



# “Being There” vs “Being Direct:” Perspectives of Persons with Serious Mental Illness on Receiving Support with Physical Health from Peer and Non-Peer Providers

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## Abstract

Individuals with serious mental illness (SMI) face significant health disparities and multiple barriers to engaging in health behavior change. To reduce these health disparities, it is necessary to enhance the support individuals with SMI receive through the collaboration of different healthcare providers. This study explored how people with SMI living in supportive housing perceived receiving support from peer and non-peer providers for their physical health. Qualitative interviews were conducted with 28 participants receiving a peer-led healthy lifestyle intervention in the context of a randomized trial in supportive housing agencies. Interviews explored participants' experiences working with the healthy lifestyle peer specialist and a non-peer provider who assisted them with health. Interviews were audio recorded, transcribed, and analyzed using strategies rooted in grounded theory. Participants viewed their relationships with peer and non-peer providers positively, but described differences in the approach to practice, power dynamics present, and how they identified with each provider. Participants described peers as process-oriented while non-peer staff as task-oriented, focusing on accomplishing concrete objectives. Each provider sought to boost participants' motivation, but peers built hope by emphasizing the possibility of change, while non-peer providers emphasized the consequences of inaction. Participants related to peer staff through shared experiences, while identifying the importance of having a shared treatment goal with their non-peer provider. Overall, participants appreciated the unique roles of both peer and non-peer staff in supporting their health. Study findings have implications for integrating the use of peer-based health interventions to improve the health of people with SMI.

**Keywords** Peer Support · Physical Health · Qualitative · Supportive Housing · Mental Illness

## Introduction

Compared to the general population, individuals with serious mental illness (SMI; e.g., schizophrenia, bipolar disorder) experience excess mortality, largely due to high rates of cardiovascular disease and metabolic illnesses (John et al., 2018). Numerous factors contribute to the health disparities faced by this population including cardio-metabolic side effects of anti-psychotic medications, high rates of smoking and obesity, sedentary lifestyles, and inadequate medical care (Druss et al., 2001; Hert et al., 2011; Newcomer & Hennekens, 2007). While many of these risk factors are modifiable, persons with SMI face significant obstacles to engaging

in behavior change and managing health conditions. Though SMI can negatively impact help-seeking behavior, people with SMI also experience systemic barriers to accessing care and are less likely to receive high quality medical care compared to people without mental illness (Lawrence & Kisely, 2010; Mitchell et al., 2009). Provider discomfort as well as separation of medical and psychiatric services has led to a majority of people with SMI receiving fragmented care in multiple treatment settings (Benefits of Integration of Behavioral Health, 2018; Cunningham, 2009; Elhauge, 2010; Fleischhacker et al., 2014; Katon et al., 2003; Mittal et al., 2014; Rathore et al., 2008).

Given these challenges, improving the health of persons with SMI will require expanding access to quality care and providing increased support for health behavior change (Kelly et al., 2014). Several initiatives aim to facilitate this, including the push toward integrated care, the implementation of healthy lifestyle interventions, the use of

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peer-delivered services within health programs, and recognition of permanent supportive housing as a potential nexus of care for people with SMI (Deenik et al., 2019; Weinstein et al., 2013). Integrated care models seeking to maximize collaboration between physical and mental health providers (e.g., medical doctors, social workers, case managers, paraprofessional staff) have gained traction to counteract reliance on separate specialists providing treatment in silos (Rodgers et al., 2016). Such approaches are associated with improved care quality and physical health outcomes (e.g. improvements in cholesterol), and lower overall costs (Walker & Druss, 2018; Scharf et al., 2016).

Additionally, peer specialists, who use their lived experience of recovery from mental illness or substance use and formal training to support others experiencing similar concerns (SAMHSA, 2016), are increasingly employed in a variety of roles addressing physical health of people with SMI (Pitt et al., 2013). Peer-based health interventions have been associated with improvements in diet, self-management behaviors, and communication with physicians (Bellamy, Schmutte, & Davidson, 2017; Cabassa et al., 2017). Peers are able to speak directly from their experiences with navigating the challenges of accessing care and incorporating suggested interventions into one's life, allowing peers to serve as role models for clients (Beehler, Clark, & Eisen, 2014; Bochicchio et al., 2018; Gidugu et al., 2015). Further, integrated care teams comprised of peer and non-peer staff have been associated with increased treatment engagement and a greater sense of self-efficacy (Corrigan, Pickett, et al., 2014; Bartels et al., 2013).

Implementing healthy lifestyle interventions, which seek to improve nutrition and physical activity, have been associated with improvements in weight, BMI, waist circumference, and other cardiometabolic indicators among people with SMI (Cabassa et al., 2010; Daumit et al., 2013).

