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THE PEER SUPPORT SOLUTION: A COMMUNITY-BASED MODEL FOR CLOSING THE GAP IN MENTAL HEALTH AND SUBSTANCE USE DISORDER WORKFORCE SHORTAGES

PRESENTED TO THE CENTER FOR ADVANCING RURAL HEALTH EQUITY PLANNING COMMITTEE

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EXECUTIVE SUMMARY

Mental health and substance abuse in the United States is a pressing crisis of mental health. The crisis has only been exacerbated by the onset of the COVID-19 pandemic. As a result, the demand for mental health and substance abuse support resources has never been higher. Unfortunately, a nationwide labor force shortage in mental health and substance use support means the supply of resources to adequately treat and prevent severe instances of mental health and substance abuse cannot keep up with the demand. The labor force concerns with regards to behavioral health can be broken into three primary categories. First, access: there are not nearly enough clinicians to support the number of individuals who need their help. Second, cost: clinical support for mental health is extremely expensive. Third, asking for help: the formality of mental health care delivery in a clinical setting increases the barriers to asking for help. In this report, we outline how peer support solves these three key issues by improving access to care, decreasing cost of delivery, and decreasing the formality of care, increasing the ease with which individuals can feel comfortable asking for care.

In Section 2 of this paper, we discuss the federal and peer state efforts to combat rising levels of mental health and substance use disorder demand. Funding at the federal level seeks to enhance behavioral health research at universities and hospitals nationwide through the National Institute of Mental Health. In addition, the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration work in concert to partner with on-the-ground support programs, especially in rural areas, with demonstrated results in improving local mental health and substance abuse conditions. Public funding provides vital revenue streams for such efforts along with public partnerships that can be leveraged for acute care partnerships that integrate peer support with a patient's more general health care delivery plan.

Section 3 provides two key comparison states for the activation of the peer support labor force: Maine and Connecticut. Maine is a relevant comparison state given similar demographics and the rural nature of the state. Connecticut, while not necessarily facing the same geographic complexities as New Hampshire, has a particularly effective network of mental health and substance abuse support fueled by federal funding for non-profits and partnerships with hospital systems.

Section 4 of this paper assesses the existing situation for mental health peer support in New Hampshire, and Section 5 provides improvement options based on the assessment of the current landscape and infrastructure. In conclusion, an assessment on existing models of peer support across the country, built upon a robust literature, demonstrates three key features of an effective approach to building out peer support avenues for mental health delivery: leveraging the unique benefits of peer support, community-centric models, and grounding peer support in clinical guidelines and advice.

1 INTRODUCTION: THE PROBLEM AND THE PEER SUPPORT SOLUTION

The United States is facing a crisis of mental health and substance abuse. Depression, anxiety, suicide, and substance abuse are rising. Across the country, mental health workers are struggling to keep up with rising demand. Indicative of a nationwide problem, Massachusetts-based social worker Tom Lachiusa told the New York Times in December "All the therapists I know have experienced a demand for therapy that is like nothing they have experienced before. Every available time slot I can offer is filled."[1] This lack of mental health labor supply in the post-acute space has put an undo amount of stress on the acute setting of healthcare delivery, forcing emergency departments, EMS divisions, and law enforcement to play an increased role in preventable mental health and substance abuse crises. The limited capacity of these avenues of care delivery along with elevated costs pose a serious barrier to the availability of mental health and substance abuse support. Mobilization of the peer support labor supply provides an avenue through which mental health and substance abuse crises can be realized as not only treatable but preventable.

According to the 2016 National Survey on Drug Use and Health, 11.8 million Americans believed that they had unmet mental health care needs.[2] Leading reasons for this reported lack of met healthcare needs include cost, respondents believing they could handle their needs without treatment, patients not knowing where to go for services, lack of time, and social stigma surrounding mental illness.[3] As a result, unmet mental health needs can be categorized two ways. First, individuals seeking care who are not able to access it. Second, individuals who are in need of care but are not yet willing to seek it out. For the purposes of this report, we will focus on the first category of mental health patients who are actively seeking support but are unable to find support resources for reasons like cost, labor supply shortage, and access issues. Specifically, labor supply shortages have made it such that appointments with existing mental health professionals are difficult to schedule. Patients frequently face long wait times. In addition, especially in rural environments like New Hampshire, patients often have to travel a significant distance to receive mental health support. Travel time issues have been partially abated by the growth of telehealth, though connectivity issues and the value of in-person mental health support remains an issue of concern.

