Structured Abstract

Purpose: The purpose of this paper is to examine the gap between recovery-oriented processes and clinical outcomes in peer support, an exemplar of recovery-oriented services, and offer suggestions for bridging this gap.

Design/methodology/approach: Viewpoint

Findings: Clinical outcomes like hospitalizations or symptoms remain a focus of research, practice, and policy in recovery-oriented services and contribute to a mixed evidence base for peer support services, in which recovery-oriented outcomes like empowerment, self-efficacy, and hopefulness have more evidentiary support. One approach is to identify the theoretical underpinnings of peer support services and the corresponding change mechanisms in models which would make these recovery-oriented outcomes mediators or process outcomes. A better starting point is to consider which outcomes are valued by the people who use services and develop an evaluation approach according to those stated goals. User driven measurement approaches and more participatory types of research can improve both the quality and impact of health and mental health services.

Originality/value: This viewpoint provides a brief review of peer support services and the challenges of outcome measurement in establishing an evidence base and recommends user driven measurement as a starting point in evaluation of recovery-oriented services.

Capturing the Value of Peer Support: Measuring Recovery-Oriented Services

Historically, recovery in mental health has been conceptualized as the absence of psychiatric symptoms and functional impairments, but more recently has shifted to being understood as a process allowing for a range of experiences relating to symptoms of mental illness and its impact on one's life (Davidson *et al.*, 2005). Recovery involves changes in attitudes, values, feelings and goals in order to develop meaning and purpose in life (Anthony, 1993). These changes in the conceptualization of recovery were driven by the mental health consumer/survivor movement that highlighted the value of knowledge derived from people's own narratives and challenged mental health services to empower people in their recovery journey (Peebles *et al.*, 2007). Further, the recovery movement seeks to promote cultural change in mental health services towards full citizenship rather than continuation of pessimistic diagnoses (Davidson *et al.*, 2010). More recently, and in alignment with the goal of citizenship, concepts of hope and agency are increasingly referenced in literature about recovery, as well as a focus on the need to address material, economic and social realities as well as treatment of illness (Tang 2018).

As policy makers and providers have embraced a recovery-oriented approach to mental health services (Daniels *et al.*, 2012), more interventions based on recovery principles, such as Illness Management Recovery and Person Centered Care Planning, are being developed and implemented. As services are increasingly intended to reflect more closely the interests of service users, questions arise on the extent to which the outcomes used to evaluate services within health care systems also align with the outcomes valued by services users. This matters because what is measured in services influences activity and practice. Challenges are

encountered in navigating from policy to practice, where a variety of imperatives and interests compete in influencing what is to be measured.

This viewpoint will review the current literature on outcomes commonly measured in peer support services, an increasingly visible recovery-oriented service. We examine the gap between research evidence and policy and practice implementation, which becomes a discussion of the differences between recovery-oriented processes and clinical outcomes. Then, we offer research approaches in order to establish stronger evidence for recovery-oriented services. Finally, we offer practice and policy approaches on how to promote recovery-oriented outcomes in health and mental health services.

Evaluating recovery-oriented services

The recovery model was conceptualized as an alternative to the biomedical model (Thornton and Lewis, 2011) that has dominated mental health services since the middle of the last century. Despite this embrace of recovery-oriented services, most mental health services operate in health systems where biomedical or clinical outcomes remain privileged. It is not that symptom management stands in opposition to recovery-oriented or quality of life outcomes, and many service users value both outcomes as contributing to their health and wellbeing, but this more balanced approach has not translated adequately into health care systems. A more nuanced approach opens up the possibility of addressing discrepancies between health-related clinical outcomes, like symptom reduction and medication compliance, with recovery-oriented outcomes, like quality of life and meaningfulness, which allows for the agency of individuals in recovery to be identified, acknowledged, and encouraged.

The continued focus on clinical outcomes by health care providers, despite an embrace of recovery principles, has raised concerns about recovery being co-opted or becoming rhetoric rather than reality (Atterbury, 2014; Davidson *et al.*, 2005). The need for public mental health systems to demonstrate immediate short-term outcomes that can translate into cost savings (most notably reduced hospitalization rates and service use) constrain the ability of the system to align itself with authentic recovery-oriented outcomes. Instead, the tendency is towards focusing on "recovery from" which encompasses the traditional, clinical outcomes like symptom reduction, medication compliance, and therapy; rather than "recovery in", which is concerned with more personalized processes like hope, connectedness, self-efficacy, identity, meaningfulness, and empowerment (Davidson and Roe, 2007).