Despite these positive developments, inclusion of health services within permanent supportive housing (PSH) remains the exception and access to healthy lifestyle interventions is hindered by a focus on implementation in clinical settings using health professionals (Cabassa & Stefancic, 2019). PSH combines stable housing and a range of services (e.g., case management; mental health, substance use treatment, and employment services) to support people with SMI, and there have been recent calls to expand these supports to more comprehensively include linkage to healthcare and other health promotion services (Henwood, Stanhope, et al., 2013; Henwood, Cabassa, Craig, & Padgett, 2013). However, wider dissemination of peer-led and integrated care approaches is often hindered by limited understanding of how different roles and providers approach and attend to participants' physical health issues and how to engage in successful interdisciplinary collaboration (Rodgers et al., 2016). Further, few studies have attempted to juxtapose the ways

in which peer vs. non-peer providers support persons with SMI in general, and even fewer have done so with respect to physical health. One study comparing clients' perceptions of a chronic disease self-management group co-facilitated by a peer and non-peer staff reported that clients emphasized that the non-peer staff offered "book learning" while the peer specialist offered their own experiences to further contextualize the material delivered in group (Muralidharan et al., 2020). Given that such studies are an exception, more research is needed to understand the contributions of both peer and non-peer providers in supporting people with SMI, particularly in healthcare. To help fill this gap, this qualitative study explored how participants attending a peer-led healthy lifestyle intervention nested within a PSH agency described working with both peer and non-peer providers to address their physical health. Increased examination of how these different provider roles and approaches are perceived by participants is critical to creating a shared understanding of care across both patients and different providers and can inform implementation of more collaborative and integrated care approaches.

## Methods

### Setting

This study is a part of a larger hybrid type I trial testing the effectiveness and implementation of a peer-led healthy lifestyle program for people with SMI who are overweight/obese (i.e., BMI  $\geq$  25) and living in three supportive housing agencies (Cabassa et al., 2015). All study participants had the opportunity to engage with a range of standard health-related services offered by non-peer staff as part of agencies' usual care services; those assigned to the intervention additionally received the peer-led healthy lifestyle intervention.

The Peer-Led Group Lifestyle Balance Program (PGLB) is an adaptation of the Group Lifestyle Balance Program (GLB), itself derived from the Diabetes Prevention Program (Kramer et al., 2009; O'Hara et al., 2017). GLB is a group-based intervention that seeks to reduce risk of cardiovascular disease and diabetes by improving participants' diet and physical activity (Kramer et al., 2009). It is a 22-session, year-long manualized program consisting of weekly sessions for the first three months (core), followed by biweekly sessions (transition) for 3 months, and monthly sessions (maintenance) for the remaining 6 months. PGLB was adapted for delivery by peer specialists and provided increased support to participants living with SMI (e.g., in-between session check-ins), flexible session formats (group or individual), and make-up sessions for individuals who had missed sessions (O'Hara et al., 2017).

Peer specialist facilitators were trained and certified in peer-led services by their state accrediting board. Peer specialists also participated in a 2-day GLB certification program with certified PGLB master trainers. In addition, prior to facilitating the intervention, peer specialists participated in 3 months of intensive training led by research staff. During this training, all session materials were reviewed session-by-session and each peer specialist facilitated mock sessions (Cabassa et al., 2020; Velez-Grau, Stefancic, & Cabassa, 2019). Peer specialists were employed by the supportive housing agencies and received weekly supervision from the agency and the research team consisting of session preparation, fidelity monitoring, and feedback.

The degree to which non-peer support was coordinated with the healthy lifestyle intervention varied greatly across sites. Some of the primary care doctors working with participants coordinated closely with the healthy lifestyle intervention (including being a supervising team member of the intervention), while other primary care doctors were part of external clinics and not affiliated with the agencies. Most nursing staff and case workers/social workers were part of the agency and aware of the lifestyle intervention, but provided separate support services (e.g., care coordination, help with shopping). The non-peer providers described in this study did not receive specific training in health promotion outside of their professional training or education. For non-peer providers whose training was not directly in health services, health support described by participants consisted of coordinating healthcare appointment times, assisting with travel to/from appointments, and offering general advice and support (e.g., sharing healthy recipes). Almost all non-peer staff had training in providing support to individuals with SMI, with the exception of some of the primary care doctors external to the agencies.

## Sample

To be eligible for the qualitative sub-study, participants had to have met criteria for the RCT (see Cabassa et al., 2015 for details) and have completed at least two PGLB sessions. This study used a purposive sampling approach to maximize the diversity of participant experiences, recruiting participants based on both program attendance (high/low) and session format (group/individual). High attenders completed  $\geq 75\%$  or more of PGLB core/transition sessions and low attenders had completed  $< 75\%$ .

