

Key skills and challenges in one-on-one peer support for older adolescents and young adults with serious mental health conditions

Received: 7 March 2025

Accepted: 2 July 2026

Published online: 23 July 2026

Cite this article as: Walker J., LaPelusa B., Klodnick V.V. *et al.* Key skills and challenges in one-on-one peer support for older adolescents and young adults with serious mental health conditions. *BMC Psychol* (2026). <https://doi.org/10.1186/s40359-026-05128-7>

Janet Walker, Brianne LaPelusa, Vanessa V. Klodnick, Rebecca P. Johnson, Maria Hermesen-Kritz & Shannon M. Blajeski

We are providing an unedited version of this manuscript to give early access to its findings. Before final publication, the manuscript will undergo further editing. Please note there may be errors present which affect the content, and all legal disclaimers apply.

If this paper is publishing under a Transparent Peer Review model then Peer Review reports will publish with the final article.

Running Head: Young Adult Peer Support Skills

Key Skills and Challenges in One-on-One Peer Support for Older Adolescents and Young Adults with Serious Mental Health Conditions

Authors:

Janet Walker, PhD, Regional Research Institute for Human Services, Portland State University, Portland, OR, United States

Brianne LaPelusa, MFA, CRSS, Texas Institute for Excellence in Mental Health, The University of Texas at Austin, Austin, TX, United States

Vanessa V. Klodnick, PhD, LCSW, Texas Institute for Excellence in Mental Health, The University of Texas at Austin, Austin, TX, United States

Rebecca P. Johnson, MA, LCPC, Texas Institute for Excellence in Mental Health, The University of Texas at Austin, Austin, TX, United States

Maria Hermesen-Kritz, MSW, Systems of Care Institute, Portland State University, Portland, OR, United States

Shannon M. Blajeski, PhD, MSW, School of Social Work, Portland State University, Portland, OR, United States

Corresponding Author: Janet S. Walker janetw@pdx.edu

Keywords: youth peer support, peer support practice, peer support skills, peer support on-the-job challenges,

Abstract

Background Peer support for older adolescents and young adults has become increasingly available as a formal mental health service. Alongside this increasing availability has been a steady accumulation of studies examining the potential for peer support to lead to positive outcomes for

peer support users. However, a consistent refrain from the literature on peer support is that research and practice are hampered by a lack of theory-based models that specify the activities and skills of specific peer support roles, and describe how skillful practice is linked to outcomes. As part of a larger study intended to help fill this gap, the current study aimed to define a set of key skills and related challenges in one-on-one peer support for older youth and young adults.

Methods The study engaged peer support specialists (PSSs) and peer support users (PSUs) from first episode psychosis (FEP) and non-diagnostic-specific (NDS) programs across the United States in a series of discussion groups focused on the activities, skills and outcomes of effective peer support. Qualitative analysis of the discussion group material led to the specification of six general skill areas and, within each of these, a series of sub-skills and key practice challenges. In a second phase of the study, the PSSs reviewed a document describing these, rated the importance of each of the skills and challenges, and provided open-ended feedback on wording and conceptualization. Based on feedback, wording of practice skills and challenges was finalized, and a set of related organizational challenges connected to each skill area was added to the document.

Results All of the mean importance ratings for sub-skills and challenges were above 4.25 on a 5-point scale for which 4 = *very important* and 5 = *extremely important*. PSSs from FEP and NDS programs provided similar ratings for sub-skills and challenges, with a few exceptions.

Conclusions The final document produced from this study contains information about skills and challenges that has similarities to other studies of PSS skills, but also has unique features. Results from the study have practical implications for training, supervision and organizational development to support the PSS role.

Key Skills and Challenges in One-on-One Peer Support for Older Adolescents and Young Adults with Serious Mental Health Conditions

Background

The availability of one-on-one peer support as a formal mental health service has increased rapidly in recent years, particularly in the world's high-income countries (1-5). While peer support specifically intended for

adolescents and young adults is a newer addition to the mental health services array, its growth has accelerated in the past decade (6–9), driven in part by the expansion of first-episode of psychosis (FEP) programs, many of which offer peer support as part of their comprehensive service package (9–11). This article focuses on one-on-one peer support provided within programs that offer a coordinated, multidisciplinary approach to serving older youth and young adults experiencing psychosis and other serious mental health conditions. This peer support is provided by young adults who are near in age to the young people receiving support, and who have experience receiving mental health treatment. The age range for “older youth and young adults,” also often described as “transition aged youth and young adults,” is not consistently defined either in the research literature or in information about program eligibility; however, the typical age range provided is 16 to 24 or 25 (6,8).

