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ORIGINAL PAPER

From Physical Wellness to Cultural Brokering: Unpacking the Roles of Peer Providers in Integrated Health Care Settings

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Abstract

This qualitative study explored peer provider experiences working in newly integrated mental health and primary care pilot programs within a large public mental health system. Nineteen peer providers participated in semistructured interviews that focused on experiences delivering care within integrated teams. Interviews were analyzed using constant comparative methods informed by grounded theory. Findings were organized into three themes that speak to variation in the definition and function of peers; lack of clarity in the peer role; and relating to other providers. Integrated settings need ongoing support to ensure clarity in the peer role and an inclusive work environment.

Keywords Integrated care · Peer providers · Integrated health teams

Introduction

Persons with serious mental illnesses are at elevated risk for a range of health vulnerabilities, and studies have demonstrated that this population experiences many years of life lost compared to the general population (Colton and Manderscheid 2006; Druss et al. 2011). This health disparity has been attributed largely to treatable and preventable chronic care conditions (Janssen et al. 2015), calling for the widespread implementation of integrated mental health and primary care services. In recent years, an expanding cohort of individuals with personal experience with recovery from a mental illness has taken leadership in the delivery of integrated health care (Swarbrick et al. 2016). These individuals, known as peer providers, are part of a movement that promotes inclusion and social justice among persons living with mental illness, and add credibility to health promotion interventions, while promoting trust and engagement with consumers (Swarbrick 2013). Peer providers in mental health systems are individuals who have personally experienced mental illness (Davidson et al. 2006) and have received formal training to deliver care to consumers of mental health services (SAMHSA-HRSA Center for Integrated Health Solutions 2016). Recently, the scope of peer-based services has expanded to include promotion of physical health (Cabassa et al. 2017; Allen et al. 2010; Center for Substance Abuse Treatment 2009) through health navigation (Kelly et al. 2017), wellness coaching (Swarbrick 2013), and facilitation of chronic disease self-management educational groups (Druss et al. 2010; Goldberg et al. 2013). These approaches, especially navigation and self-management interventions, have demonstrated promising outcomes (Cabassa et al. 2017).

Previous studies have reported on factors that affect the implementation of peer providers in community mental health settings and have noted that a lack of understanding of the peer role among peer providers themselves (Gates and Akabas 2007; Mancini 2018) and their supervisors (Kuhn et al. 2015), stigma from agency staff, and lack of training

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(Gates and Akabas 2007) can undermine their contributions. While these findings can assist traditional mental health settings with the inclusion of peer providers, less is known about the peer provider role in the delivery of integrated physical and mental health care and whether the definition of a peer provider working in these settings should also include lived experience with a physical health condition. Regardless of whether peer providers are understood to have personal experience with recovery from a mental illness or both mental and physical illnesses, the issue of whether peer providers should also have a shared cultural background has not been widely discussed, which may be particularly important in a public mental health setting that serves a large number of persons from underserved racial and ethnic populations where addressing culturally nuanced barriers to accessing mental health services is essential (Barnett et al. 2018). This qualitative study explores the experiences of peer providers working in newly integrated mental health and primary care programs in Los Angeles County, which is one of the most racially and ethnically diverse counties in the United States.

Methods

Study Setting

The present study was conducted in under a large-scale implementation of integrated mental and physical health pilot programs funded by Los Angeles County's Department of Mental Health (LACDMH). LACDMH is the among the largest county mental health systems in the country and serves more than quarter million county residents annually. Beginning in 2012, under a program known as Los Angeles Innovations (LA Innovations), LACDMH implemented 24 integrated pilot programs designed to improve access to physical health care among persons with serious mental illness, chronic general medical conditions, and co-occurring substance use disorders. These programs followed one of three approaches to care. Of the 24 integrated care pilot programs, five were co-located clinics that used an integrated clinic model (ICM), where integrated clinics consisted of collaborations between with community mental health centers and FQHCs. Five other programs focused on homeless populations using a Housing First approach with primary care embedded in assertive community treatment teams, known as an integrated mobile health team (IMHT). These mobile health teams also collaborated with federally qualified health centers (FQHC) to provide field capable medical services such as blood draws, blood pressure measurements, and wound care, and to coordinate general medical care with the FQHC. However, the majority of programs (n = 14) were community-designed programs intended to target specific underserved ethnic communities, known as the integrated services management (ISM) model. ISM programs were designed by and targeted specific racial/ethnic communities that have been traditionally underrepresented or underserved by the public mental health system, such as persons of Latino, Asian/Pacific Islander, African/African American, Native American/Alaskan Native, and Middle Eastern decent. These programs focused on cultural and linguistic competency, community-specific outreach and education, and the use of non-traditional wellness services. Findings from the larger evaluation have been published previously (Gilmer et al. 2016; Henwood et al. 2017).