## Data Collection

Participants completed a semi-structured interview, lasting 45 min on average, regarding their experiences of receiving support from both the PGLB peer specialist and other non-peer providers for their physical health. Participants were

asked to identify a non-peer staff (NPS) that supported them with their physical health. Participants were then asked to describe and compare their experiences working with the PGLB peer specialist (PS) and the NPS. The interview guide was developed in collaboration with an expert in the field of peer-delivered services and through a review of existing literature of peer-based services (Gidugu et al., 2015; Solomon, 2004). Sample questions included: “How comfortable did you feel working with [PS]?” and “Was your level of trust or comfort working with [peer specialist] the same or different than with other non-peer staff?” All participants provided written informed consent and all procedures were approved by the Columbia University Institutional Review Board (IRB) and the Philadelphia Department of Health IRB.

## Data Analysis

Participant demographics taken from RCT from baseline structured interviews were analyzed using descriptive statistics. Qualitative analyses occurred concurrently with data collection using analytical strategies rooted in grounded theory, such as coding, consensus and constant comparison (Glaser & Strauss, 1967; Willms et al., 1992). Through constant comparison and identification of patterns, the analysis built on an in-depth understanding of how peer and non-peer providers are approaching their work. An initial codebook was developed consisting of concepts identified both a priori (i.e., from existing literature, such as “credibility” and “empathy”) and from two researchers’ readings of four transcripts (e.g., “not alone” and “on our level”). This preliminary codebook was used by two researchers to independently code 12 transcripts and make final revisions to the codebook. A third researcher helped resolve discrepancies between the two coders to reach consensus. Following completion of 25 interviews, the researchers speculated whether additional interviews would yield new information. Five additional interviews were conducted and confirmed that data saturation had been reached. All transcripts were coded in ATLAS.ti. Atlas reports were then generated of codes organized by provider type being referenced, allowing the team to review content and patterns emerging within and across codes by peer and non-peer provider designation. Following initial review of reports, researchers identified themes emerging in the data (e.g., content, time, hierarchy) and then re-reviewed transcripts to identify if and how themes were described in reference to each provider. Researchers met weekly to debrief and discuss, compare, and contrast how preliminary themes differed or were consistent across providers. To maximize rigor, multiple coders independently coded transcripts and following analysis of interviews, the researchers presented findings to PGLB peer specialists, who reported that

the findings were consistent with their experiences engaging participants in PGLB.

## Results

### Sample Characteristics

Of 56 participants who were eligible for this sub-study, 30 were invited to participate (see Table 1). All 30 participants completed interviews, but two interviews were terminated early (one due to a participant's refusal to answer questions and the other due to difficulties directly answering questions), resulting in 28 participants in the final study sample. Participants on average were 49.8 years old with 14 males and 14 females. A majority of participants identified as Black (71.0%) and had at least a high school education (60.71%). Depression was the most commonly reported psychiatric disorder, followed by schizophrenia/schizoaffective disorder, and bipolar disorder. The most commonly reported physical health conditions were hypertension, high cholesterol, diabetes, and arthritis. Sixty-four percent of participants (median of 21.5 sessions/22 sessions) had high attendance and 36% had low attendance (median of 13.5 sessions/22 Sessions).

**Table 1** Participant Characteristics ( $N = 28$ )

	Mean (SD)	N %
Age (years)		
Mean (SD)	49.82 (9.27)	
Sex		
Female		14 (50%)
Ethnicity		
Hispanic/Latino		0 (0%)
Race		
African-American/Black		20 (71%)
White		6 (21%)
Multiracial/Other		2 (7%)
Self-Reported Psychiatric Condition		
Depression		24 (86%)
Schizophrenia/ Schizoaffective Disorder		21 (75%)
Bipolar Disorder		13 (46%)
Anxiety Disorder		12 (43%)
Drug Abuse/Dependence		9 (32%)
Alcohol Abuse/Dependence		9 (32%)
Other Psychotic Disorders		1 (3%)
Self-Reported Health Condition		
Hypertension		17 (61%)
High Cholesterol		13 (46%)
Diabetes		9 (32%)
Arthritis		9 (32%)

When asked to identify a NPS that assisted them with their physical health, the majority of participants identified someone who worked with them directly regarding their health including their primary care doctor or psychiatrist (28.5%), nursing staff (14.3%), case worker (17.9%), social worker (7.1%), program director (7.1%), nutritionist (7.1%), or group leader of a health class (3.6%). The remainder of participants identified another member of the supportive housing agency staff (14.3%), such as their art therapist or another group facilitator, who supported them with their health more informally. However, we did not systematically track the unique count of non-peer providers described in this study, though, there were more non-peer providers named ( $n = 28$ ) than total number of peers ( $n = 4$ ) who delivered the health intervention.