The Covid-19 pandemic has made this problem far worse, increasing demand and straining mental healthcare workers. Anxiety, depression, insomnia, and more have led to an increase in Americans seeking treatment for mental health issues. More than a third of psychiatrists were seeing more patients in April 2021 than before the start of the pandemic, according to the American Psychological Association (APA).[4] This survey fails to include the number of patients who were turned away due to mental health workers with already fully booked schedules. Online platforms have seen a dramatic rise in demand during the pandemic. For example, the telehealth provider MDLive, which has more than 62 million members in the United States, saw a five times increase in online therapy and psychiatric care services in 2020 compared with 2019.[5] In addition to the pandemic's exacerbation of the pre-existing mental health crisis, the NIH has confirmed that substance use and drug overdoses have increased in the United States since March 2020.[6] The acceleration in drug use and overdoses as a result of the pandemic are likely driven by factors such as social isolation and stress.

New Hampshire is not immune to this mental health and substance abuse crisis. According to nonprofit Mental Health American's state care rankings, New Hampshire is ranked tenth in overall care and second-worst amongst all 50 states and the District of Columbia for percentage of adults

with all mental illnesses reporting unmet needs Mental health crisis.[7] 221,000 adults in New Hampshire have a mental health condition and over thirty percent of adults with all mental illnesses did not receive treatment in 2020.[8] In addition, with regards to substance use disorder, New Hampshire is the third highest state nationwide in opioid-involved overdose deaths per 100,000 persons.[9] The nationwide shortage in professional help, combined with the access issues brought on by the rural landscape of New Hampshire, has left New Hampshire natives in need of an alternative means to access mental health and substance use support. One such alternative route to accessing mental health and substance use care is through a mobilization of the peer support workforce. Peer support resources often come in the form of individuals who have prior experience with these issues. As a result, New Hampshire is both exceptionally in need and exceptionally capable of a peer support workforce mobilization.

There are a number of benefits to peer support as a way to meet mental health demand. Peer support is generally highly cost-effective and is far more accessible than professional services such as a traditional therapist visit. Peer support can happen 24/7 based on when needed and when convenient for those who receive it.[10] Furthermore, the peer model is inherently more of a horizontal power dynamic than therapy, providing a relationship model of care through a care provider with whom the recipient can more easily relate.[11] The peer support model allows for a more personalized approach to mental health and SUD support, along with providing reciprocal benefits for the individuals providing care, implying that the benefits of peer support are inherently mutual.[12] Finally, the informality of the peer support model represents a cultural approach to combating mental health concerns and substance use disorder by developing a community of individuals seeking and willing to provide care. The network effects of support have significant upside in terms of improving the discourse surrounding these often-neglected topics, allowing for the delivery of support to occur before it is too late.

2 THREE KEY OBSTACLES

Three key obstacles exist with regards to the robustness of the existing mental health and substance abuse support labor forces: access, cost, and the ease of asking for help. Upon clarifying each of these obstacles, this paper will seek to demonstrate how peer support effectively combats each of the following.

2.1 ACCESS

The clinical support staff labor force for mental health treatment and prevention has been unable to keep up with the recent escalation in demand for services. In New Hampshire alone, 92,510 people live in a community without an adequate number of mental health professionals.[13] These state numbers are consistent with the national statistic of more than half of Americans with mental health conditions being unable to access care.[14] Increased caseloads mean physician calendars are being booked up long in advance. In addition, in New Hampshire, due to the inadequacy of professional support resources within so many communities, access to care is often limited to geography, forcing individuals with mental health needs to drive long distances to visit with clinicians who can only see them for limited amounts of time on a limited number of days per month.