While recovery-oriented services are becoming more common in the public mental health services landscape, a further shift in values is required if they are to be implemented consistently and with integrity. Recovery-oriented values, which include self-determination, hope, and dignity require embedding at the organizational level in to promote recovery in its broader sense (Davidson *et al.*, 2007). While there has been some effort in addressing the implementation process and uptake of recovery-oriented services (Park *et al.*, 2014), there has been less effort towards aligning outcomes in health care systems that support a recovery orientation. A rethinking of what outcomes or "successes" mean in the context of recovery-oriented services must be considered at the practice and the policy levels.

Peer Support as a Case Example

One example of a recovery-oriented service that is gaining acceptance in mental health and integrated health services in the United States is peer support services, an increasingly visible recovery-oriented service. Peer services arose from self-help and 12-step programs

(Solomon, 2004) and the consumer/survivor/ex-patient movements (Ostrow and Adams, 2012). Peer support is characterized as a mutual helping relationship in which respect, shared responsibility, and agreement on helpful practices are the hallmarks (Mead, Hilton, and Curtis, 2001). Peer specialists are role models for recovery, provide support, and add credibility to the services being provided (Cook, 2011). Intentional self-disclosure is a defining feature of peer support as peers share their own experiences of mental health services as means to achieve the above stated goals (Marino, Child, and Krasinski, 2016). The growing utilization of peer support services has necessitated a negotiation between recovery principles and the policy infrastructure which regulates and dictates the reimbursement of publicly funded services. One effect of this is the increasing professionalization of peer support, which has implications for measurement.

The Professionalization of Peer Support

As the value of peer support has increasingly been recognized in the United States, there has been corresponding efforts to regulate it as a mental health service. . Under the Affordable Care Act of 2010, Medicaid expanded its definition of services to include those delivered by peers, which then necessitated a definition of peer services and their scope of practice (Daniels *et al.*, 2013). With the financial incentive of reimbursement, peer support services have proliferated with more than 40 states having a peer specialist training and certification program (Kaufman, Kuhn, and Manser, 2016). States have had to carve out a role for peer specialists that is not duplicative of other mental health professionals and captures their contribution rooted in lived experience.

A national survey revealed that peer specialists have a variety of titles and primarily work in direct peer support roles (Cronise *et al.*, 2016). Settings included peer-run programs, mental health settings, crisis services, residential services, employment settings, and criminal justice

settings. Certified peer specialists in mental health work in a variety of programs, including case management, partial hospitalization, vocational rehabilitation, and independent peer support and their activities included providing peer support, supporting self-determination and personal responsibility, promoting health and wellness, addressing hopelessness, and improving communication with providers (Salzer, Schwenk, and Brusilovskiy, 2010). Clearly peer specialists have become a vital component of the mental health workforce.

Another growing area for peer support services is within integrated health care programs. Driven by the alarmingly high rates of mortality among people with severe mental health problems (Colton & Manderscheid, 2006), there has been a sustained effort driven in part by the Affordable Care Act to integrate primary care, mental health and substance use services. At the clinical level, the goal has been to promote wellness self-management, implement coordinated care and cultivate an "informed activated patient" (Alexander & Druss, 2012). Peer specialists are now being employed to facilitate all three of these goals within health promotion programs, which include wellness self-management, smoking cessation, health navigation and lifestyle interventions. A less tangible but as important peer specialist contribution is to role model how to live a life that is not defined by one's diagnosis, behavioral or physical (California Association of Behavioral Health Agencies, 2014).

Within the wellness model adopted by the U.S. Substance Abuse and Mental Health Services Administration, health is conceptualized as being multi-dimensional including physical, emotional, intellectual, environmental, social, spiritual and financial domains (Brice *et al.*, 2013). Peers specialists are viewed as a way to bridge to this holistic approach by sharing experiences of how their mental and physical health interact and shape their lives. A key contribution of peer specialist is to encourage engagement by providing a "true emotional connection that enables

individuals to engage in the level of services appropriate for their circumstances and take the necessary actions to improve their health and wellness" (California Association of Behavioral Health Agencies, 2014, p.31). Therefore, while professionalization has driven a specification of peer specialist roles and tasks, there is also an understanding that there is something inherently subjective in the power of peer support that cannot be captured by programmatic functions.

