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ORIGINAL PAPER

Perceived Educational Needs of Substance Use Peer Support Specialists: A Qualitative Study

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Abstract
The opioid crisis is an ever-growing issue nationwide. The role of peer support specialists has received widespread acceptance in the substance use and behavioral health spheres. However, there is a lack of standardization on the training required for peer support specialists to function as competent members of integrated behavioral health teams. We conducted qualitative focus groups with 14 practicing certified peer support specialists to determine their perceived educational needs. Inductive thematic analysis was used to analyze the data and six themes emerged: mental health and suicide prevention training, diversity, equity, and inclusion training, counseling skills training, family systems approach to care training, professionalism training, and taking care of self – mind, soul, and body training. To improve peer support specialists' confidence in their ability to competently perform their jobs, important topics need to be incorporated into their educational training and preparation.

Keywords Substance Use Disorder · Peer Support · Education · Training · Mental Health · Behavioral Health

Introduction

The substance use epidemic is a public health crisis that has been exacerbated by the COVID-19 pandemic. With astounding overdose deaths exceeding 100,000, in 2021 (Centers for Disease Control and Prevention [CDC], 2022), the need for peer support specialists and other behavioral health paraprofessionals has significantly increased (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). Peer support specialists positively impact substance use disorder (SUD) patients' outcomes through role modelling and sharing of one's own experiences. This in turn increases treatment retention, improves relationships with treatment providers and social supports, increases patient satisfaction, and reduces relapse rates (Bassuk et al., 2016; Burton et al., 2018; SAMHSA, 2019). To increase the effectiveness and competencies of peer support specialists as crucial parts of the integrated behavioral healthcare team, educational and training programs that address several facets of recovery are urgently needed. The standardization of training programs and competencies is foundational to providing evidence-based substance use support and community resources (Almeida et al., 2020; McCarthy et al., 2019). The purpose of this study was to examine the perceived educational and competency needs of currently practicing peer support specialists and to use these identified needs to restructure and enhance an existing state-affiliated substance use peer support specialist training program.

Significance and Background

Several models have been proposed related to training of peer support specialists; from one day training models (Xia et al., 2022), to multiple variations across states in the United States of America (Mental Health America [MHA],

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2022). Xia and colleagues (2022) found that their single day online-training program was not only effective in providing knowledge and skills necessary to support patients with SUD, but it was also a useful tool to increase counseling confidence among study participants (Xia et al., 2022). However, this training focused on university students who already had a background in health-related disciplines; thus, these findings may not be generalizable to many individuals who are training to be peer support specialists in the United States. Therefore, a single day is not enough to adequately train peer support specialists who may not have a background in health-related disciplines.

Peer recovery support specialists are expected to build and maintain healthy relationships with patients in order to facilitate patient recovery. This is achieved through mentorship and sharing their own experiences, providing linkages to community resources and recovery wrap-around services, promoting access to and engagement with recovery services, and advocating for and teaching others to advocate for themselves. However, peer support specialists in the field often feel that they are not adequately trained to carry out all the expected duties and lack appropriate competencies to function in their roles (Almeida et al., 2020; SAMHSA, 2019). For example, peer support specialists have previously reported that they need more training in setting and maintaining boundaries with patients and assisting patients with coping skills (Almeida et al., 2020; Tate et al., 2022). Moreover, peer support specialists have also reported that other clinicians on integrated behavioral health teams often expect them to perform duties for which they did not receive training (Almeida et al., 2020). Therefore, it is important to standardize educational and training programs for peers, while promoting the adoption of standardized competencies to ensure that their roles and scope of practice are clearly defined. Failure to clearly define roles and obtain administration buy-in may impede successful integration of peer support specialists in primary care teams (Shepardson et al., 2019) and other behavioral and mental health teams. Additionally, role confusion may lead to burnout and frustration.