In parallel with the increasing availability of peer support has been a steady accumulation of studies investigating the potential for peer support in mental health contexts to lead to positive outcomes for peer support users. Despite wide variability in study quality and inconsistencies in the definitions of peer support roles, research over several decades on the outcomes of peer support for adults has shown the potential for positive impacts on psychiatric symptoms, inpatient use, personal recovery, hope, empowerment, social functioning and quality of life (3,4,12–14). More recently, studies have begun to examine outcomes from peer support for

youth and young adults experiencing serious mental health conditions. Systematic reviews of this literature have reported a wide variety of positive (albeit typically modest) impacts, including increasing overall wellbeing; reducing isolation/increasing social and emotional support; building hope, empowerment and self-efficacy; increasing coping skills; (re-)engaging young people in services; and supporting services users and treatment teams in prioritizing and building treatment plans based on the personal goals of the young person (8,15,16).

Despite this emerging evidence, there is a prominent and consistent cautionary refrain in discussions of mental health peer support for both adults and young people, namely, that research and practice are hampered by a lack of theory that clearly defines the activities and skills of specific peer support roles, and that explains why skilled performance of a given role should lead to positive outcomes (8,16–18). While the literature identifies a number of challenges arising from underdeveloped theory, the lack of clarity regarding the activities and skills of the role may have the largest direct impact on peer support specialists (PSSs, i.e., those providing peer support). Studies have documented a variety of ways that this lack of clarity contributes to work-related stress among PSSs, for example by increasing job dissatisfaction, emotional distress and burnout (17,19–21). Young adult PSSs appear to be especially likely to encounter uncertainty about their roles (16,20,22–25). This lack of role clarity can contribute to difficulties not only in PSSs' direct work with peer support users (PSUs), but also in their

interactions and relationships with supervisors, non-peer co-workers and the family members of PSUs (1,17,26–28).

In the last decade, several research groups have proposed theories of change for peer support for adults in mental health contexts. These models outline the mechanisms by which peer support produces positive outcomes; however, this work remains at an early stage (e.g., 10,15–19). Other interested parties have worked to define specific aspects of peer support roles. For example, at the national governmental level, both the Mental Health Commission of Canada (33) and the United States' Substance Abuse and Mental Health Administration (34) have convened collaborators with relevant experience and expertise to describe competencies for peer support work. National advocacy organizations in the United States such as the National Federation of Families (35) and Mental Health America (36) have likewise developed descriptions of peer support competencies. However, none of these initiatives included a specific focus on peer support for youth and young adults.

Regarding peer support for young people specifically, researchers and people connected to implementation consistently call for theory that defines specific peer support roles, activities and skills; that describes the mechanisms linking skilled practice to outcomes for PSUs; and that addresses whether and how peer support for young adults differs from peer support for other populations (6,8,37,38). Recent literature (e.g., 22–24) has begun to address this need by identifying elements of theory—including

skills, activities, outcomes and mediators—and/or proposing mechanisms of change. In one project focused on clarifying several of these elements, the Massachusetts Department of Mental Health worked with the Children's Behavioral Health Knowledge Center (42) to develop a document describing the “practice profile” for young adult peer support in the context of mental health services. The document identifies the basic functions of peer support and provides details on how these functions are translated into “ideal” practice. Other similar documents, mostly unpublished, have been developed at the state and local program level.

The current study is the conclusion of a larger project focused on clarifying theory, activities and skills for one-on-one near-age peer support in community-based programs that use a multidisciplinary team approach to serve youth and young adults diagnosed with serious mental health conditions. In the first phase of its work, the project collected qualitative data from interviews with experienced PSSs and PSUs to develop a theory of change that links skillful PSS practice to PSU outcomes, and describes mechanisms of change (39). A central feature of the theory of change is the key importance of the “peerness-based relationship” between a PSS and a PSU as the driver of PSU outcomes, which include both changes in perceptions/self-perceptions (i.e., increased hope, decreased existential loneliness, decreased anxiety, increased personal agency/empowerment) and changes in activity (taking action, with PSS support as desired, to undertake activities consistent with personal goals and needs; and learning

and using strategies to communicate perspectives and priorities to others, including the treatment team, other providers, parents and family). While “peerness” has often been defined as arising from shared lived experience, the theory of change developed in the first phase of the project sees lived experience as necessary, but not sufficient as a driver of outcomes. Instead, the theory proposes that outcomes are enabled when a specific type of relationship—the peerness-based relationship—is developed through the PSS’s intentional and skillful use of an interpersonal approach that is unique to PSSs versus other providers in mental health treatment contexts.

According to the theory of change developed from the project’s data from phase 1, a PSS nurtures a peerness-based relationship by the skillful implementation of an interpersonal approach that is grounded in empathic listening, and focuses on drawing out and validating PSUs’ priorities, perspectives and ideas. A PSS also promotes the peerness-based relationship through being acutely attuned to a PSU’s communications about what they find motivating—including values, commitments and passions, as well as relationships and activities that bring satisfaction or joy. The PSS supports the PSU in exploring these priorities and motivators, in communicating them to others (e.g., treatment team members, family members) and in planning and engaging in activity connected to them. Crucially, the development of a peerness-based relationship depends on a PSS’s skill in sharing from personal experience in a way that is open and genuine about past and current struggles and successes.