### Overview

Overall, participants viewed their relationships with PS and NPS positively, describing how each provider assisted them with their health through the provision of knowledge and resources. However, participants consistently described differences in how each provider assisted them with their health-related goals, specifically in the providers' approach to practice, the power dynamics present in the relationship, and how they identified or shared commonalities (e.g., shared experience vs. shared goals) with each provider (Fig. 1).

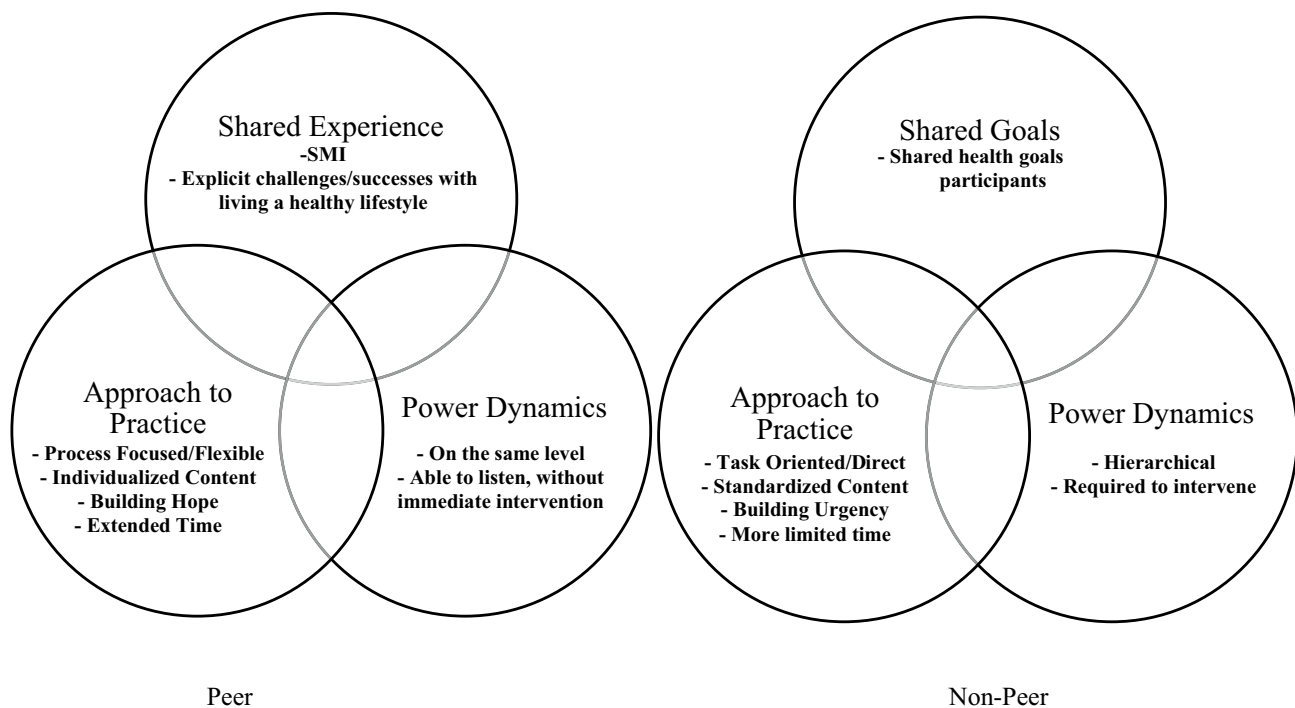
### Approach to Practice

**Process vs. Task-Oriented** Differences between the peer's process-oriented and NPS's task-oriented approach to practice were effectively summarized by one participant,

[NPS] does her job effectively and that's all that really is required I guess...[PS], on the other hand, she's always...really joyous. She comes in, oh, hello everybody, come on, let's go downstairs. We're going to learn about salads today...she's able to bring a lot of information out of a person when otherwise the person wouldn't be sharing in the first place...

In addition to the ability of PS staff to deliver intervention content, there was frequent emphasis on their ability to cultivate a positive social environment, in which people felt comfortable sharing their own experiences and participating in the intervention.

He... makes a situation where...It's less intense... where you'd like to be and where you'd like to go. And he makes you feel as though that you will achieve that - just give yourself some time and relax and have fun



**Fig. 1** Participant Descriptions of Peer and Non-Peer Staff Providing Physical Health Support

while you're doing it...because, as again I mentioned, everything is not supposed to be work ...