The role of a peer support specialist is often described as high-stress, leading to difficulties maintaining recovery and avoiding burnout (Tate et al., 2022). Peer support specialists have also reported that their duties are demanding, and they often face heightened stigma in the workplace (Tate et al., 2022). Tate and colleagues (2022) also found that peer support specialists do not receive adequate training on selfcare and strategies to avoid burnout due to the demands of their roles. Moreover, the high-stress, high-demand, and low-salary work environments in which peer support specialists often work, lead to elevated turnover rates, reducing their effectiveness and negatively impacting substance use treatment outcomes (Almeida et al., 2020; Tate et al., 2022). Therefore, peer support specialists training programs need to incorporate these topics to ensure longevity and sustained impact of this role. Lastly, there is a need for adequately trained and experienced supervisors in practice settings who can reinforce the content learned in educational programs to ensure translation of knowledge into clinical practice (Almeida et al., 2020; Tate et al., 2022). Our research question was: what are the perceived educational and competency needs of practicing peer support specialists?

Methods

Design, Sampling, and Recruitment

This was a qualitative research study to investigate effective training improvements for peer support specialists assisting in mental health and substance use disorder care. We primarily employed a phenomenological approach and utilized in-person focus groups to explore the perceived educational needs of practicing peer support specialists that they think would make them more effective in their roles (Creswell & Poth, 2017). The study was approved by the Institutional Review Board (IRB) at the researcher's institution.

Participants were recruited primarily through word-of-mouth advertising. The research team has a certified peer support specialist on staff. This person distributed recruitment flyers to other practicing peer support specialists. This was done through various community events and peer support groups. Inclusion criteria were 19 years or older, currently certified to work as a peer support specialist with experience (current or past) working as a peer support specialist, able to communicate in English, and willing to participate in focus groups. It was not a requirement of our study for the peer support specialist to be employed at the time of the interview as long as they had a history of working as a peer support specialist. Exclusion criteria are actively suicidal or homicidal. Participants were randomly assigned into four focus groups comprised of three to five participants each. At the time of the study, there was only one state-run peer support training program, through which all peer support specialists in the state were certified. That is why this study was done – as a collaboration with the state to understand what educational enhancements were needed for that program to better equip peer support specialists in the state. To be certified by the state, all peers support specialists need to provide proof of at least two years in recovery.

Researchers explained the purpose of the study to interested participants and answered all questions about the study prior to participants providing written informed consent. Fourteen people participated in the study. Data saturation was reached with four focus groups and 14 individuals.

According to a systematic review on sample size determinations for qualitative studies, saturation was often reached with 9–17 interviews or 4–8 focus groups (Hennink & Kaiser, 2022). Therefore, our sample size meets these criteria and is consistent with the literature.

Data Collection

Prior to beginning the focus group, participants completed an investigator-developed demographic form, which included questions regarding age, gender, race, marital status, employment status, and educational attainment. Semi-structured focus groups were utilized for data collection. Data collection occurred between September 2021 to December 2021. Focus groups were sixty to ninety minutes in duration and were audio-recorded. The recordings were transcribed verbatim by a trained research assistant. The study principal investigator randomly selected two out of four focus group transcriptions to ensure quality control and accuracy of transcripts by listening to the focus group records while following along with the transcriptions.

Researchers used a semi-structured interview guide to direct the focus groups. This interview guide included topics such as educational needs, personal experiences, core competencies of peer support specialists, and managing the role of a peer. Each topic covered four to eight specific questions to elicit responses from participants regarding their views on the knowledge and resources necessary to succeed as a peer support specialist. For the purposes of this manuscript, we discuss findings related to the educational needs and core competencies of peer support specialists. Other findings related to personal experiences and managing the role of a peer will be discussed in a future publication.

Examples of questions specific to these educational needs and core competencies include: 1). Tell us about what your peer support training program was like. 2). What topics were covered in your peer support training that you wish you could learn about in more depth? 3). What types of issues do you come across in your practice of being a peer support specialist that you wish you had training on? 4). Tell us more about the core competencies you wish you could receive additional training on. Researchers used follow-up and probing questions to encourage participants to clarify participant thoughts. Researchers also encouraged participants to speak openly about their experiences and emotions as was relevant to each question. Participants were asked to choose a pseudonym to promote confidentiality of focus group participants.