Measuring Outcomes Associated with Peer Support: Challenges and Tensions

Despite the increasing use of peer support services in mental health services and systems, the research evidence for the effectiveness of peer support services remains mixed (Fuhr *et al.*, 2014; Lloyd-Evans *et al.*, 2014). Peer services have been shown to improve relationships with providers, facilitate engagement, decrease self-stigma, and increase activation, empowerment, hopefulness, and quality of life (Chinman *et al.*, 2014; Cook *et al*., 2011; Cook *et al*, 2012; Rogers *et al*., 2016; Russinova *et al*., 2014). Health promotion programs utilizing peers have been tested on a variety of outcomes, including frequency of self-management activities and healthy behaviors, self-reported health, and physical health indicators. Cabassa and colleagues (2017) found positive findings related to self-management activities, such as level of activation and locus of control, and some improvement in health behaviors such as dieting and exercise. But there were limited effects found both for subjective feelings of health and objective indictors related to cardiometabolic indicators and weight loss. A study of smoking cessation program using peers found modest gains that were not sustained over time (Dickerson *et al.*, 2016). Research is beginning to show that peer support services may be less effective in changing clinical outcomes, at least in the short term, but more effective with recovery-oriented outcomes such empowerment, self-efficacy, and hopefulness (Bellamy, Schutte, & Davidson, 2017; Fuhr *et al.*, 2014; Lloyd-Evans *et al.*, 2014; Mahlke *et al.*, 2017; Vayshenker *et al.*, 2016). Yet uptake of

these research findings has not been fully embraced by practitioners and policy makers in healthcare systems.

Conceptualizing a framework for measurement of peer support: Research approaches

Researching peer support services means addressing the breadth of services offered and the lack of conceptual clarity about how peer support operates. Identifying the underlying mechanisms, or critical ingredients, is the next step in a research agenda for peer support services (Chinman *et al.*, 2017; Gillard, *et al.*, 2015). Peer support is a complex social intervention and needs to be evaluated by modeling how the intervention processes are linked to change. Identifying and testing the change mechanisms of peer support will uncover the process by which peer support operates. These mechanisms can then be linked to process outcomes (or mediators) that may or may not be linked to downstream outcomes, like clinical outcomes of symptoms and hospitalization. Much of the research to date has focused on these clinical outcomes without a clear understanding of the mechanisms on which peer support operates and the intermediary or process outcomes that may directly influence clinical outcomes. These distal, clinical outcomes as treated as measures of effectiveness; however, these intermediary outcomes have shown more potential evidence (Bellamy, Schutte and Davidson, 2017).

Scholars have identified possible theoretical underpinnings that would help to isolate the mechanisms of peer support and facilitate change in service users. Solomon (2004) identified five theoretically-based psychosocial processes of peer support services: social support, experiential knowledge, social learning theory, social comparison theory, and helper-therapy principle. In a review of peer support services, Rogers (2017) proposes exploring the core conditions of the working alliance like being listened to, feeling respected, and valued, along with sharing lived experiences that may be important to forming bonds that lay the foundation

for change. In an extensive qualitative study that involved peer providers, service users, mental health staffs and managers, Gillard *et al.*, 2015 draw from therapeutic alliance and attachment theory in addition to social comparison and social learning theories to develop a theory of change associated with peer services. They identify the change mechanisms of peer services (building trusting relationships, role modeling recovery, and engaging service users) and link them with process outcomes of hope, empowerment, social functioning, self-care, engagement with services, and strength of social networks, which are then linked to downstream outcomes of recovery, wellbeing, and service use. These conceptualizations shed light on how peer support services operate and are linked to outcomes.

Concepts such as hope, empowerment, self-care, and quality of life have been commonly measured in efficacy studies of peer support services, but are treated as outcomes. If we ground research in conceptualizations based on theory, the model being tested is expanded. In a scenario that remains focused on clinical outcomes, the recovery-oriented outcomes become mediators (process or proximal outcomes) that possibly lead to downstream, distal, clinical, or biomedical outcomes. By expanding the models being tested and showing how recovery-oriented concepts are related to clinical outcomes valued by health care systems, the recovery-oriented concepts become more valuable in the process.