PS's process-oriented approach was also reflected in descriptions of their being attuned and responsive to participants' emerging priorities and subjective experiences during interactions, such as mood and feelings. This notion was commonly expressed by participants as the PS "just being there for me." Peers were also seen as being present with participants by validating their experiences through expressing empathy, showing emotions such as shedding tears, and using physical touch (i.e., hugging) to demonstrate caring:

"[PS] kind of understands, you know, my, not just my medical situation, but [PS] understands my family situation, my living arrangements... even my emotional standings at some point."

Alternatively, NPS were seen by participants as employing a more task-oriented approach that was attuned to participants' accomplishing concrete treatment objectives (e.g., weight loss). NPS's interactions with participants were often described as "direct," characterized by NPS explaining a health issue and outlining the steps participants needed to take to address it. One participant noted, "[NPS] was nice, and she showed us what we have to do, and we just do it, you know?" This focus on being straightforward was generally appreciated: "It's not a whole lot of BS, you know what

I mean? It's straight about dealing with these issues, you know?" However, at times, this directness was perceived by participants as NPS being more focused on their agenda and not understanding participants' concerns: "[NPS] seemed more rushed...she originally was very abrupt and she told me 'you have to do an hour a day of exercise...even when you're sore, and when you lose energy you've got to do it'...and I explained that I get weak." Moreover, NPS were sometimes perceived as jaded due to fewer expressions of emotionality or empathy, and a lack of appreciation of the complexity of behavior change. "it's easy for them to give us medication and then in the same breath talk about losing weight is so hard. But that's what they do." However, most participants attributed this task-oriented approach to the nature of the NPS's job and caseload rather than a personal trait.

[PS is] not as stern as [NPS] is...after a point in time, you deal with so many people and you—you, that takes a lot out of you. I understand that.

**Time as Interaction vs. Time as History** Peers were seen as more flexible, spending more time with participants and engaging in more spontaneous interactions, rather than focusing solely on treatment objectives.

“[PS] would call us on the phone and you wouldn’t expect [them] to call you on the phone. I mean that’s time and effort that [the PS] putting into it... that makes you feel good when somebody calls you and they take time out [when] they are home...”

This additional time helped participants perceive the PS as someone who was “always there,” and, in part, facilitated those broader conversations that went “beyond healthy the lifestyle thing.”

Alternatively, while it was acknowledged that non-peer staff spent less time with participants overall, NPS were appreciated for the total length of time they had worked with participants. Participants emphasized that a long history of working with a particular NPS fostered a sense of trust and familiarity. “It’s been three years...I get an honest response from her...I know she’s not lying to me.” Once again, participants usually attributed NPS’ limited time to their large caseload, but also noted they felt NPS were generally still approachable and responsive:

it’s not an extended amount of time...[as] I can [have] with [PS]. But I know I can talk to [NPS]. I know if – if I bring some things to his attention, he will give me the proper resources to get there.

**Individualized vs. Standardized Content** PS tended to individualize intervention content to a participant, whereas NPS tended to use a more standardized approach that incorporated expertise from their particular formal qualifications. One participant explained how PS made the content more personal “[PS] brought in hummus because... I’m a vegetarian, so the hummus could be a special thing...[we] tried roasted garlic hummus and that’s my favorite hummus now.” While NPS staff could tell participants to “cut down on your sugar, cut down on your cholesterol,” PS could use their in-depth knowledge of participants to offer more specific guidance, “[PS] is trained to tell us about our diet, are we eating wrong? Are we eating right? And [PS] keeps up on what we eat through the week cause we write it down.”

The more “one-size-fits-all” approach of NPS was explained by one participant, “[NPS], in his line, in his profession...everything is pretty much textbook.” However, clients also valued the specialized knowledge and pedagogical role of NPS:

they know what they’re talking about...they’re doctors, and they went to school for things. And if they say I need to lose a couple of pounds, then they’re right...the doctor is more focused on...the objective sides...blood pressure, vital signs, blood work. And she checks in to what else I’m doing in terms of activity, work, diet...

Participants emphasized that while content was standardized by NPS, it was presented understandably, increasing their comprehension of subject matter. One participant explained,

That’s the biggest thing...He did put it in things I could understand, but because he worded it certain ways, I was able to relate more to my own problems. I was able to communicate my own problems better because it was in simple, plain English.

Another participant articulated the importance of their NPS’s expertise in conveying health data, “she showed me the levels of diabetes in my blood work...she took her time to explain what each level meant...they have different signs and signatures on the graph...but she helped me understand.”

**Building Hope vs. Building Urgency** When motivating participants to address health concerns, PS emphasized hope and the possibility of change, and NPS emphasized negative consequences of inaction and the urgency of change. PS focused on celebrating successes, normalizing slips, and speaking without judgment in efforts to convey an unwavering positive belief in participants’ ability to engage in behavior change:

She always was patient. If I took off a pound a month, she was congratulate me, and if I didn’t take off a pound for the month, she said ‘you didn’t gain weight so that’s good and next month you have a chance to take off more.’