Data Analysis

Initial data analysis was completed by two researchers. An inductive thematic analysis was utilized to conduct the data analysis (Creswell & Poth, 2017). These investigators developed a coding scheme that was used to discern patterns, themes, and subthemes. A multilevel contextualizing of themes and patterns was used to code all transcripts. Initially, two of the investigators independently coded the same transcript. After that, the two researchers had a meeting to compare emerging codes and subthemes. Where there was disagreement on a code, the two investigators consulted with the principal investigator (PI) who assisted in achieving consensus regarding that code. The coding process was repeated twice until the intercoder agreement was acceptable. This is how interrater/intercoder agreement was reached for this study (Creswell & Poth, 2017). Because of the nature of the data analyzed, we calculated percentage agreement between the two coders on the third-round coding procedure, and it was 94%. This was an improvement on the first-round intercoder agreement of 60%.

Additionally, our team has an extensive background working with peer support specialists. Therefore, to promote reflexivity, we encouraged team members to maintain notes about their personal feelings related to the study procedures, participants, data collection, and data analysis. Reflexivity was important to ensure that personal biases, values, experiences were not interjected into the data collection or analysis processes. After agreeing on the coding structure, the investigators worked together to complete the analyses for the remainder of the transcripts. Lastly, to further promote trustworthiness of the research findings, we employed Lincoln and Guba (1985) criteria for trustworthiness, including transferability, confirmability, dependability, and credibility. For example, credibility was established through prolonged engagement with the research participants and transcripts, asking probing questions during the data collection phase to ensure that the research team understood the context within which meaning was being assigned to responses and keeping detailed field notes that were referenced throughout the data analysis process.

Once the data analysis was completed by the core team, all investigators met to review and approve all the codes and themes. Six overarching themes emerged from the data analysis. Some interrelated themes such as professionalism and documentation were combined because of the underlying perceived knowledge need or associated core competencies being addressed by the combined theme. For example, while documentation is a core competency for peer support specialists, the ability to document patient encounters accurately and properly was considered an enormous aspect of professionalism within the workplace. This was also the

case for combining motivational interviewing and active listening. For example, active listening is an important component of motivational interviewing. However, it is also an independently important skill to possess by peer support specialists, outside the context of motivational interviewing. The research team agreed on all final themes, including the themes that had to be combined. All data analysis was conducted using NVivo software for qualitative analysis.

Results

Sample Characteristics

Of the 14 people who participated in the focus group, 57% were women (n = 8), and 43% were men (n = 6; one out of the six was transgender male). Age ranged from 38 years old to 61 years old, with a mean age of 48.7. 50% (n = 7) identified as African American and the other 50% (n = 7) identified as White. Of the participants, 71.4% (n = 10) were single, 21.4% (n = 3) were divorced, and 7.2% (n = 1) were engaged. Regarding income, one person was not employed at the time of the research study, another person declined to answer; of the people who responded to this question, income ranged from $20,000 per year to $60,000 per year, with a mean annual income of $27,500. Educational levels varied from high school diploma to bachelor's degree; 21.4% (n = 3) had a bachelor's degree, 28.8% (n = 4) had an associate degree, 28.8% (n = 4) were in college or had some college education, and 21.4% (n = 3) had a high school diploma. We did not collect information about work setting and total time recovery other than verifying that all peers had at least two years of recovery in compliance with state requirements.

Emerging Theme and Subthemes

Six main themes were identified from the data analysis process from the people who responded to our research questions through the focus groups: mental health and suicide prevention training; diversity, equity, and inclusion training; counseling skills training; family systems approach to care training; professionalisms training; and taking care of self – mind, soul, and body training. Below we discuss each theme in detail. These themes emerged in every single focus group. Often an individual would bring up related information and all members of the focus group would explain in their own words how that aspect of training was either personally important to them, how that particular deficit in training affected their practice, and/or how receiving that training or acquiring that skill would significantly improve their clinical competence and self-confidence. That is how were able to reach data saturation with four focus groups as the identified needs were echoed across the board.