These skills overlap to some extent with the skills/competencies identified in the various sources cited above. These sources tend to highlight importance of using a style of personal presentation and communication that

encourages and supports a PSU to express and explore their own thoughts, ideas and priorities; supporting PSUs to communicate these thoughts to others, including other providers; knowing when and how to share information about one's own experiences; and using a PSU's own goals to guide the work.

The current study was designed to contribute to the existing literature by developing a nuanced description of skillful practice from the perspective of young people who have provided one-on-one peer support in the context of youth- and young adult-serving mental health programs. To do this, the study aimed to provide detail for the general skill areas identified in the theory of change by defining a series of key sub-skills and key practice challenges within each general skill area.

Methods

The study protocols were approved by the Institutional Review Board (IRB) at Portland State University in accordance with the regulations of the United States Department of Health and Human Services (45-CFR part 46). In accordance with these regulations, electronic informed consent was obtained from all participants involved in the study, and participation was voluntary. The project was conducted by a research team that included both researchers and practitioners with experience studying and/or providing peer support and supervision for peer support. Specifically, young adults who had experience providing peer support, and training and supervising PSSs, were paid staff members of the university centers collaborating on the research.

As full partners on the research team, these young adults participated in conceptualizing and carrying out all aspects of the project.

Participants

To develop descriptions of the key subskills and practice challenges, the research team conducted further analyses of the qualitative data that was used in phase one of the study to create the theory of change. This phase one data was collected from young adults from across the United States with experience providing and/or using peer support in multidisciplinary community-based programs for young people diagnosed with serious mental health conditions, including first episode psychosis (FEP) and non-diagnosis-specific (NDS) programs. Both types of programs used clinician-led teams to organize and coordinate individualized care, which was primarily provided by program staff such as psychiatrists, mental health therapists, vocational/educational support specialists and PSSs. The most common program models used in the FEP programs were NAVIGATE (43) and EASA (44), while the NDS programs most commonly used Wraparound (45) and TIP (46).

Research team members sent an announcement and informational flyer to email lists that they belonged to and that reached peer support specialists (PSSs) and peer support users (PSUs) across the United States. The announcement and flyer were also sent to individuals connected to local- and state-level peer support initiatives, with the request that they forward the materials to PSSs and PSUs in their own networks. The outreach

materials included an electronic link to further study information, and to an online interest form that requested contact information as well as information about PSSs'/PSUs' background and experience with peer support. A study team member followed up with potential study participants to confirm eligibility, provide information about study risks and benefits, and schedule groups.

Insert Table 1 about here

In phase 1, 52 young adults participated in one or more discussion groups. Self-reported participant characteristics are provided in Table 1. Participants in study phase 1 were aged 18-29. Five months after phase 1 data collection was concluded, the research team successfully re-contacted 31 of the original 35 PSSs (15 from FEP programs and 16 from NDS programs). These PSSs were invited to participate in phase 2, which involved providing feedback on the practice skills and challenges identified in phase 1 via two online surveys that were developed specifically for this project. (The feedback survey task was broken into two parts due to the length of the whole task. See supplementary files 1 and 2 for the full text of the two surveys.) Participants were paid \$50 per survey. A total of 30 PSSs (15 from FEP programs and 15 from NDS programs) participated in the first survey, with 27 of these (14 FEP, 13 NDS) also completing the second survey.

Data Collection and Analysis

Phase 1

PSSs and PSUs in phase 1 participated in small group online discussions with others from similar program types (i.e., NDS and FEP groups

were held separately). The discussion groups were about an hour and fifteen minutes long. The project convened 24 discussion groups in total: 17 for PSSs (7 FEP, 10 NDS) and 7 for PSUs (3 FEP, 4 NDS). The discussion groups were convened in three sets, with intervals of about one month between. During the intervals between sets, the project team analyzed data and developed new questions for the subsequent set of discussion groups. Project staff aimed to schedule participants in groups of 3 or 4, and though the modal group size was 3, groups ranged from 1 to 5 participants. The two groups with only one participant occurred due to no-shows, but these were conducted using the same procedures as the larger groups. Each PSS was invited to participate in each set of discussion groups—the mode for their participation was two groups. The discussions for PSUs took place after all of the PSS groups, and there was only one set of discussions for PSUs. In most cases, two project staff facilitated each group, and one of these was a young adult with experience as a PSS. For four of the groups, however, only one facilitator was available. Discussion group participants were offered honoraria of \$25 per hour, paid electronically by Venmo or gift card.