One client described how this differs from the role of the NPS.

I lost about 14 to 15 pounds...[my NPS] hasn’t gone over the wins, the successes as much... [My PS] is entirely different... She’ll go and on about the successes and build me up... And after you get built up she’ll go on to new information... [she’s] very encouraging.

Unlike PS, NPS tended to focus on the repercussions of participants’ inaction and the problematic nature of slips in order to convey the seriousness and urgency for health behavior change:

Well, he didn’t beat around the bush, you know...He really made it simple. He was blunt actually at times. I kind of appreciated that, you know? ‘Look, you drink, you’re going to die. You don’t take your medication, you’re going to have a seizure.’

When slips occurred, NPS were described as more assertive in highlighting participants’ negative behaviors and the

need for an immediate course-correction. One participant explained how he imagined NPS feel when they see clients make mistakes based on his experience working with his primary care doctor: “And when you see someone that has a chance and they blow that chance, it’s like, wow... ‘What were you thinking? You came so close... I thought you had this together’ and things like that.”

## Power Dynamics

**On the Same Level vs. Hierarchical** Participants also described their experience of the implicit hierarchy present in their relationships with both providers. Participants described the non-hierarchical nature of the peer relationship: “he didn’t put himself... above... He allowed us to understand that... sometimes we have struggles with living a more healthier lifestyle.” Another participant shared their appreciation of PS taking both a mentorship role while in group sessions and a peer role in their other interactions, “when we in class, she acts like a teacher. But when she’s out like right now like this, she’ll be like, a regular, like one of us... It’s us together.” In contrast, NPS were described as more authoritarian, emphasizing what needs to be done, rather than demonstrating an understanding of the difficulty of engaging in behavioral change.

...she was very demanding... She would come in the apartment and tell me what should I do and do it this way... she used to be very aggressive... And I don’t like that part... I don’t like to be talked to like I’m a child.

These experiences led participants to describe PS as less forceful and less authoritative compared to non-peer staff: “[NPS] staff tells us you better do this, you better do that. You can’t do this and you can’t do that, but [PS] will say something like ‘well, this is what I would do.’ Instead of telling us, you know.”

**Listening vs. Intervening** Given peers’ roles within the agency, they were able to maintain participants’ confidentiality, rather than immediately intervening or referring to another provider when participants confided in them about relapses or other behaviors. One participant stated, “I just felt confident whatever I tell [PS], it won’t go any farther.” Unlike PS, NPS within the agency were often described as unable to maintain the confidentiality of participants, repeating information to other agency staff. One participant explained,

It’s like a 24-h gossip column around here... everybody’s going to be gossiping about this and that. And I’m not into that. If I want gossip, I’ll go to church. The less they know about me, the better.

Further, participants also articulated appreciation of PS for respecting their space when they did not want to interact and welcoming them back when they were ready to return. One participant explained,

[The PS] worked with me... because some days I wanted to cut... But she still called and she tried to encourage me to come to the group so we could learn... she was real nice as far as with that- just trying to get me to come to groups. She didn’t have attitude neither, so that was a good thing because most people would probably have attitude.

The PS’s ability to respect participants’ space allowed participants to experience them as facilitators who helped “Without putting force on no one. Emphasis on no force, it’s just do it yourself. If you want help, I’m here type stuff.” Additionally, participants explained that the peer specialists would work with them to help them “catch up” on missed sessions.

...if we miss a group, she’ll take us in one of these rooms and...—let us catch up... the other staff would keep moving on if you miss it... but she’ll make an appointment with you... her and she’ll go over the lessons she taught that you missed.

Unlike peers, NPS did not have the luxury of allowing for participants to disengage and would, at times, be unable to respect participants’ desire for space. One participant explained, “Couple of [agency] staff members entered my home by key without me even knowing about it and came up in my house.”

## Shared Experience vs. Shared Goals

Participants highlighted the importance of shared experience with PS and shared goals with NPS. Participants appreciated how the PS shared their own successes and challenges navigating living a healthier lifestyle, often describing how they implemented PGLB strategies in their own lives. In the words of one participant, “he shares the fact that he goes to the gym and work out, and he applies his lifestyle to the manual.” Participants also felt that the PS’ shared experience of SMI connoted a common understanding and increased their level of comfort working with the PS. One participant explained, “I might say ‘I had a day dream’ and [NPS] might think I’m hallucinating. But with [PS], [PS] has mood swings too and [PS] would understand that. We both have [subtype] schizophrenia.” This often allowed participants to speak more openly with the peer specialists than other providers, as one participant noted, “Cause some stuff I can talk to [PS] about, I can’t talk to nobody else about.”