Consistent with LACDMH's larger efforts to promote peer support, pilot programs of each type were asked to include peer providers on their integrated service teams, but programs were given leeway to tailor the peer provider involvement to their own agency contexts. While LACDMH requires that peer providers have certain values such as "lived experience" and "sharing and connecting with others" through their lived experience, (County of Los Angeles Department of Mental Health 2013) there were no specific instructions for LA Innovations programs to follow when hiring and implementing their peer providers. This system wide effort to integrate primary and mental health care services was the final initiative of California's Mental Health Services Act.

Data Collection

To identify peer provider key informants to interview for the present study, LA Innovations program directors were contacted via email and asked for the names of the peer providers on their teams. Peer providers were then recruited through a combination of emails and follow-up phone calls. In total, 24 peers were recruited from 17 programs. A total of 19 peers were interviewed, with between 1 and 3 peers being interviewed per program. The semi-structured interviews focused on peer providers' experiences delivering care on their LA Innovations integrated teams, as well as barriers and facilitating factors that affected their experience delivering integrated care. Example questions included "What is your role on the LA Innovations team?" and "Please describe your experiences working with other providers on an integrated team." Interviews were audio-recorded and professionally transcribed verbatim. Participants also completed a brief demographic survey. Data collection occurred during spring 2015. The University of Southern California Institutional Review Board approved all study procedures.

Data Analysis

A procedure of "coding consensus, co-occurrence, and comparison" (Willms et al. 1990) was used. This analytic strategy is rooted in grounded theory, which is theory derived

from data and then illustrated by characteristic examples of data (Glaser and Strauss 1967). Qualitative coding occurred in four steps. First, the first author and two trained research assistants developed an initial list of codes, which consisted of a list of themes, issues, and opinions that related to the roles and experiences of peer providers. Example codes include "client engagement," "team functioning," and "stigma of mental illness." Second, the code list was finalized through consensus. Third, the first author and at least one trained research assistant co-coded 75% of transcripts. Any disagreement in assignment or description of codes was resolved through discussion, and by refining code definition (Boyatzis 1998). The first author independently coded the remaining 25%. NVivo (QSR International, Cambridge, MA, USA, Fraser 2000) was used to code transcripts and generate a series of project codes that connected segments of transcripts grouped into separate project nodes.

Results

Study participants represented a range of racial and ethnic categories including Black, Armenian, and Cambodian. Several of the study participants spoke a language other than English. These languages included Khemer; Armenian, Korean, Lakota, Mandarin and Cantonese. The majority of study sample had completed more than high school, with seven individuals having completed some college, and seven having completed a BA or more. Study participants also represented each of the LA Innovations program types. Table 1 summarizes sample characteristics. In this table, we do not report the exact numbers and percentages of certain descriptive characteristics (i.e. ethnicity, language, and program type) to help ensure the anonymity of study participants.

Qualitative analyses included approximately 30 codes and 15 sub-codes which were organized into three major themes that speak to: (1) variation in the definition and function of peer providers; (2) lack of clarity (and credibility) in the peer role in an integrated system; and (3) how peers relate to other healthcare professionals. Each theme consisted of several subthemes, which are detailed below.