The study used Zoom to convene and record the discussion groups. During the first set of discussions, the facilitators gave a brief overview of the study, followed by a discussion prompted by the question *“What do PSSs do when they are working effectively?”* As participants responded, facilitators asked them to explore and define terms that came up, aiming to elicit concrete descriptions and specific examples. This was followed by a

similar discussion of a second question, *“What kind of impact does this have on PSUs?”* During the intervals between sets of discussion groups, the research team conducted preliminary qualitative analysis using discussion group transcripts, and developed questions for the next set of discussion groups, with the goal of having participants provide concrete detail about abstractions and concepts that were emerging as elements in the theory of change. Additional questions were developed focusing on topics or concepts that came up repeatedly and were connected to the larger context within which PSS practice occurs. These questions focused, for example, on PSS supervision and training, organizational policies and support, and relationships with co-workers, managers and PSUs’ family members.

The study team used thematic analysis to analyze the recorded Zoom transcripts of the discussion groups (47,48). The team elected to use thematic analysis to analyze the transcript data because the process is flexible, and can be used to combine elements of a more inductive approach to qualitative analysis (coding and themes are directed by the content of the data) and a more deductive approach (coding and themes are directed by existing concepts or ideas) (48,49). For this study, it was clear that pre-existing concepts and constructs (specifically, existing theory and concepts related to the theory and practice of peer support) would need to be considered as potential components of the structure of emergent conceptual patterns and themes. In using TA, we followed the steps of a specified process(47,48,50), using the data to critically examine, reflect on and

define/redefine existing concepts, and to develop new constructs and conceptual structures as relevant. The study approach—with rounds of analysis taking place between sets of discussion groups—supported this goal, allowing for the formulation of new questions that encouraged participants to reflect on existing concepts and constructs—as well as emerging ones—using their own words and understanding.

To begin the analysis, team members worked individually, reading the transcripts from a completed set of discussion groups, developing preliminary names and definitions of codes for key constructs and concepts, attaching these to exemplar excerpts from the transcripts, and creating “memos” for later group discussion. In the next steps of analysis, team members worked collaboratively and iteratively to integrate and refine the preliminary codes, and to group codes into themes, referring to the exemplar excerpts and discussing memos throughout. Based on these early analyses, the team developed questions for the next set of discussion groups. The questions were designed to encourage participants to reflect on key constructs and themes that had emerged in the analysis to that point. After this set of discussion groups was completed, team members reviewed these new transcripts individually creating/attaching codes, identifying exemplar excerpts and grouping/re-grouping codes within themes, and revising code and theme definitions to reflect the additional examples. This process was repeated for the transcripts from the third set of PSS discussion groups. At this point, the team decided that the coding structure was well developed.

The team then worked in pairs, with each pair including one person with experience as a PSS, to review each transcript, with each pair working only on transcripts that they had not coded previously. The pairs worked collaboratively to resolve any discrepancies, and forwarded any unresolved questions to the whole team for discussion. Transcripts from the PSU discussion groups were analyzed by pairs—again with each pair including a person with PSS experience—using the coding structure developed previously. After these transcripts were analyzed and no changes were made to the coding structure, the team determined that data collection was complete.

Phase 2

Analysis of phase 1 data led the team to propose a theory of change for one-on-one peer support for older youth and young adults(39). The theory of change identified six general skill areas. Within each skill area, the theory also identified a series of sub-skills and related practice challenges—i.e., difficult situations that come up with some frequency. Phase 2 focused in on these practice skills more specifically. Returning to the analysis of the phase 1 data, the research team prepared a document with descriptions of each of the six general skill areas, together key sub-skills and key practice challenges within each skill area. These descriptions were entered into an online feedback survey that PSSs were invited to complete.

For each general skill area, the survey followed the same pattern. First, the overall description of the skill area was provided, followed by the following text: *Key skills in this area are listed below. For each, please*

indicate how important it is for a PSS to have this skill in order to work effectively with [PSUs]. Respondents were then presented with a matrix that gave a description of each sub-skill and a choice of ratings on a 5-point scale from 1 = *not important* to 5 = *extremely important*. Below this matrix, respondents were provided with a text box and the following prompt: *If you have comments about the content or wording of any of the skills listed above, please add them here. Also please make a note if you think there are important skills in this area that are *not* listed above.* After this, respondents were shown a second matrix introduced with this statement: *Challenges in this area of peer support are listed below. Please indicate how important each of them is for peer support work—meaning that it’s a challenge PSSs are likely to encounter in their work, and might have difficulty navigating.* This matrix provided the text of each of the key challenges within the general skill area, and asked respondents to rate each one using the same 5-point scale. Finally, respondents were given a text box to comment on the wording of the challenges or to make notes about whether key challenges were missing from the list. As noted previously, this survey was split into two parts, with each requiring between 20 and 30 minutes to complete. Each of the two surveys included an open-ended text box at the end for further comments or reflections.