Professionalism Training

Professionalism was one of the most prominent themes discussed by the peer support specialists in the focus groups. They expressed concerns about not having the skills to speak effectively to patients and other members of the integrated behavioral health care team, particularly in professional environments. Specifically, participants expressed a need for training that focuses on how to behave appropriately, including polite behavior, strong and clear communication (both oral and written), interpersonal and problem-solving skills, and how to present oneself. Other areas of concern included improving digital literacy and other computer skills necessary to function in high paced clinical settings. Our study participants noted that because of their own personal experiences with substance use issues, experience in professional work settings is limited and it causes significant distress when they are expected to be professionally competent wherever they are employed. Anthony said:

> *I really think that, um, the peers could benefit from some type of customer service or professionalism class...How should you address people? You know, because, um, a lot of us have never been in professional positions...But when you're in a professional atmosphere, you know, there's a different type of way to present yourself, and I think a lot of peers lack that.*

This idea of feeling out of place and a lack of experience in the professional setting was further expressed by Bobby when he stated that peer support specialists need to "*learn to be more professional because they hadn't needed to in the past, especially as they were recovering from substance abuse disorders*".

Similarly, adequate documentation training was noted as lacking from current peer support specialist training programs. Documentation skills was a subtheme of professionalism main theme. Several participants expressed their initial discomfort with documentation, explaining that they did not have the training or the knowledge to appropriately document their day-to-day patient care activities. Recording events in writing allows peer support specialists and their coworkers to have a record of therapeutic activities and other treatment protocols that patients are participating in. It also allows for continuity of care and prevents duplication of efforts, thereby saving resources. Study participants also viewed ability to document accurately and concisely as an important aspect of professionalism. However, many of our participants expressed low documentation competency

levels when they first started working with patients. Documentation is a necessary skill for peer support specialists, as explained by one participant.

> *I think one of the things that I hold very important is documentation. Because if you don't document it, it just falls through the cracks. And I think a lot of time as peer specialists a lot of us have been out of the work force for a long time or not at all, so we think that it's not important… we are thinking Oh, as long as I take someone to treatment or as long as I help somebody find a meeting. No, if you're going to work in this field and do something that's going to be accounted for, you're going to have to learn documentation because if you don't write it, it did not happen (Nancy).*

Mental Health and Suicide Prevention Training

Focus group participants expressed a need for training that builds on the crisis management training they already receive and training that emphasizes a whole health approach to substance use recovery. A whole health approach focuses not only on the physical wellbeing of people in recovery, but also the mental health aspects of recovery. Specifically, study participants requested additional training on mental health and suicide prevention training. Additionally, participants acknowledged that many of the patients they encounter have co-occurring mental health conditions; therefore, training on supporting people in recovery with co-occurring mental health conditions is urgently needed. One statement by a peer support specialist expressed this need very well:

> *I think that one of the things they could have included a little more was understanding mental health compared to substance abuse disorder. I know nowadays it kind of runs hand in hand...I mean if they're just substance abuse with mental health disorders and you don't know about the mental health you're not gonna move anywhere with them. They need to handle that and then come back into the substance abuse part... Get them a mental health assessment and then you can start working towards that (Wendy).*

Additional suicide prevention training was also identified as a needed improvement to peer support specialist training. It is important that peer support specialists know how they can navigate situations where they suspect suicidal ideation, as well as understanding the resources that are available to individuals. Participants specifically identified Question Persuade Refer (QPR) suicide prevention training as an essential component of peer training and should be incorporated into their training programs. For example, Tiffany mentioned that:

> *…everything that I've learned from APPR [Action Planning for Prevention and Recovery] and QPR it's been important, and I've went outside of just normal training to get that stuff. I needed to know what I knew how to handle these issues. It made me more comfortable in my role. So, you know QPR made me not afraid to ask, hey are you suicidal? Because so many people are like you don't want to bring up suicide because it might make them suicidal and that's not true, you know. But a lot of people think that way and they don't wanna ask …so you know like I was telling him I've done so many trainings...*

Diversity, Equity, and Inclusion Training

The third theme that emerged from the focus groups was the need for diversity, equity, and inclusion training. Our participants noted that they work with patients from a wide variety of backgrounds. Patients have different races, ethnicities, nationalities, and socioeconomic and cultural backgrounds. Furthermore, individuals with substance use disorders are disproportionately impacted by structural and social determinants of health. Therefore, peer support specialists require specialized training addressing these issues among individuals with whom they work. In this regard, some peers noted that they did not feel very comfortable addressing some of these issues although they constantly run into these issues in their practice settings. Participants shared that this was a significant need in order to improve treatment outcomes for people from all backgrounds. Nathan detailed the need for diversity training saying:

> *I think it's important as well that we get some type of training on cultural diversity...because I'm seeing so many different cultures. People from the north, people from the south, people from the Midwest, people that are African American, people that are Caucasian, Native Americans. We all have different cultures, and if we don't have some type of cultural diversity skills then we are going to miss it when it comes to some of these people.*

Counseling Skills Training

The two types counseling skills training identified were motivational interviewing and active listening. Motivational interviewing is a client-centered counseling style that

focuses on active listening and gentle guiding (Hamera, 2014; Hettema et al., 2005). It is a helpful skill for mental health and substance use professionals and paraprofessionals alike. Focus group participants noted the need for peer support specialists to be trained in motivational interviewing and other counseling strategies to facilitate effective communication between patients and themselves. This communication is essential not only for peer support specialist-patient trust, but also for effective, focused counseling and guidance. When asked what skills should be taught during the training programs, focus group participant stated, "*probably motivational interviewing and how to obtain community resources"* (Bobby) *...sometimes it's learning how to ask the important questions and getting to the root of things. Otherwise, it's like you just keep going around in circles*" (Holly).

Moreover, while a portion of peer support involves giving advice or speaking on one's life experiences, a large part of the peer support specialist role is to listen. Many patients need someone to listen to their issues without judgement or disapproval. This is an essential role for the peer support specialist. Although this is widely known, peers expressed that this is not usually a focus of current training programs. Rene stated, "*so really you gotta have that active listening and clear communication. It's real important*." Peer support specialists must have the ability to listen attentively and without bias. They must ensure that patients feel seen and heard without feeling judged or ignored. Multiple focus group participants noted the importance of active listening and communication in the context of patient care, with one participant explaining, "*I think one of the most beneficial skills is active listening. Because you know a lot of times people will say thank you so much and all I did was just listen*" (April).

Family Systems Approach to Care Training

An important role of a peer support specialist is working closely with the patients within the context of the family system. Focus group participants identified supporting, educating, and interacting with family members as a training area that needs improvement. Participants expressed the desire for training on how to educate the family on the disease concept of substance use disorders and how to support both patients and their families through community resources. Steve described the importance of incorporating family support:

> *Yes, umm the family's education is really important. The family and loved ones. And in listening to them and I hear the anguish and the frustration. It's real important like April said, the disease concept. The obsessions and compulsions. The decrying and mental health. Because a lot of times they say he's crazy or he's acting out, or she's this and she's that and I can't. And I tell them, I say it's a disease. It's a disease and they're not themselves. The more you put in (substances) the more you get a mental decline and they go hand in hand. The substance abuse and the mental decline go hand in hand. And so, they're very thankful when you take the time to explain to them and not rush them through the call.*

Nonetheless, study participants identified barriers related to obtaining consent to include family members in the treatment plans. Sometimes patients don't want their family members to know they are struggling with substance use or a mental health problem. Additionally, another challenge is balancing engaging family members in care while maintaining patient confidentiality and wishes. Sara said

> *...I always made sure it was alright with the peer- I mean- yeah, with the peer, and uh, and I never did it without the peer present, you know what I'm saying. I never talked to the family member without the peer present. Um, I think it would be good to learn how to handle those situations and to have some kind of, uh, you know consent to sign. You know, uh, and to learn about the violations, you know, a little about the violations. What you can and cannot say. You don't want to get in trouble for helping.*

Taking Care of Self – Mind, Soul, and Body Training

A significant number of substance use programs tend to focus on abstinence only and may not necessarily take a holistic approach to recovery. However, many factors can influence recovery, including nutrition and other lifestyle behaviors. Focus group participants voiced a concern that they do not receive training in how all these other facets can help their clients improve their chances of recovery. Therefore, they may not be aware of resources or referrals for such needs within their communities. For example, sometimes when people are in active addiction, they may neglect their physiological needs, including eating. This concern was discussed when a participant stated:

> *The other part I believed would be more effective is teaching them healthy lifestyles as far as nutritional value that's been lost, and they don't even eat. You know I would use drugs as my diet plan - it made sense for it to be a diet plan (Wendy).*

