, so webMOVE was tested in a research study.

Ralf Schneider: Right.

Dr. Anjana Muralidharan: So, to my knowledge, I don't know if it has been disseminated or implemented in clinical care.

Ralf Schneider: Right. Right.

Dr. Anjana Muralidharan: If others know about that…

Ralf Schneider: The next question, right, right, we don't know that yet. And how about PGLB, I think the um, the research study was in a supportive housing setting, that's where the peers delivered that – has it been used in other settings? And again, I'm not sure if that's been used further yet, and um, that's one question.

Dr. Anjana Muralidharan: Yeah sure, I don't even think there are, as far as I can find, I couldn't find the published results from that study yet, so, um I don't think it's been rolled out anywhere else. I think it was an intervention, the Lifestyle Balance intervention that I think has been used in other settings and they sort of adapted it for folks with mental illness in supportive housing to be delivered by peers. So, hopefully the results from that come out soon and we might see steps to implement it in the future.

Ralf Schneider: Right. And there was a similar question from Michelle Kelly about a curriculum for Living Well and I think your answer would be similar to that.

Dr. Anjana Muralidharan: Yeah, exactly, we've published the results from Living Well, but at the moment it's not implemented in the VA.

Ralf Schneider: Right, so I guess we, our advice to folks is to look out for new developments about even limited roll-outs of some of these interventions. Although they certainly apply to the work that peers are doing already naturally.

Dr. Anjana Muralidharan: Yes. Absolutely.

Ralf Schneider: Great. Let me see if there were any other questions. In the meantime, though, just folks are just interested in more information and we want to draw their attention again to the slide set that we have in files to download. And, yes, the Living Well model was a peer and non-peer co-facilitated training to answer Eric Gary's question. And I think…

Dr. Anjana Muralidharan: Yes, it can be led by two peers…

Ralf Schneider: It can be led by two peers.

Dr. Anjana Muralidharan : Uh huh, uh huh.

Ralf Schneider: Great. As you can see, a lot of thank yous for this. Thank you everyone for attending. So as a reminder, please go to TMS and complete the 10-item test and the Webinar evaluation within the next 30 days so you can receive a CE credit. This is a monthly presentation. Our next Webinar is on May 11th at 12:00 PM EST. Drs. Peeples, Hack and Muralidharan will present VA connection plans and Introduction in Clinical Training on a Social Connection Intervention for Veterans. So, we look forward to seeing you all back. And thank you again.

Dr. Anjana Muralidharan: Bye everybody. Thank you. If you have any other questions you can E-mail me, my contact information is there.