When the feedback survey data collection was completed, the team compiled the ratings and feedback. The team then collaboratively reviewed this material and edited the skills and challenges document in light of the

feedback from surveys and, as needed, referred back to data from the original discussion groups. As a result of this review, minor wording changes were made to many of the items. Additionally, one skill aspect and two challenge items were dropped, and two more items (challenge 4.b and challenge 5.d) were edited extensively enough that the team determined that the survey ratings no longer applied to these particular items.

The comments that the PSSs provided in response to the open-ended questions on the survey included a large number focused on organizational-level challenges that impact PSSs' ability to practice skillfully. For example, many of these comments described challenges related to supervision, job conditions, and misunderstanding of the PSS role on the part of co-workers. Other comments focused on how supervisors and other co-workers responded to misunderstandings of the role on the part of PSU's family members. Organizational-level challenges had not been included on the survey, which focused specifically on PSS practice. However, because participants so frequently mentioned these, the research team returned to the original discussion group analyses and, working with this previously-coded data and the comments from the feedback survey, added a section on "related challenges in the larger context" to each general skill area.

Results

The finalized titles for the six general skill areas are 1) Understanding and Describing the Peer Support Specialist Role; 2) Being a Peer, Being Genuine and Drawing on Personal Experience; 3) Drawing Out and Supporting PSUs'

Preferences, Perspectives and Ideas; 4) Providing Empathy and Validation; 5) Supporting Motivation and Activity; and 6) Supporting Personal Agency and Empowerment. The finalized wording for the general skills, sub-skills and practice challenges, as well as mean ratings for sub-skills and challenges are provided in Table 2. The table also lists “challenges in the organizational context” for each general skill area.

Insert Table 2 about here.

The mean importance ratings across all sub-skills ranged from 4.44 to 4.94 on the scale for which 4 = *very important* and 5 = *extremely important*. Only two of the mean importance ratings were below 4.5: 1c (*Is comfortably able to explain why they are considered a “peer.”*) and 5d (*...plan and engage in activities together in the community...*). The two sub-skills with the highest means were from general skill 3, *Drawing Out and Supporting PSUs' Preferences, Perspectives and Ideas*. Sub-skill 3a focuses on maintaining a non-judgmental attitude and using active listening skills, while sub-skill 3f focuses on acknowledging and owning misunderstandings. The two other highest rated sub-skills were 1f, related to boundaries, and 4e, related to normalizing.

Importance ratings for the practice challenges tended to be slightly lower, with means ranging from 4.28 to 4.75, with about half of the means above 4.5 and half below. The highest rated practice challenge, challenge 6d, has to do with maintaining confidentiality. All of the practice challenges connected to general skill 6, *Supporting Personal Agency and Empowerment*,

received relatively high mean importance ratings. The lowest mean rating was for practice challenge 3b, handling situations in which a PSU does not want to communicate.

The importance means for sub-skills for the FEP PSSs and the NDS PSSs had similar ranges, with the FEP means ranging from 4.25 (5d, activities in the community) to 5.00 (3a, non-judgmental attitude/active listening skills); and the NDS means ranging from 4.22 (1c, explains why they are considered a “peer”) to 5.00 (1e, explaining confidentiality/mandatory reporting to PSUs). When the rankings of the two groups’ mean importance ratings were compared, the two sub-skills with the greatest discrepancy in ranking were 1e (explaining confidentiality/mandatory reporting to PSUs, NDS rank 1, FEP rank 35) and 3c (handling situations where PSUs are reluctant to engage in conversation or activities, FEP rank 6 and NDS rank 35).

The importance means for practice challenges for the FEP and NDS groups likewise spanned similar ranges, with the FEP means ranging from 4.94 (item 6d, maintaining confidentiality) to 4.18 (item 3a, avoiding trying to “fix” or “steer” PSUs); and the NDS means ranging from 4.89 (6a, remains non-judgmental regarding PSUs’ ideas about diagnosis, experiences and treatment) to 4.14 (4c, avoiding inauthentic or excessively positive reflections/responses). The practice challenge with the greatest discrepancy in ranking between the FEP and NDS groups was challenge 5b (responding

when PSUs' goals etc., seem unrealistic or ill-advised, NDS rank 2, FEP rank 27) and challenge 2a (avoiding oversharing, NDS rank 4, FEP rank 21).

Many of the responses to the open-ended questions included endorsements of the skills, sub-skills and challenges. For example, responses to these questions for general skill 1 included these:

I feel that these skills are all very important. The PSS absolutely needs to be able to communicate what is different from other roles of the treatment team, as most clients I worked with had never worked with a peer before. I feel that the PSS needs to be able to understand their own internal boundaries in order to explain to participants and clinicians why they are a peer.

Role differentiation and role boundaries feels crucial when describing your role to clients, as well as when really understanding it yourself (e.g., knowing how much you are responsible for).

I do think that peers need to be extremely clear what is in scope for them and have good boundaries when asked to do things out of scope. When I was working at the early psychosis program, it was also unclear what was in scope for me because I never received training on this. Explaining to the participant that you are not a therapist, and what this means, is extremely important.