2.2 COST

One set of problems with existing mental health services provision is cost. Therapy sessions cost $65 to $250 per hour according to online therapist directory GoodTherapy.[15] Another problem is insurance coverage. While the 2008 Mental Health Parity and Addiction Equity Act barred insurers from blatantly refusing to cover mental health services, mental health care still lacks the same level of insurance coverage as physical health care does.[16] For example, while 90 percent of non-mental health physicians are covered by some commercial insurance, only 56 percent of psychiatrists accept it. Another related problem is network adequacy.[17] This occurs when insurers in-network options are unable to meet the need for mental healthcare in a reasonable way.[18] In this scenario patients have to wait for long periods to get treatment or travel far to see an in-network provider.[19] The result is that they may not be able to see an in-network provider who can help them, and instead they might have to see an out-of-network professional which forces them to pay very high out of pocket costs.[20] Health plans often only have very narrow networks of mental health providers, which, compounded with the low rates of network participation from mental healthcare professionals to begin with, drives the need for expensive out of network visits.[21] Compared to general medical care, out of network care is three times more common for mental health care.[22] Peer solutions may be able to better help our population by providing some mental health services at a far lower cost than it takes to see a licensed professional, especially a physician.

2.3 EASE OF ASKING FOR HELP

A significant barrier to providing effective mental health care is the ease with which individuals feel that they can ask for support. Professional resources can feel overly formal and intimidating for first time users of mental health support. As a result, the peer support model is particularly attractive because it can function as a kind of springboard for individuals into receiving care the care that they need.[23] By relieving the existing power dynamic that exists between professional mental health clinicians and individuals seeking support, the avenue of peer support increases the ease of asking for help, improving the robustness of mental health care delivery.

3 THE CURRENT STATE OF MENTAL HEALTH AND SUD EFFORTS

3.1 FEDERAL MENTAL HEALTH AND SUD EFFORTS AND FUNDING

Before detailing region-specific metrics for New Hampshire, it is important to provide an event broader context regarding the federal appropriation of time, personnel, and financial resources to mental health and substance use initiatives. With regards to research on this topic, the NIH, the research arm of the department of health and human services, created the National Institute of Mental Health (NIMH) to provide the research necessary to transform mental health care delivery nationwide. Operating with a roughly $2B budget, the NIMH supports research grants at universities and academic health centers across the country. [24]

Beyond the research efforts provided by the NIMH, there are two primary federal agencies engaged in the work that is presently applicable. First, the Health Resources and Services Administration works

to connect primary care clinicians with individuals in the United States with limited access to support through a program called the National Health Service Corps (NHSC).[25] The NHSC provides financial support, most often in the form of student loan repayment or scholarships, to clinicians who are willing to work in rural environments and underserved communities that desperately need their services. In the early 1990s, the NHSC added a mental health discipline.[26] By the 2010s, the behavioral health discipline became the top discipline for NHSC clinicians, and mobilized telehealth technology to further increase outreach to rural communities.

The second federal agency committed to combating these issues, and perhaps the most readily applicable for the purposes of this paper, is the Substance Abuse and Mental Health Services Administration (SAMHSA), which leads public health efforts to advance the behavioral health of the nation, receiving $9B in funding in 2022.[27] Specifically, SAMHSA provides support through mental health block grants (MHBG), which funds community-based, mental health resources, several of which have been awarded to New Hampshire. [28]

3.2 THE CURRENT STATE OF PEER SUPPORT IN VT AND NH

The New Hampshire and Vermont state governments have recognized that there is a role for peer support and have acted on this in some capacity. In this section we provide an overview of various efforts in the two states.

3.2.1 NEW HAMPSHIRE

In New Hampshire, there is already some infrastructure in place for peer mental health and substance abuse support that works along with nonprofits to provide care to residents. For substance abuse, the New Hampshire Board of Licensing for Alcohol and Other Drug Professionals has a process for becoming a Certified Recovery Support Worker.[29] Mental health peer support certification is overseen by the New Hampshire Bureau of Mental Health Services. Obtaining this certification requires going through training, passing the Certified Peer Support Specialist exam, and completing continuing education requirements.[30] The New Hampshire Bureau of Behavioral Health partners with several Peer Support Agencies (PSAs) located across the state.[31] In an effort to combat the challenges of the rural environment, the Bureau of Behavioral Health website lists all of the PSAs broken down by region, allowing people to identify places to get support in the area in which they live. There are 17 PSAs across the state and at least one in every region, as well as 10 designated Community Mental Health Centers (CMHCs), which provide comprehensive, community-based mental health support.[32]

In March of 2021 the Bureau of Mental Health Services released a "New Hampshire Peer Workforce Advancement Plan."[33] In this plan, they lay out how they hope to see peer support working in an all-encompassing and coordinated network of mental health support in New Hampshire (See Figure 1). According to the plan, at least 43 peer support specialists were employed in CMHCs as of December 2020. Of those peer support specialists, 19 were certified peer support specialists, while the other 24 had yet to complete their training and certification process.[34] State rules allow peer support specialists up to 12 months to complete their training and pass the exam after being hired.[35] The report identified availability of training sessions, cost, and time away from work as barriers in the certification process. They also recognized the challenge of the fact that taking time to complete the training may take away time peer support specialists would spend working with clients. At the same time, they recognized the value in having properly trained employees.