Table 1 Sample characteristics of peer providers (n = 19)

Variable	N	%
LA INN program type[a]		
ISM		
ICM		
IMHT		
Male	10	52.2%
Age[b]	46	SD = 12
Languages spoken[a,c]		
English only		
Armenian		
Khmer		
Lakota		
Mandarin and Cantonese		
Korean		
Race/ethnicity[a]		
Armenian		
Persian		
Black		
Cambodian		
Chinese		
Korean		
American Indian (Lakota)		
Education		
High school diploma	2	10.5%
Some college	7	36.8%
Associates degree	3	15.8%
BA	2	10.5%
Masters	3	15.8%
MBA	1	5.3%
Doctorate	1	5.3%

[a]No numbers reported to protect anonymity of study participants

[b]Mean and SD

[c]All interviews were conducted in English

Variation in the Definition and Function of Peers

Despite lack of clarity in their role, peer providers generally performed one or more of three primary functions: informal promotion of physical health self-management, health navigation, and engagement through shared cultural identity. Of note, engagement through shared cultural identity without attention to having lived experience with mental illness or physical health matters or was a function that was, in general, unique to the ISM programs that served under represented racial and ethnic minority populations, whereas the peer providers working on ICM and IMHT teams generally promoted physical health informally and through health navigation. Interestingly, the idea that peer providers should have lived experience with mental illness did not hold true in these programs.

Informal Promotion of Physical Health Self-Management

Some peers involved in the promotion of client physical health used informal strategies to promote client self-management of physical health, and several participants reported drawing from their own experiences managing chronic diseases to motivate their clients to improve treatment adherence. In one ICM setting, a peer provider described using her own experience managing diabetes to activate her client towards diabetes self-management.

> I'm a diabetic. I understand the issue of diabetes for clients. We talk medication. I try to make them understand the importance and the urgency of getting some of these things done. Sometimes I wish there had been someone there for me because I put off treatment for four or five years. So, I try to make our clients aware that this is something that you need to deal with. (ICM peer)

This peer demonstrated the melding of insight from an individual experienced with the consequences of delaying caring for a chronic disease and the authority of a service provider. Other peer providers informally used their capital as service professionals to employ a scared-straight approach to remind clients of the negative consequences of not managing their diabetes or other chronic diseases. To ensure her clients were aware of the dangers of poorly managed diabetes; one peer provider brought them to a morgue:

> So, we went over to the morgue and [my client] kept looking at me. I said this is where you're going to be at if you don't take your medicine and insulin like you're supposed to. Do you know how many people die of diabetes every day? I said, show me a person that died of diabetes today. [The morgue worker] said how about yesterday? He said she went into insulin shock. He said at least three or four people die every day." (ICM peer)

Health Navigation Supported by DMH

Other peer providers reported using skills learned in formal trainings related to Health Navigation. To become a Health Navigator (Kelly et al. 2014) in LACDMH, peer providers participated in a manualized training during which they learned how to train clients to access and eventually manage their own primary care service use. One peer provider described using these skills to help clients become more proactive in asking questions of primary care providers:

> Part of the health navigation training told me to inform my client about being specific when you get to [a nurse practitioner]. Have the members get three questions that they want to ask specific questions. We don't want people to go in there and just to get prodded and poked. We want them to ask questions while we're in there to help ease anxiety. (IMHT peer)

As health navigators, peer providers were trained to provide practical advice to clients, which can alleviate apprehension that individuals can experience as a patient with limited experience in accessing primary care services.

Evoking Shared Cultural Identity to Engage Clients

Whereas peer providers within IMHT and ICM programs reported having shared experiences of recovery from mental illness, addiction, and chronic physical health conditions, some peer providers employed by ISM programs did not have their own experience with recovery from a mental illness. Instead, these peer providers shared a cultural identity and linguistic background with their clients, which were often evoked to conduct program outreach. Several ISM peer providers reported that both mental and physical illness were stigmatized in their communities and described how culturally specific stigmas and perceptions of mental illness can influence an individual's likelihood of accessing care in their program. In this respect, ISM peer providers described understanding the cultural nuances of stigma as essential to engaging their populations. A peer provider described the importance of understanding the negative connotations of the word *mental* in the Cambodian culture:

> We could use the word mental, but 'mental' in Khmer, it means that, you're crazy, you're losing it. So, we use 'heart' instead of 'mental'. It's not your head. It's your heart. Your heart is sad. You need to heal your heart. (ISM peer)

This peer provider used his knowledge to avoid describing mental illness in a way that is "off limits" in his culture. In describing the how culture influences the experience of stigma, some persons hired into the peer role also noted the historical contexts at the foundation of stigma for their cultural groups.