Not allowing peer roles to be treated as gophers, interns, or junior clinicians.

Many other comments were reflections or suggestions about particular items or groups of items. The project team integrated this feedback in making revisions. For example:

I think suicidality and self-harm might make more sense if moved as an example for the challenge on risk. Self-harm and suicidality can be difficult for peers to discuss because of stigma or their own preconceptions of the topics, but I think the safety challenges (and sometimes confidentiality challenges) that self-harm/suicidality pose make the topics different from the other examples (sexuality, political views) provided.

I would call into question the phrasing "manage situations" for the third one, it isn't the situation that I need to manage, but my own expectations, reactions, and responses to the situation.

Occasionally I have had clients who insist that there is nothing pleasurable in life, nothing they care about. That is challenging because it seems like there is nothing to "work with". Being able to remain patient -- and, again, follow the client on their journey -- is really important there.

Finally, another large portion of the comments focused on how the larger context—particularly including supervisors, co-workers and PSUs' families, and their understandings and expectations—created challenges for PSS practice.

Managing the desire to get a participant to pursue goals or activities, when they are not interested ... is a challenge, but it's particularly a challenge if you feel pressure from people above you to make progress or show outcomes or showing impact. That to me feels like more of a challenge.

Trying to support a client in a way that feels authentic to my values, while being in an agency setting (going along with when a treatment team is pressuring a PSS to do something) has been a challenge at times.

Do you have a supervisor [and] providers who are willing to help support you when they're like "you're working on behalf of this young person, so we have your back also" versus feeling like you're out on an island?

I still experience a lot of confusion [from other treatment providers] about what peer support is. This translates to lack of referrals, inappropriate referrals (e.g., wanting peer support to act as a mentor, case manager, skills trainer, etc.), and miscommunication to families/clients about what peer support is.

Just dealing with like power dynamics and feeling like you want to protect your client but feel like you're also about to like go against your boss, or something like that. Or lose your job. It can be a challenge.

As noted previously, consideration of these kinds of comments led the team to use them, together with information from coded transcripts from the original discussion groups, to develop the “challenges in the larger context” sections shown in Table 1.

Discussion

This study’s contribution to the literature derives from its research- and theory-driven approach to clarifying young adult PSS skills and challenges from the perspectives of PSSs in adolescent and young adult multidisciplinary mental health programs across the United States. The study identified six general skill areas and, within each of these, a series of sub-skills, key practice challenges, and related challenges in the larger organizational context. PSSs from FEP and NDS programs across the United States were engaged across both phases of the study, providing knowledgeable, thoughtful insights and, in phase two, formally endorsing the importance of each of the sub-skills and practice-level challenges. This deep level of ongoing engagement is quite unique among studies on this topic and represents another novel contribution.

Study findings regarding practice skills and challenges complement other efforts to build understanding of peer support in mental health and to increase its quality and availability. Each of the documents discussed in the introduction (33,34,36,42) groups and describes skills/competencies using different frameworks, making it difficult to succinctly catalog the similarities and differences among them and/or between them and the findings from the

current study. However, certain broad categories of skill/competency are shared in virtually all cases, for example: using a style of personal presentation and communication that encourages and supports a PSU to express and explore their own thoughts, ideas and priorities; supporting PSUs to communicate these thoughts to others, including other providers; knowing when and how to share information about one's own experiences; and using a PSU's own goals to guide the work.

Findings from the current study, and to a certain extent the descriptions of ideal practice presented in the Massachusetts document, highlight other areas of skill and experience that appear to be more specific to and/or salient in the work of young adult PSSs. For example, regarding lived experience, both sources begin from the assumption that the PSS is close enough in age to the PSU to be "credible," and "relatable." This is important not just because of the shared experience of being young *now*—in the context of current youth culture, social currents and economic and climate challenges—but also because systems and treatments, as well as the larger society's understanding and/or stigmatization of involvement in systems and treatments, are continually evolving. Compared to the practice skills/competencies documents for adult peer support, both young adult-focused sources place greater emphasis on skills related to supporting a PSU in their interactions and communications with family members, which seems quite natural given the larger role that families tend to play in the lives of emerging adults. Additionally, both of these sources are relatively

unconcerned with the PSS's role in supporting *recovery*, with its emphasis on returning to a former level of functioning, instead focusing more on skills related to supporting PSUs in *discovery* and *exploration*. As noted by Klodnick et al. (51), this focus for mental health services is appropriate to the developmental stage of young adulthood, during which young people are intensively engaged in building self-knowledge and identity (52). For example, both sources place quite a bit of emphasis on PSS skills for supporting young people to explore their own values, beliefs and attitudes, recognizing that these may evolve over time and may be different from the values and beliefs held by people who are or have been influential in their lives.