Conversely, participants highlighted that shared experience was generally absent from their conversations with NPS and instead they commonly referenced the importance of having a shared goal with NPS: “she’s a doctor and her job is to help people live and I want to live... Just like she has a common goal.” In the rare instances when self-disclosure did occur among NPS, participants noted it increased their familiarity and comfort with the provider,

I do like her because I can talk to her about my diet. I can talk to her about things... she knows the [Asian] food that’s good for you. We talk about how she cooks [Asian] food and I cook—I told her about lifestyle group. [She] said ‘I’ll look up some recipes for you.’

## Discussion

This study explored how people with SMI living in supportive housing viewed and understood the support provided by peer and non-peer providers’, specifying the contributions of each provider in supporting their efforts to engage in health behaviors. Participants’ described differences in each providers’ overall approach to practice, the power dynamics present in their interactions, and how they identified with each provider. Similar to findings from prior research, participants viewed peers as process-oriented, focusing on ‘being there’ for clients; compared to non-peers who were described as more task-oriented (Paulson, 1999). Interestingly, Paulson (1999) found that peer staff were perceived as spending more time with clients despite no statistically significant difference in the actual amount of client-provider interaction. Within the context of delivering the intervention, peers often provided examples from their own lives about attempting to live a healthier lifestyle, both normalizing the process of attempting to live a healthier lifestyle and increasing participants’ comfort with the peer specialist.

While participants in this study highlighted the importance of the amount of time spent with PGLB peer staff during their scheduled sessions, participants also emphasized the importance of moments spent with peer providers outside of the lifestyle intervention. Peer staff were described as engaging with participants in more spontaneous interactions, such as calling to check in with participants in between sessions. These findings align with previous research emphasizing the importance of building relationships that include engagement outside of the direct clinical goals of the intervention at hand (Shiner et al., 2008). In fact, quality of relationships has been cited as a crucial factor in facilitating healthy lifestyle change over the content of a specific intervention (Shiner et al., 2008).

In contrast, non-peer providers were seen as embodying a more limited but similarly valued role, chiefly focusing

their interactions with participants on specific health tasks and goals, rather than addressing complexities of behavior change or engaging in conversations beyond the salient physical health issues. This specialized information was most valued when it was customized to the individual, versus standardized for all clients (Bochicchio et al., 2019). Though there was variation in the types of non-peer providers described in this study, overall, differences between healthcare and non-health care providers were much less salient than those between peer and non-peer providers. The only explicit difference was that non-peer providers without specific health qualifications more often used self-disclosure in their interactions with participants. Overall, non-peer providers were appreciated for their expertise in the domain of health, their ability to translate health information into understandable terms, and the directness of their feedback, with some exceptions.

With respect to the power dynamics and hierarchical nature of the client-provider relationship, clients appreciated the expertise of non-peer providers, however, experienced their approach, at times, as authoritarian. The peer, conversely, served as an equal who offered support, rather than forced participation. Similarly, given the peers’ role as an ancillary provider, peers were able to maintain the confidentiality of participants when participants disclosed relapses, rather than report to directly other staff. While no study to date has explicitly compared the power dynamics present in peer and non-peer provider relationships with clients, prior literature has examined how clients perceive the peer role. Embuldeniya et al. (2013) found that peer relationships, specifically, had the potential to transcend traditional biomedical hierarchies, leading to an environment where clients could more freely express their emotions. The findings from this study further expand our understanding of how peers are able to create a non-hierarchical environment, emphasizing the importance of offering solutions, rather than demanding change.

Additionally, using simple language that is also culturally familiar to clients has been consistently found to be a factor promoting behavior change (Shiner et al., 2008). Globally, non-peer providers were viewed positively by participants, but their adherence to professional boundaries and more directive approach were viewed as rigid or overly blunt at times. Participants explained that the advice of how to live a healthier lifestyle (e.g. engage in physical activity) provided by non-peer providers was, at times, too general and oversimplified the reality of implementing health behaviors as a person with SMI.

Further, non-peer providers emphasized the urgency of addressing problematic health issues, which often prompted participants’ motivation to engage in process of change. However, as participants described, motivation for change is distinct from being hopeful about their capacity to



successfully engage in change. Peer providers often attended directly to participants' sense of self-efficacy and were described as offering unwavering support and belief in participants' capacity for change. These findings are in line with extant qualitative literature examining peer-led interventions that emphasize the importance of fostering self-determination, and hope, all grounded in shared experience as a crucial means of effecting change in individuals with SMI (Lietz et al., 2014).