> In the past, even though you have a mental and emotional [challenges]… if you pray to God: God conquers everything. Everything can be handled through prayer… a Korean pastor in the past is like they don't accept mental health problem [it means] the faith is not good. (ISM peer)

This individual, who is a respected professional in the community he serves, shared his Korean identity to explain why outreach in his community can be so challenging. ISM peers' familiarity with a community's historical context of stigma allowed them to more effectively conduct community outreach and support client engagement.

In a few cases, ISM peer providers also engaged clients by blending their cultural identity with their own experience of mental illness and recovery. One peer provider described how he combined his Chinese ethnic background and his experience with depression and surviving cancer to support clients in improving their physical health.

> I tell them my depression and my other problem (*cancer*). I still recover. Now I'm fine. I can help you. I just

> try to encourage them to keep all the appointments, that you might be better later. And culture, all Chinese client sometime they believe some different thing too, like they do Buddha, they can go to the temple to pray. They feel better too. (ISM peer)

This person described the overlap of these three identities and suggested that part of his role is to help clients keep appointments with their many health care providers. Encouraging clients to take their multiple health needs seriously using a cultural perspective was optimized through a peer provider who can relate with physical and mental health concerns and shares their ethnic and linguistic background.

Lack of Clarity (and Credibility) in the Peer Role in an Integrated System

Within integrated programs, there was an overall lack of clarity and consistency about the roles of peer providers. This was evident through some peers' questioning the appropriateness of their own involvement with physical health, and the perception that other providers question the credibility of peer providers in general.

Belief that Peer Providers Should Not be Involved with Physical Health

Across all program types there were peer providers who were uninvolved in the delivery of services related to physical health. Many of these individuals reported that they understood the importance physical health, but summarized their limited involvement by saying "That's not our part." Often, these individuals described feeling unprepared and unskilled to support clients in accessing and managing health care.

> No, [*health care is*] really… that's really out of my league. I feel out of my league. All I know is if you got a Medicare card, you can get anything (IMHT peer).

This peer provider alluded to limitations in his training that made him feel unprepared to engage with clients on the topics of physical health and health care. In programs in which peer providers were not involved in the coordination of client physical health care, they instead focused exclusively on addressing mental or behavioral health needs of clients, or program outreach, and one peer provider was tasked with running a drop-in center.

Questioning Peer Credibility

Related to peers' perceptions that they lack the skills needed to participate in the delivery of physical health care, some perceived that their team members did not value the credibility of the peer role due to a lack of formal training. In the following quote, one peer reported that other members of the integrated team questioned the value of her skill set, which she acknowledges is different from her colleague's clinical background.

> I know there's a line I don't cross. But sometimes the staff can get offended because they went through college, they went through the training, they got the paperwork. I don't. I know the people though…. the staff, they got these professional lines they can't cross and everything's gotta be seen through clinical eyes (IMHT Peer).

Complementing this sentiment that peer providers lacked credibility due to lack of formal clinical training, some held the perception that other providers also did not understand the value of having a team member with expertise in the client community. The following quote highlights the sentiment that other providers on the integrated team under-value peer providers' client-level expertise.

> Not being included in some of the information for the client, having to get it myself, it's not that the team intentionally doesn't tell you some things. But sometimes you only learn it by sitting in on our case conferences…Sometimes I don't think the team understands the importance of having that person there that understands what that client's going through.

As the above quote suggests, the under-valuing of peers' understanding of "what the client is going through" was at odds with the more clinical approach used by other members of the team.

Relating to Other Providers

In the end, the individuals who were hired into the peer provider role had several valuable functions on their integrated teams. Despite the lack of role clarity and variation of the peer role within and between program models, two main factors emerged that promoted their involvement including: inclusion on the right team and exchanging expertise.

Inclusion in the Right Team

Contrary to the cases where peers reported feeling that their expertise was not valued, others reported working in a highly inclusive team environment where the culture of the team was welcoming and included respect for one another and for the clients they serve. Peer providers that worked in teams where they perceived that their fellow providers respected and connected with clients generally spoke favorably of their teammates and their experience working their team.

As noted by one peer provider who conducted outreach in an area with a high proportion of homeless persons:

> If you're sitting on the ground in trash, we're gonna sit right there with you. We're not afraid of trash. We're not afraid of poop or whatever he's sitting next to, you know? That's why I say you have to have compassion. You can't go in with your white gloves on and be like, I'm not touching that. And the doctor, he's awesome. He gets right down there on his knees. (IMHT peer)

As this quote suggests, that the primary care physician has engaged in street-level outreach, which has helped establish credibility with this peer provider.