The main differences between the two young adult-focused sources are to some extent, though not exclusively, matters of emphasis and nuance. Skill area 1 from the current study, *Understanding and Describing the Peer Support Specialist Role*, focuses on a PSS's understanding of the PSS role—including how and why the role benefits PSUs—and their ability to communicate relevant aspects of this understanding in the course of their work with PSUs. Several of the skills listed in this area are unique to this study, and stem from the way that skills were developed as part of a larger study focused on theory development. Skill area 5, *Supporting Motivation and Activity*, describes a facet of PSS work that is focused on supporting a PSU's identity development by facilitating their interactions in a way that builds awareness of and connections to what the PSU finds truly compelling

and motivating—including values, passions and aspirations, as well as people and groups/organizations that are connected to these motivators. Compared to the Massachusetts document, the included skills appear to describe a mode of interaction in which the PSS is more intentional and active, employing reflections and active listening *while also* being acutely attuned to anything a PSU expresses that is connected to these motivators and offering openings for the PUS to explore further and/or take action if desired. Skill area 6, *Supporting Personal Agency and Empowerment*, shares a focus with the Massachusetts document (42) on skills for ensuring that the treatment plan and process, including work with the PSS, reflect the PSU's perspective and priorities. However, the skills from the current study have an explicit empowerment orientation, including an emphasis on supporting PSUs to develop confidence in their own agency, as well as an understanding of the power structures and power differentials in their own lives and how these interact with personal agency. For example, this area includes PSS skill for supporting PSUs in understanding power and how to “work with, negotiate with or confront power structures as they pursue activities and goals.” This skill area also notes PSSs' role in supporting PSUs to develop and use strategies for advocacy/self-advocacy. The current study's skills also include a unique focus on supporting a PSU to explore the meanings and values that they attach to their mental health experiences. This focus might seem natural given that about half of the study's participants were connected to FEP programs, and indeed the FEP discussion groups yielded quite a bit of

material on this topic. However, it was also a topic that was relevant to participants in the NDS groups, and in fact, the NDS participants rated this skill's importance even higher than the FEP participants did.

A further contribution of the current study stems from its development in conjunction with the theory of change from phase 1 of the project (39). This theory describes how, in the views of PSSs and PSUs, skilled practice enables the emergence of a peerness-based relationship, which in turn drives outcomes through specified mechanisms of change. The theory of change document matches the mechanisms described by PSSs and PSUs to theoretical mechanisms identified in the literature and supported by significant research, including Social Learning (53), Social Comparison (54), and Self-Determination (55) theories and research; research on interpersonal trust and reciprocal vulnerability (56,57); and research on expressed empathy/empathic listening as a key common factor in promoting client outcomes across a wide range of psychotherapeutic approaches (58,59). By linking to theory in this way, the set of skills developed in this study responds to the consistently-raised criticisms about a lack of theoretical foundation for the practice of peer support.

The current study most obviously distinguishes itself from other efforts due to its inclusion of key challenges related to each skill area. At the practice level, these findings describe specific types of situations that are typically difficult to manage and that PSSs are likely to encounter in their work directly with PSUs. These challenges highlight how, even when skills are

clearly defined, the PSS role remains complex and difficult, requiring PSSs to be intentionally involved in an ongoing process of deepening *their own* self-understanding and solidifying *their own* identity. Detailed information of this nature can be particularly valuable in training and supervision, which can be structured to help PSSs learn to anticipate (and potentially avoid), recognize and respond appropriately to challenging situations. For supervisors in particular, knowing about typical challenges may facilitate their ability to respond to issues that PSSs raise in supervision in a way that is sensitive to young adult development and that promotes self-understanding and identity development. Information about practice-level challenges can be useful for supervisors in another way: they are expected to provide guidance about handling such situations despite, in the large majority of cases, never having worked as a PSS themselves. Supervisors can review the challenges to determine their confidence and readiness to provide guidance and support to PSSs, and to seek further training or supervision for themselves to address any areas of uncertainty.

When FEP and NDS participants' ratings for sub-skills and challenges were considered separately, both groups saw each of the sub-skills and challenges as very important. This finding supports the idea that the fundamental PSS skills and challenges are the same across specialized (FEP) and more general (NDS) community mental health programming. Where there were discrepancies (i.e., where importance rankings between FEP PSSs and NDS PSSs were greatest), this could be explained by differences in the