The report went on to explain that at least 91 peer support specialists, roughly 68 percent of the peer workforce, are employed at PSAs.[36] These peer support specialists allow 14 of the PSAs across the state to run peer support programs.[37] About 70 percent of PSA employees are people with lived mental health experience, some but not all of whom are certified peer support specialists.[38] Peer supporters at PSAs face similar barriers to certification as at CMHCs. PSAs also struggle to pay employees competitive wages and offer opportunities for career advancement.[39] In addition, the report notes that some peer support specialists work in other community organizations and settings, such as NAMI NH or other clubs, advocacy organizations, housing providers, hospitals, and nonprofits. There is also some overlap in the work of mental health peer supporters and substance use recovery coaches, which is an area that could be further explored.

3.2.2 VERMONT

In Vermont, there is no state certification for peer mental health supporters or substance abuse recovery coaches. The Vermont Department of Mental Health partners with 12 organizations across that state that provide peer support.[40] These organizations offer a combination of in-patient and out-patient support for a variety of demographics across the state. For substance use disorders, there is one main Vermont nonprofit that trains and certifies recovery coaches. Recovery Vermont runs a Recovery Coach Academy in which they train peers and lay people on ethics, the science of addiction, trauma informed care, stigma reduction, resource provision, and other relevant topics.[41] Most Recovery Coaches work in one of Vermont's 12 Recovery Centers, but some also work in other treatment centers and hospitals or apply their knowledge to work with youth, work in public housing, or social work.[42]

3.2.3 COLLEGES AND UNIVERSITIES

One other space in Vermont and New Hampshire where there is already some infrastructure in place for both peer mental health and substance use support is at colleges and universities. In New Hampshire, there are currently peer mental health support programs at both Dartmouth and UNH. The Dartmouth Mental Health Student Union trains peer support volunteers and holds drop in hours for students to come talk with other students who have been trained as peer support volunteers.[43] At UNH, the counseling center runs a Peer Ambassador Program.[44] At the moment, this program just involves outreach and no peer-to-peer support but has the potential to be expanded.[45] UNH does provide direct peer support through Eating Concerns Mentors.[46] In this program peer mentors provide support to other students specifically about body image and disordered eating.[47] UNH also provides some peer involvement in regard to substance use through their Alcohol, Nicotine & Other Drugs peer educators.[48] Like the counseling center ambassadors, peer educators are focused on outreach and education and do not currently do peer counseling.[49] However, with support there is potential to expand this program to include peer support. The Center for Rural Health Equity may be interested in partnering with colleges and universities to support them in expanding their capacities both within campuses and in the greater community.

3.3 PEER STATES

To understand how to most effectively improve the peer and lay mental health and substance use support systems in New Hampshire and Vermont, other states with more expansive programs can serve as models.

3.3.1 MAINE

Maine is both demographically and geographically similar to New Hampshire and Vermont in many aspects. Importantly, Maine faces the same kind of challenges in providing mental health support in rural areas. The Office of Behavioral Health in Maine's Department of Health and Human Services operates a certification through which peers and lay people can become Certified Intentional Peer Support Specialists.[50] There is a fairly extensive training required to receive the certification from the state. Interested people must attend a class on peer support or healthy connections before they even fill out an application to become a Certified Intentional Peer Support Specialist to confirm their interest in the program. Next, they must complete both online and in-person training and pass an exam on the information from those classes. They can then begin their field work, but also must complete a skills assessment after their first year. The certification is maintained indefinitely as long as Certified Intentional Peer Support Specialists continue to do field work, complete continuing education requirements, and participate in reflection groups about the experience. This program is free of charge, so there is no financial barrier to participation. There are three opportunities each year to complete the training. This comprehensive training and certification program could serve as a model for similar infrastructure that could be instituted in Vermont and New Hampshire. The Center for Rural Health Equity could either create a program like Maine's program, which could provide people with a certification recognized by Dartmouth-Hitchcock, or the center could take more of an advocacy role and work with the Vermont and New Hampshire state governments to make sure they have programs that are up to the same standards as Maine's.