Similarly, sometime people may use food as a coping strategy to avoid using drugs, which may cause other problems. For example, April said:

> *Like if I overate once I wasn't using you know drugs, food become my new substance. And when I got overweight, I said hey I know what will get it off quick. For me that was easier than knowing how to eat better because I knew more about drugs than I did about eating right. So, the part about rebuilding a person nutritionally needs to be part of the curriculum too. They need to learn the value of food and how to treat their bodies...So I believe that we need to add some sort of lifestyles nutritional, lifestyle eating.*

Beyond nutritional changes, other lifestyle changes are necessary during recovery, and there is a need for healthy lifestyle education, such as sleep health, physical activity, and stress management. All study participants indicated that practicing peer support specialists need to be equipped with better coping and self-care practices to avoid the negative impacts of poor self-care on personal recovery and well-being. Many participants noted that this was an area they struggled with, especially very early in their recovery. "*it's so easy to just want to think about others and helping others. You often forget that you too have needs and if you don't care about yourself you can easily spiral down into those dark places*" (David). Wendy also said, "*get you some self-care and just know that you aren't going to save everybody*." Sara further noted that, "*for your students I want to say that self-care is important throughout the process*".

Discussion

Peer support specialists are important members of multidisciplinary and integrated behavioral health care teams. Many studies have shown that incorporating peer support specialists in substance use treatment protocols produces better outcomes for patients (Bassuk et al., 2016). Despite this evidence, peer support specialists remain underutilized for various reasons. Some of these reasons include a lack of standardization in the educational and training requirements to function in this role, vague competency requirements, and the ambiguity in the peer support specialist scope of practice (MHA, 2022; Xia et al., 2022). To help mitigate these issues, enhanced and restructured educational and training programs are needed to address the full breadth of the issues that peer support specialists face in their daily practice. This study aimed to explore the perceived educational needs and core competencies of currently practicing peer support specialist to help inform curricular revisions and enhancements for a newly developed peer support training program that is funded by the Health Resources and Services Administration (HRSA).

Participants in this study identified six main themes related to perceived educational needs. These are mental health and suicide prevention training, diversity, equity, and inclusion training, motivational interviewing and active listening, family systems approach to care, professionalism and documentation, and taking care of self – mind, soul, and body. To our knowledge, this is the first study to explore this area with the specific intent of enhancing and restructuring an existing peer support specialist training program. Research has shown that about 50% of people who present with substance use disorders have a co-occurring mental health condition (National Institute on Drug Abuse [NIDA], 2020). Therefore, it is imperative to incorporate this type of information in any peer support specialist training program. Additionally, the advent of the COVID-19 pandemic unveiled deep seated structural and systemic inequities, especially in the treatment of substance use and mental health problems (Gondré-Lewis et al., 2022; James and Jordan, 2018; Lippold et al., 2019). Equipping peer support specialists with knowledge, skills, and competencies to care for diverse patient populations and needs is foundational to improving health equity and reducing disparities in substance use treatment outcomes.

Furthermore, evidence suggests that a family systems approach to substance use prevention and treatment has great potential. For example, research shows that children who grow up with parents or guardians who have substance use problems are more likely to have adverse childhood experiences, substance use, and mental health problems (Lipari & Van Horn, 2017; Maina et al., 2021). Moreover, equipping peer support specialists to systematically engage with families may increase their competence to function in various types of settings.

Motivational interviewing, which refers to a person-centered conversational approach of communication has been shown to improve ability, willingness, and readiness to change (Hamera, 2014; Hettema et al., 2005). Motivational interviewing further targets ambivalence to change. Thus, ensuring that peer support specialists are adequately trained in this technique is foundational to their ability to inspire change among individuals with whom they work. Relatedly, the proper conduct of motivational interviewing requires active listening skills. Participants in this study indicated that peer support specialists tend to be more comfortable with sharing their stories and talking about their experiences, rather than supporting someone using active listening. However, this is an important skill to possess and including content on motivational interviewing and active

listening in peer support specialist training programs is paramount.