Alternative Strategies for Understanding and Measuring Outcomes: Policy and practice approaches

The demand for evidence-based practices in mental health continues and recovery-oriented services, if they are to be adopted, similarly have to prove their effectiveness using mainstream research methods. Given the heterogeneity of recovery-oriented services in terms of models, roles and objectives, there are clear and significant challenges in identifying which

outcomes could or should be selected to more usefully evaluate their effectiveness. Perhaps a different starting point could be to consider which outcomes are valued by the people who use services and develop an evaluation approach accordingly. The Person-Centered Outcomes Research Institute in the U.S. was established by the Affordable Care Act to redress the predominant focus on drug trials and symptom reduction in health care services research (www.pcori.org). Part of their reframing of the research task is to conduct participatory research with service users selecting outcomes that reflect their needs and preferences and help them make decisions about their health care. This marks a shift in focus for government funded research priorities and a potential avenue to identify and test more recovery-oriented outcomes.

In the United Kingdom, including Scotland in recent years, orienting evaluation to personal outcomes has developed over a period of many years and has identified three key categories of outcome consistently shown to be valuable to people using services (Nocon and Qureshi, 1996; Miller, 2012; Cook and Miller, 2012). These include change outcomes, quality of life outcomes and process outcomes. Change outcomes correspond with health-related aspects of recovery and include symptom management, improved confidence and skills, and quality of life outcomes include social connections, having meaningful things to do and feeling safe. Process outcomes correspond closely to the 'core conditions of the working alliance' such as being listened to, feeling respected, and valued (Rogers, 2017). These outcomes provide an overall framework, which can be used first of all to engage people in identifying their priorities (or personal outcomes) through conversation with the provider or peer. Initially, the outcomes tend to include change and/or quality of life outcomes. Process outcomes such as being listened to would tend to be considered at a later stage, when the outcomes identified at the outset are also being reviewed. Simple scale measures can be used to quantify which measures are being

identified, and whether they have changed over time. There is also scope to further improve understanding of impact through even limited narratively expressed outcomes, or qualitative data (Miller, 2012).

There is a great deal of learning and a set of principles which support a user driven measurement approach. One example is the principle that it can be more helpful to think about contribution rather than attribution in considering outcomes. A key challenge for any evaluation is determining cause and effect. And indeed, attempts to establish linear causation can be counter-productive in that the provider may be tempted to claim sole responsibility for a positive outcome, even where the person has made a significant effort and contribution, which should be acknowledged in its own right, and may be evidence of increased motivation, for example. Further, it is often the case that more than one service may contribute towards the same personal outcome, such as where both a peer and a nurse support an individual towards an outcome they have identified such as learning a new life skill.

Conclusion

In this viewpoint, we have outlined how different approaches to measurement, particularly the selection of outcomes can drive either a clinical or a recovery orientation to health and mental health care. These tensions become evident in reviewing the research on peer support services, which demonstrates limited impact on clinical outcomes in relation to recovery-oriented outcomes. Expanding research models to include recovery-oriented outcomes as process outcomes (or mediators) that bridge the gap between the intervention and clinical outcome seems the better choice, especially when the theoretical underpinnings of recovery-oriented services are made explicit and guide research designs. Additionally, in the case of peer support services,

explicitly focusing on clinical outcomes may miss important relational qualities that are unique to shared experiences.

Another way to bridge the gap between clinical outcomes and recovery-oriented outcomes is to start with service users' priorities. Including measurement of personal outcomes as identified by service users would fully encompass a recovery orientation and would also require more participatory research methods. This aligns with the focus on agency as a component of recovery (Tang 2018), by engaging people in recovery in a process of defining their valued life goals. These personal outcomes include key aspects of quality of life such as social connections and feeling safe; change outcomes such as managing symptoms and improving morale, and process outcomes such as being listened to and treated with respect. This approach offers a route to help navigate through some of the identified tensions, through blending diverse outcomes which include clinical concerns in ways that do not eclipse valued recovery outcomes, as well as including process outcomes which can help to capture benefits associated with the working alliance (Rogers 2017).

RCTs are identified as the gold standard in establishing evidenced based practices and the task is not to just identify causal pathways, but to more fully understand the underlying mechanisms (or mediators) that support these connections. The use of theory can help to identify these mediators, which, in turn, can identify which components or processes are responsible for desired outcomes. Recently, an alternative gold standard in evaluation research has been proposed, randomized explanatory trials (RET), that identify program components that are successful in bringing about change (Jaccard & Bo, 2018) that may be better suited to recovery-oriented research.

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