Non-profit organizations also play a role in supporting Maine's peer and lay mental health and substance use support systems. MaineHealth, a hospital system in Maine that appears to play a similar role in serving the community to Dartmouth-Hitchcock, has a fairly extensive peer mental health counseling system in place. They play a vital role in the implementation stage of the system, hiring Intentional Peer Support Specialists who have been certified by the state and pair them with people who could benefit from the support.[51] The Alliance for Addiction and Mental Health Services, another Maine nonprofit, also supports the process of peer support by connecting residents to a local provider. They have compiled a list of their members, which includes both nonprofit and for-profit organizations incorporated in the state of Maine.[52] Though not limited to peer support, the list includes organizations that offer peer support for mental health and substance use. They provide a description of the services of all of their member organizations, as well as a map of where they are located, making it a particularly helpful resource in a rural state for connecting people with mental health and substance abuse support resources. The Center for Rural Equity at DHMC could play a role in promoting peer support through both of the methods employed by MaineHealth and the Alliance for Addiction and Mental Health Services.

3.3.2 CONNECTICUT

Connecticut is another New England state that has a fairly robust peer support network that can provide models for programs that could be implemented at the Rural Health Equity Center at DHMC. Instead of certification happening at the state level, there are a couple of organizations in Connecticut that certify peers and lay people to provide mental health and substance use support to residents in need.[53] One of these organizations is Advocacy Unlimited, which trains people with lived mental health experiences to become Recovery Support Specialists.[54] Becoming a Recovery Support Specialist requires 80 hours of formal training done through Advocacy Unlimited. Recovery Support Specialists can then go work for other mental health programs in the state, and people with this certification are increasingly being included on teams at agencies that receive funding from the Connecticut Department of Mental Health and Addiction Services.[55]

Another organization that runs a certification is CT Community for Addiction Recovery (CCAR). CCAR trains Recovery Coaches to support individuals with substance use disorders, and has trained over 75,000 individuals since 2010.[56] The recovery coach academy is broken up into a 46 hour baseline requirement which includes ethics training and recovery assistance skills training.[57] CCAR has five centers in Connecticut and is beginning to expand their practice nationwide.[58] Recovery Coaches have been dispatched to 22 hospitals in the state and are looking to add additional hospitals in the coming year.[59] CCAR has a triaged model in which recovery coaches work directly in concert with clinicians, building relationships with individuals suffering from SUD that often starts in the acute care setting but continues long after the individual is discharged.[60] This relationship-based model decreases the strain on acute setting clinicians and allows for a tailored approach to each instance of SUD.

The effectiveness of CCAR recovery coaches has bolstered the reputation of hospitals they partner with, driving demand away from acute care settings that don't provide recovery coach options. As a result, CCAR is frequently approached directly by hospital systems and funded as a partner within their acute care practice without being direct employees of the hospital.[61] Partnerships with hospitals allow for a seamless integration of recovery coaches with the acute care setting and assure that CCAR can pay their support coaches a full-time, living wage. CCAR emphasizes that recovery coaches shouldn't have to volunteer, and their training costs just over $1,000 to ensure buy-in on the part of the recovery coaches selected for the job.[62] The fact that recovery coaches are able to operate without being employees of the hospital decreases regulatory and liability concerns, though recovery coaches are still insured.[63] In addition to direct partnerships with hospitals, CCAR also has a strong relationship with their Single State Agency for Substance Abuse Services, a state-level implementation of SAMHSA a part of the Connecticut Department of Mental Health and Addiction Services, that provides financial support to ensure that training and recovery coach presence in hospitals continues to proliferate.[64] CCAR agile adjustment to the advent of telehealth has given reason to believe that the recovery coach model can be implemented in rural settings, and CCAR is encouraged by the decreased barriers to receiving such support that online avenues provide.