Exchanging Expertise

Several peers reported working in an environment that fostered the mutual exchange of information and expertise with their fellow providers. Peer providers who worked in such settings reported the positive experience of being valued and feeling heard on their interdisciplinary teams, and several felt invited to draw from their own experience with mental illness and recovery to educate their fellow services providers on the realities of having a mental illness.

> I'm the one that they always go, 'OK we have a question', and then they look at me to see my reaction, you know? Because I came from the streets. (IMHT peer)

While this person's team looks to her for expertise and interpretation client experiences, other peer providers described the value of working in a team environment where they were able both teach and learn from their fellow providers. The following peer describes the value of learning from their team, despite feeling excluded at first. This peer also implies that such an environment can take time to cultivate.

> They've learned to understand me. I was kind of sidelined at first. It has changed because they appreciate what I can bring to the team. And I definitely have gained so much knowledge from our team, so I think now that's why we're such a good blend. I think they appreciate what I can bring to the team. (IMHT Peer)

Other study participants echoed the importance of learning from their team members. Nearly all participants worked in multidisciplinary health care settings with clients who had co-occurring mental illness and chronic care conditions. For many, effectively supporting clients with these needs required on-the-job learning. One peer provider described how the providers on her team created environment that was conducive to developing these skills:

> Our psychiatrist is there. He's at all of our meetings. Everyone's door is an open door so if you have any questions, you know, whether small question to big question, there's no intimidation. It helps when the psychiatrist adds their thought or the physician adds in their thought. They're down to earth; they're not mean, snotty people and they're willing to teach us. If I don't understand I let them know like I don't understand what that means, and they explain it. (IMHT peer)

While several peer providers described working in an environment where they exchanged their expertise in the client community with the knowledge of other staff members, not all shared in this experience. Some peer providers questioned the expertise of their own team members who they believed understood neither the client community nor experience. In these cases, some used their lived experience with mental illness to challenge their colleagues when they appeared misinformed about the experience of having a mental illness or expressed unrealistic expectations of a client.

> I'm the only one that has a mental illness here in the office, and sometimes they'll say stuff and I'll be like 'until you know, you don't know…Until you know what it's like to be homeless, you don't know why they got there, you don't know what their background is or none of that and then you're passing judgment at the same time because you want them to do what you want them to do but you don't know what's happening. (ICM peer)

Discussion

The purpose of this qualitative study was to understand peer providers' experiences delivering care in newly integrated mental health and primary care settings. This study is among the first to incorporate the perspectives of peer providers to explore their roles in these newly integrated health care teams. From this analysis emerge five main points of discussion.

First, our study found that that some individuals in the peer role of LA Innovations programs did not have disclosed lived experience with mental illness and instead shared a cultural background or had lived experience with certain physical illnesses. This project, in effect, seemed to expand the concept of peer providers to not only include persons with the lived experienced of mental illness but also include what the literature would more commonly describe as community health workers (CHWs). A recent systematic review of community health workers (CHWs) in mental health settings reported that CHWs, or interventionists without formal mental health training who are members of the community they serve can address culturally nuanced barriers to accessing mental health care such as stigma, and deliver some

mental health interventions (Barnett et al. 2018). Public mental health systems that serve large numbers of persons from underserved racial and ethnic minority groups might consider expanding their mental health service teams to include CHWs to meet the needs of these populations. One could argue, however, that it would be important to call these persons CHWs, in an effort to protect the fidelity of the peer provider role. It may also be that the complexity of the peer role within settings that serve an extremely culturally diverse population such as that of Los Angeles County blurred the line between peer providers and CHWs. In this study, it is possible that DMH's definition of the LA Innovations peer role expanded after recognizing the importance of peer providers having a shared a cultural background or experience in managing chronic health conditions. Alternatively, there might have been miscommunication in the process of setting up these new and innovative program models. Another paper published from this initiative (Siantz et al. 2016), reported that several participating programs had difficulty hiring individuals for the peer role who had co-morbid mental and physical health conditions along with a shared cultural background with their clientele which may have led to a loosening of the definition of a peer. In fact, pervasive stigma of mental illness across various cultural communities seemed to contribute to having individuals in the peer provider role who did not have experience with mental illness and instead had shared cultural backgrounds.