Overall, the support provided by non-peer providers was viewed largely positively, but the depth of that support was often insufficient to ensure that participants were able to interpret, integrate, and implement treatment interventions towards improving the health of participants with SMI. Therefore, peer providers often served as an intermediary between the dissemination of health information and the application of behavior change, simultaneously building hope and providing tangible strategies to incorporate new behaviors (Brar-Josan & Yohani, 2014). Peer providers engaged participants in discussions of how to live a healthier lifestyle through tailoring intervention content and providing real life examples of challenges and successes to engaging in health behavior change. These descriptions of peer staff are consistent with those from prior literature that have described the peer role as a "liminal position" where peers play a unique, multifaceted role as both a treatment provider and role model, embodying the successes and challenges of coping with medical and mental illnesses (Watson, 2017). Overall, our findings suggest that these two types of providers complement one another, such that the limitations of one approach are reciprocally reinforced by the strengths of the other. Clients need both experts and peers, unconditional support and guidance, hope and urgency. Though both approaches were viewed positively, the more directive approach of non-peer providers was, at times, perceived as abrupt and dismissive.

In a recent systematic literature review examining health outcomes among persons with SMI receiving services in behavioral health homes, the inclusion of peer support and/or training in self-management skills were associated with the greatest reduction in cardiometabolic risk factors (Fortuna et al., 2020). This suggests that targeted efforts to assist people with SMI with health behavior change using peer support may be key to impacting health outcomes. Within the context of the large study, results from the effectiveness trial indicated that a larger proportion of participants in PGLB than in usual care achieved clinically significant weight loss at 12 and 18 months, yet these differences were not statistically significant (Cabassa et al., 2020). However, PGLB outcomes (e.g., clinically significant weight loss, reductions in CVD risk) were comparable to the outcomes reported in other healthy lifestyle interventions for people with SMI (Bartels et al., 2013; Daumit et al., 2013). These

findings suggest further research is warranted to explore the use of peer delivered healthy lifestyle interventions in supportive housing, and to determine whether and how they should be coordinated or integrated with existing healthcare.

The present study expands current understanding of the role of peer providers in assisting people with SMI with their physical health and how this work may facilitate a greater understanding and application of the information provided by non-peer staff. As peers continue to be integrated into behavioral health care settings, it is necessary to continue to explore their role and understand their unique contribution to client care. Siantz, Rice, Henwood, and Palinkas (2018) began to elucidate the role peers embody on newly integrated behavioral health teams by measuring the level of value team members assigned to the peer role. Their findings emphasized the importance of maintaining "quality assurance processes" to assure that the unique contributions of peer providers are being supported and appropriately utilized within the larger clinical setting.

### Limitations

This study had several limitations. While all study participants worked with a peer specialist who delivered the healthy lifestyle intervention, the types of health-related supports received from non-peer providers were more varied, thus this analysis does not explicitly compare peer and non-peer providers performing the exact same functions. Further, participants identified a number of different types of non-peer providers from a range of disciplines including nursing, social work, and psychiatry. Therefore, it is unclear if the practices of non-peer providers described in this study are reflective of a specific discipline or role. All participants resided in supportive housing agencies who were early adopters of health services. Therefore, participants may have had access to a wider array of healthcare services than other agencies typically offer. Our findings regarding peer and non-peer providers may not be representative of techniques and approaches used by all peer specialists and non-peer health providers. The approaches of the peer specialists described in this study may be a product of training in the healthy lifestyle intervention, rather than attributable to characteristics of peer specialists providing health-related services more broadly. Further, non-peer staff interactions and time spent with participants may have been attributable to caseload size and other factors related to agency standards, rather than indicative of a non-peer staff approach more broadly. Additionally, future research should seek to identify metrics to measure the fidelity of peer providers' approach to client interactions to create a replicable model for efficacious interventions, standardized training, and future outcomes research (Siantz, Rice, Henwood, & Palinkas, 2018).

## Conclusion

Given the high prevalence of physical health comorbidities among persons with SMI, many will require additional support to ensure that they can understand, integrate, and implement treatment interventions and/or recommendations to improve their health. The current study illuminates the unique facets of peer-delivered health interventions which can serve as emerging guidance for the training of peer providers while also helping non-peer providers to understand how the peer role can complement traditional health services. The findings from this study underscore the need to increase the use and integration of peer providers in more mainstream health services to support clients in identifying how to incorporate healthcare experts' suggestions into their daily lives. As peer roles are further defined and differentiated from existing services, there is the potential for more collaborative and integrated care across peer and non-peer providers.

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## Compliance with Ethical Standards

**Conflict of interest** The authors declare that they have no conflict of interest.

**Ethical approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

**Informed consent** Informed consent was obtained from all individual participants included in the study.

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