Finally, the Connecticut Certification Board, which is a nonprofit, not a state-run organization, offers a program to become a Certified Peer Recovery Specialist for both substance use and mental health. This certification has a slightly more extensive training and requires a high school diploma or GED and the completion of 50 hours of training broken down between advocacy training, education and mentoring, recovery and wellness support, ethical responsibility, and either mental health or addiction electives. Then, participants must complete 500 hours of supervised experience and 25 hours of face-to-face or group supervision. After the experience, applicants must pass an exam to become Certified

Peer Recovery Specialists. The Connecticut Certification Board requires that Certified Peer Recovery Specialists complete continuing education and ethics training every year. There is a somewhat significant cost associated with becoming a Certified Peer Recovery Specialist. There is a $150 filing fee, $150 exam fee, and $50 annual renewal fee. The state is working to obtain funds to cover the costs of the application and exam, but at this point the fee may be prohibitively high for some people interested in receiving the certification.

4 SOLUTIONS

In the next portion of this paper, we examine several outside models for delivering peer mental health care services in order to help meet demand.

4.1 NEW YORK CITY MODEL: MENTAL HEALTH SERVICE CORPS

In early 2020, New York City Health + Hospitals, a city-wide, integrated healthcare system, joined forces with the city's Mayor's Office to launch the Mental Health Service Corps (MHSC).[65] The MHSC is a three-year training program for aspiring behavioral health clinicians. Aspiring clinicians will serve thousands of New Yorkers who otherwise had no access to behavioral healthcare, all while gaining valuable experience and logging required hours for their certification.[66] MHSC members will be fully integrated into the New York City Health + Hospitals public health system, providing support for overwhelmed clinicians and underserved patients.[67] To ensure that a high level of behavioral health care is maintained, MHSC members must apply and be approved to join.[68] Once they've been accepted, aspiring clinicians are paired with existing in a manageable ratio to oversee provided care.[69] In addition, the MHSC program will serve as the city's clear path toward bolstering the behavioral health clinician labor force. The MHSC budget was $13M in FY2021, and the program hopes to oversee the development of over 3,500 aspiring health clinicians.[70]

There are four key characteristics of the NYC MHSC that make it a groundbreaking model for lay avenues of mental health and substance use support. First, by generating the involvement of 3,500 aspiring behavioral health clinicians, NYC has increased the access to mental health support while simultaneously decreasing the cost of receiving such support and keeping the quality of care consistent. Certified clinicians have limited time, and what limited time they do have is quite expensive. Aspiring clinicians prove a win-win solution of an affordable option that means increased access with lower costs, and consistent quality. Second, incentivized participation keeps labor force demand high, providing a clear pathway toward certification that benefits all parties. Finally, the MHSC is fully integrated into the public health system in NYC. This is crucial as it provides a seamless avenue through which those in need of increase behavioral health attention can be paired with behavioral health professionals. This pairing process is fundamental to closing the labor force gap and works extremely well in a formal setting such as one that is integrated with a public health system.

4.2 ONLINE PLATFORMS

One means of meeting mental health needs may be through internet-based or telehealth solutions. One of the advantages of this kind of support maybe. People may often be more comfortable from their own homes, rather than having to make a journey to get support. This also could allow for services to be extended to rural communities that may be too small to have their own dedicated mental

health workers or have difficulties attracting them to live in their community. So long as there is reliable internet connectivity, not a given in rural New Hampshire or Vermont, these can be viable means of addressing this issue.

Developed by college students (including by recent Dartmouth College graduate Sanat Mohapatra '20), the online platform Unmasked uses an anonymous may offer a model for internet-based mental health services.[71] The platform relies on peer engagement on its app to provide emotional and mental health support for college students.[72] The platform aims to destigmatize conversations around mental health and relies on strong moderation. It has over 10,000 users at 46 universities.[73] This model has interesting benefits, such as how engaging with others may also help those suffering from mental health conditions realize that they are not alone, instead allowing them to see how many others struggle with similar affiliations.

Unmasked's model takes a triage style approach to mental health, not seeking to replace clinical methods of service but instead offering a convenient and comfortable alternative for those who aren't ready or able to seek therapy and other traditional solutions.[74] At each university campus, Unmasked recruits a handful of student volunteer moderators and uses the nonprofit Crisis Text Line's training program to prepare them to be peer responders.[75] In the future, the platform hopes to develop its own moderation training through hiring clinicians, who can develop curriculum and oversee moderators.[76] This approach allows just a few expert practitioners to oversee care for thousands.