Second, despite these programs' emphasis on physical health, persons in the peer provider role had varying jobs in the delivery of integrated care and varying levels of involvement in the promotion or coordination of physical health care. Further, several others reported being uninvolved in this aspect of service delivery. Some peer providers who were involved in physical health promotion used their personal experience to encourage and support self-management of chronic care conditions, while others were formally trained in DMH supported Health Navigation. This indicates that that persons in the peer role valued client physical health, but the varying and unstructured roles in delivering care suggests a need for public mental health authorities to prioritize the training of peer providers to serve clients with complex health care needs. A recent systematic review suggests that peer based-physical health services for persons with mental illness can be effective, especially those that focus on health navigation and self-management (Cabassa et al. 2017). To facilitate the implementation of peer providers in delivery or coordination of physical health care, a study that is currently in progress has included external practice facilitators to engage clinic staff and leadership, problem solve, develop information exchange networks and otherwise market the use of peer specialists to staff of integrated programs (Chinman et al. 2017). External facilitators (Harvey and Kitson 2015) could be one mechanism for scaling up the use of peer staff while maintaining the authenticity of their role.

The primary challenge that peers described in working on integrated teams pertained to their credibility and qualifications to deliver integrated care. Despite the enthusiasm with which some peer providers supported client health through health navigation and by borrowing from their own experience in accessing physical health care, several others reported feeling unprepared to partake in the delivery of physical health services. This is unsurprising, given that previous studies have reported that various types of mental health clinicians do not feel prepared to assist consumers with their physical health (Kilbourne et al. 2012). Further, several public mental health systems throughout California are in the process of integrating peer providers into the physical health care of their clients and continue to formalize their roles (California State Association of Rehabilitation Agencies [CASRA] 2014). At present, there are limited resources available to support public mental health systems in expanding the roles of peer providers to include tasks related to client physical health. Increased communication between health systems through mechanisms like statewide learning collaboratives would allow mental health systems to share best practices for expanding the peer role in this manner.

Peers in the present study also reported that others on their teams did not respect their credibility as mental health professional. That some peer providers held this perception is not surprising, given that previous studies have indicated that mental health agencies can be unsupportive to peer providers (Carlson et al. 2001), while other studies have reported that mental health providers often question the importance of the peer role in general (Gates and Akabas 2007). Many providers on multidisciplinary teams, and primary care professionals in particular, likely have limited experiences working with peer providers. Teams charged with delivering integrated care would benefit from training to alleviate these tensions. It is also important for mental health systems to have open dialogue with peer providers during program implementation to ensure that the necessary organizational supports are in place to help them do their work. A first step is for public mental health authorities to clearly delineate the roles of peer providers, and then provide the appropriate training to prepare the workforce for their involvement in delivering care.

Finally, it is worth noting that some peer providers in the present study described team environments that they felt were highly inclusive conducive to effective communication and mutual exchange of skills and experiences. Program leadership has much responsibility to ensure that their organizations are maintaining an environment that is inclusive and welcoming to peer providers. As discussed previously (Mancini 2018), this involves adequate orientation and

training of staff on the history of the consumer movement, peer providers' code of ethics, and highlighting the empirical evidence of their effectiveness. These organizational issues could also be addressed using external practice facilitators (Chinman et al. 2017).

Limitations and Future Directions

Due to the geographic location of the present study, the experiences of peer providers employed in these integrated programs might not be generalizable to other integrated setting. Further, this study was limited to the perspectives of peer providers. Future research should investigate the perspectives of other providers within integrated settings to understand how to most effectively implement the peer role. Future studies should also incorporate the perspectives of consumers of integrated care, to understand how peer-based services affect their motivation for self-management of chronic diseases, and engagement with physical health services from a cultural perspective.

Conclusions

Additional efforts are needed to support DMH in incorporating the range of potential peer roles in integrated care settings. Organizational supports, including the formal training of peer providers on matters related to physical health and wellness from a cultural perspective, are needed so that public mental health authorities can continue improving the physical health and wellness of people living with mental illness using peer-based services.

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Compliance with Ethical Standards

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

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