Furthermore, the ever-evolving healthcare environment requires peers to be equipped with digital literacy skills. This has become even more important with the shift to telehealth services in a post COVID-19 pandemic world (Fortuna et al., 2022). Since many training programs for peer support specialists only require a high school diploma to become certified as a peer support specialist (MHA, 2022), some peers may not have the technological savvy to function in some roles that require these skills, inadvertently diminishing possibilities for employment. Peers who are able to upscale their digital literacy skills have the potential to better support a variety of clients through various platforms and meeting the patients where they are.

Similarly, professional etiquette training might prove useful to incorporate into training program so that peer support specialists can easily integrate into high paced interprofessional teams. Additionally, teaching documentation skills is important especially for reimbursement purposes. Documentation skills are however best acquired though experiential training opportunities. As such, we propose an approach that employs an apprenticeship model that allows substantial on-the-job training with a highly skilled mentors to allow peer support specialist to receive the required supervision in a failsafe environment prior to assuming independent practice.

Finally, our last theme of taking care of self – mind, body, and soul is supported by literature. Although our participants reported a need for more education on nutrition and stress management, other self-care strategies should also be considered. For example, both sleep and physical activity have been shown to be associated with substance use treatment outcomes (Guo et al., 2022; Valentino & Volkow, 2020). It is important to always remind practicing peer support specialists that while they are altruistic and enjoy helping others reach their recovery goals, they too need to be constantly aware of their personal needs – mind, body, and soul. That is the only way to ensure longevity in their role, but also to provide the best support possible to those with whom they have been entrusted to work.

Conclusion

The substance use prevention and treatment landscapes are ever changing and the need for peer support specialists has reached unprecedented heights. Nonetheless, educational and training requirements, competencies, and scope of practice vary widely. This leaves many peer support specialists feeling like they do not have the necessary knowledge, skills, and competencies to adequately function in their roles. This study highlights the perceived educational and core competency needs of currently practicing peer support specialists. Current and future training programs nationally and internationally should take these educational needs into consideration when developing or enhancing their programs. Incorporating these topics in training programs promises to produce peer support specialists who are adequately prepared to function in high need, high demand areas as well as in various types of clinical and community settings. The findings from this study we utilized to enhance and restructure the state peer training program from one-week 40-hour training program into a 15-week 3-credit hour university level training program that included all the suggested educational needs and core competencies. This enhanced and restructured program is described in detail in another publication (Witte et al., 2023).

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Declarations

Conflict of interest The authors have no conflict to declare related to this work and have all significantly contributed to the conduct of the research, analyses, and development of the manuscript.

References

Almeida, M., Day, A., Smith, B., Bianco, C., & Fortuna, K. (2020). Actionable items to address challenges incorporating peer support specialists within an integrated mental health and substance use disorder system: Co-Designed qualitative study. *Journal of Participatory Medicine*, *12*(4), e17053. https://doi.org/10.2196/17053.

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment*, *63*, 1–9. https://doi.org/10.1016/j.jsat.2016.01.003.

Burton, E., Farrier, K., Hill, K. D., Codde, J., Airey, P., & Hill, A. M. (2018). Effectiveness of peers in delivering programs or motivating older people to increase their participation in physical activity: Systematic review and meta-analysis. *Journal of Sports Sciences*, *36*(6), 666–678. https://doi.org/10.1080/02640414.2017.1329549.

Centers for Disease Control and Prevention (2022). U.S. overdose deaths in 2021 increased half as much as in 2020 – but are still up 15%. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design* (4th ed.). Sage Publications Inc.

Fortuna, K. L., Brooks, J. M., Myers, A., Sivakumar, B., & Lebby, S. R. (2022). Effectiveness of a digital peer support training program designed for rapid uptake among peer support specialists pilot study. *The Psychiatric Quarterly*. https://doi.org/10.1007/s11126-022-09997-0. Advance online publication.

Gondré-Lewis, M. C., Abijo, T., & Gondré-Lewis, T. A. (2022). The opioid epidemic: A crisis disproportionately impacting Black Americans and urban communities. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-022-01384-6Advance online publication.

Guo, R., Vaughan, D. T., Rojo, A., & Huang, Y. H. (2022). Sleep-mediated regulation of reward circuits: Implications in substance use disorders. *Neuropsychopharmacology: Official Publication Of The American College Of Neuropsychopharmacology*. https://doi.org/10.1038/s41386-022-01356-8Advance online publication.