4.3 COMMUNITY COLLEGE WORKFORCE PROGRAMS

One source of potential mental health workers may be through local community college programs. While most of the Community College System of New Hampshire's seven campuses have general social services or similar programs, few offer specialized programs to prepare mental healthcare and substance abuse treatment workers. Two colleges buck the trend and stand out in their offerings: New Hampshire Technical Institute in Concord, and Manchester Community College.

NHTI offers an addiction counseling degree program, which offers substance use disorder treatment certificates, Certified Recovery Support Worker course (geared towards meeting the state credentialing requirements), and a Mindful communications certificate.[77] According to the program's website, it is designed to provide "education and training required for a career in the substance use disorder treatment (SUD Tx) profession and to become licensed in alcohol and drug counseling in N.H." Additionally, the college offers an Advancement Human Services certificate program, offering substance use disorder treatment and mental health as two focus areas.[78] The program's website says that post-completion of the program students seek employment in mental health, SUD Tx, social services, child and family services, crisis services, assistance programs, and senior centers.[79] It lists case manager, direct support worker, mental health worker, veterans' services worker, recovery support worker, behavioral management aid, group home worker, residential counselor, and social worker assistant as post-completion careers.[80]

Manchester Community College offers four certificate programs in mental health and substance abuse support. First, a general direct support services certificate is general but does include mental health as a focus area.[81] Second, the Mental Health Support Worker Certificate offers training specific to the field of support to people with mental health disorders.[82] According to its website, "the coursework is intended to help develop the student for work as a trained paraprofessional in the field of

mental/behavioral health." While there is no state certification for this role currently, the program is designed so that it would provide sufficient educational background for a future one.[83] The program trains for roles such as mental and behavioral health aides and technicians and intake counselors and is geared towards those without prior experience in these fields.[84] Finally, MCC offers certificates in Recovery Support and Substance Misuse. These programs seem particularly well-matched for employment outcomes.

In particular, the Recovery Support program provides the education to get a job or the required hours of experience to become a Certified Recovery Support Worker through the state endorsed process.[85] Graduates work as recovery coaches and recovery support workers for state contractors, private organizations, and other relevant areas.[86] The RSC trains students to be a Certified Prevention Specialist, a position with over 50 schools, agencies, and communities within 13 regional public health networks who contract with the state and do not have enough workers.[87]

5 RECOMMENDATIONS

Across the cases, we have examined in this paper there are several shared characteristics which may be useful when considering implementation of peer support services in New Hampshire in Vermont.

Important considerations include:

1. Leveraging the unique benefits of peer support
2. Community-centric models
3. Grounding peer support in clinical guidelines and advice

First, mental health peer support solutions should take advantage of the peer support model. While peer support implementation is necessary, there are benefits which have been discussed in earlier sections. The availability of peer support outside of a traditional 9-5 once a week format that therapists or other clinicians typically use offers strong advantages for patients.

Second, taking advantage of existing communities allows for easier implementation and promotes buy-in on both the supporter and supportee side. Examples include the Unmasked Project's University-level implementation, or the use of hospitals as a delivery for mental health and addiction support services. Further examples include faith-based organizations, community groups, or high-schools. Leveraging these existing communities allows for build up of peer supporters in an organized and streamlined manner compared to ad hoc recruitment. Additionally, it emphasizes the peer nature of the relationship as the supporter is a member of the same community as the supportee.

Finally, a common thread among these programs is that they are heavily grounded in existing medical systems. While peer support is not the same as clinical support, effective peer support needs to include training led by clinical standards and/or clinicians themselves. In addition to incorporating these principles, integration with hospitals and mental health experts is crucial. Tight integration allows those requiring more advanced care to be easily handed off to therapists, psychologists, and other professionals.

6 CONCLUSION

In this report, we identified and outlined the issue of lack of mental health care both nationally and in New Hampshire and Vermont, describing some of the key challenges. We have posed peer support as a potential avenue for meeting demand for mental health service, describing the benefits and drawbacks of this approach. Through case studies including outside states, nonprofits, and other organizations, we analyzed various peer support training and delivery programs. We believe that a few common traits exhibited by these programs help inform what future programs in our states could look like, identifying three core characteristics of these programs: leveraging the benefits of peer support, community-based models, and grounding peer support on a clinical basis. We hope that this research will help to inform future policies that will ultimately help our states and those many people struggling with mental health to get the support that they need.

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