Hamera E. (2014). Motivational interviewing. In Wheeler, K. (Ed). Psychotherapy for the advanced practice psychiatric nurse: A how-to guide for evidence-based practice (2nd ed., pp. 299–312). Springer.

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social science & medicine* (1982), 292, 114523. https://doi.org/10.1016/j.socscimed.2021.114523.

Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology*, *1*, 91–111. https://doi.org/10.1146/annurev.clinpsy.1.102803.143833

James, K., & Jordan, A. (2018). The opioid crisis in black communities. *The Journal of Law Medicine & Ethics*, *46*(2), 404–421. https://doi.org/10.1177/1073110518782949.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Lipari, R. N., & Van Horn, S. L. (2017). Children living with parents who have a substance use disorder. *The CBHSQ Report* (pp. 1–7). Substance Abuse and Mental Health Services Administration (US).

Lippold, K. M., Jones, C. M., Olsen, E. O., & Giroir, B. P. (2019). Racial/Ethnic and age group differences in opioid and synthetic opioid-involved overdose deaths among adults aged ≥ 18 years in metropolitan areas - United States, 2015–2017. *MMWR Morbidity and mortality weekly report*, *68*(43), 967–973. https://doi.org/10.15585/mmwr.mm6843a3.

Maina, G., Ogenchuk, M., & Gaudet, S. (2021). Living with parents with problematic substance use: Impacts and turning points. *Public Health Nursing (Boston, Mass.)*, *38*(5), 730–737. https://doi.org/10.1111/phn.12888

McCarthy, S., Chinman, M., Mitchell-Miland, C., Schutt, R. K., Zickmund, S., & Ellison, M. L. (2019). Peer specialists: Exploring the influence of program structure on their emerging role. *Psychological Services*, *16*(3), 445–455. https://doi.org/10.1037/ser0000250.

Mental Health America (2022). How to become a peer support specialist. https://www.mhanational.org/how-become-peer-support-specialist.

National Institutes on Drug Abuse (2020). Common comorbidities with substance use disorders research report. https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness.

Shepardson, R. L., Johnson, E. M., Possemato, K., Arigo, D., & Funderburk, J. S. (2019). Perceived barriers and facilitators to implementation of peer support in Veterans Health Administration primary care-mental health integration settings. *Psychological Services*, *16*(3), 433–444. https://doi.org/10.1037/ser0000242.

Substance Abuse and Mental Health Services Administration (2022). Peers – wo are peers. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

Substance Abuse and Mental Health Services Administration (2019). Issue brief: Integrating peer support workers in interdisciplinary care teams. https://c4innovates.com/brsstacs/BRSS-TACS-Integrating-Peer-Support-Workers.pdf.

Tate, M. C., Roy, A., Pinchinat, M., Lund, E., Fox, J. B., Cottrill, S., Vaccaro, A., & Stein, L. (2022). Impact of being a peer recovery specialist on work and personal life: Implications for training and supervision. *Community Mental Health Journal*, *58*(1), 193–204. https://doi.org/10.1007/s10597-021-00811-y.

Valentino, R. J., & Volkow, N. D. (2020). Drugs, sleep, and the addicted brain. *Neuropsychopharmacology: Official Publication Of The American College Of Neuropsychopharmacology*, *45*(1), 3–5. https://doi.org/10.1038/s41386-019-0465-x.

Witte, T., Mumba, M. N., Jaiswal, J., Evans, T., Z., & Mugoya, G. T. (Published, 2023). Pedagogical considerations for enhancing peer support specialist training in an Online University Environment. *Journal of Mental Health Training Education and Practice*, *18*(4), 338–346. https://doi.org/10.1108/JMHTEP-07-2022-0053.

Xia, W., Li, H., Liang, T., Luo, Y., Ho, L., Cheung, A. T., & Song, P. (2022). Structured online training for university students to deliver peer-led addiction counselling for young drug abusers in China: Effect on improving knowledge, attitude, confidence, and skills. *Patient Education and Counseling*, *105*(4), 1009–1017. https://doi.org/10.1016/j.pec.2021.07.038.