populations served. For example, the relatively high importance rating that NDS participants gave to sub-skill 1e (explaining confidentiality/mandatory reporting) likely reflects the fact that these programs tend to serve a higher number of young people with histories of involvement in the child welfare/foster care systems. Similarly, the relatively high importance rating that FEP participants gave to sub-skill 3c (handling situations where PSUs are reluctant to engage in conversation or activities) is consistent with FEP study participants' comments about how frequently they encounter PSUs who appear to have low levels of motivation for interpersonal engagement. Despite the generally consistent and shared high level of endorsement for the subskills identified in the study, it seems very likely that PSSs in different kinds of programs will need a more nuanced repertoire within certain specific subskills. For example, key challenge 4a, under the general skill of *Providing Empathy and Validation*, has to do with how PSSs manage and respond "when feeling overwhelmed or unable to genuinely understand or validate emotional experiences or ideas that PSUs talk about, such as those connected to trauma; racism, sexism, homophobia, transphobia or other forms of oppression; and extreme or unusual experiences related to mental health." In FEP programs, the nuanced skill may have more to do with the "unusual experiences related to mental health," while in NDS programs, issues related to complex trauma and gender non-conformity will require extra skill and attention. Similarly, PSSs working in programs serving non-White populations or young people in extreme poverty may require nuanced

skill to respond and manage to PSUs experiences of racism, classism, other forms of oppression, and trauma.

Study findings related to challenges in the organizational context are consistent with themes from studies such as those cited in the introduction. Relative to these sources, findings here present a relatively comprehensive and concrete list of challenges. Also important is the way that these challenges are tied to PSS skill areas, reinforcing the causal connections between organizational context and PSSs' ability to skillfully carry out their work.

Findings from this study should be considered in light of limitations. Most obviously, the study samples were very small, and cannot be considered representative of PSSs/PSUs generally. While participants represented a range of sociodemographic backgrounds, our sample was mostly White, cisgender and well educated. It is likely that young adults who were relatively "successful" in mental health programs were overrepresented in our samples, i.e., PSUs that stayed in treatment, and PSSs who were perceived by their employers and/or themselves to be good sources of information about the role. Study participants were recruited through existing email lists and it is possible that these individuals have different perspectives from PSUs and PSSs connected to programs that are unconnected to national networks. Any of these factors could possibly have contributed to favorable inflated ratings of skill importance. Additionally, it should be remembered that the skills described here are limited to those for

working directly with PSUs. The study did not focus on other kinds of job skills that are needed for the role, such as skills related to time management, professional communication and punctuality, and skills related to teamwork and collaboration. Finally, many of the subskills as described here do not easily lend themselves to assessment or rating by an observer or supervisor. Further work would be to develop observational assessments or fidelity tools based on these skills.

Conclusions

Results from the study have practical implications for training, supervision and organizational development to support the PSS role. The concrete descriptions of skills and challenges makes practical application of the findings particularly feasible. Taken together, study findings on practice-level skills and challenges support their potential usefulness as a framework for structuring training, supervision and/or ongoing professional development for PSSs. Such trainings could easily be adapted to include special attention to situations most typically encountered in a particular program context (e.g., FEP versus NDS or other types of programs). As noted previously, the findings can also be useful in developing training for supervisors, and may be particularly helpful for supervisors with no experience in the peer role. Finally, the findings on organization-level challenges can be helpful to managers seeking understand the extent to which they are providing a hospitable context for their PSSs' work.

List of Abbreviations

FEP—First Episode of Psychosis

NDS—Non-Diagnosis Specific

PSS—Peer Support Specialist

PSU—Peer Support User

Declarations

Ethics approval and consent to participate: The study protocols were approved by the Institutional Review Board (IRB) at Portland State University in accordance with the regulations of the United States Department of Health and Human Services (45-CFR part 46). In accordance with these regulations, electronic informed consent was obtained from all participants involved in the study, and participation was voluntary.

Consent for publication: Not applicable

Availability of data and materials: The dataset analyzed during the current study available from the corresponding author on reasonable request.

Competing interests: The authors declare that they have no competing interests.

Funding: National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR grant number 90IFRE0054). NIDILRR is a Center within the Administration for Community Living (ACL), United States Department of Health and Human Services (HHS).

Authors' contributions: JSW Conceptualized the study. JSW, VVK, BP, MH-K and SMB collaboratively developed the questions/items for the qualitative/quantitative portions of the study and analyzed the data. BP took the lead for recruitment. BP, MH-K, RPJ, VVK and JSW facilitated/co-facilitated discussion groups. JSW and VVK took the lead in preparing the manuscript, with all authors participating in editing manuscript drafts. All authors read and approved the final version.

Acknowledgements: The authors would like to thank the Peer Support Specialists and peer support users who participated in this study. The contents of this article were developed under a grant from the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR grant number 90IFRE0054). NIDILRR is a Center within the Administration for Community Living (ACL), United States Department of Health and Human Services (HHS). The contents of this article do not necessarily represent the policy of NIDILRR, ACL, or HHS, and you should not assume endorsement by the Federal Government.

References

1. Adams WE. Unintended consequences of institutionalizing peer support work in mental healthcare. *Soc Sci Med*. 2020;262(July).
2. Burr C, Rother K, Elhilali L, Winter A, Weidling K, Kozel B, et al. Peer support in Switzerland – Results from the first national survey. *Int J Ment Health Nurs*. 2020;29(2):212–23.
3. Gillard S. Peer support in mental health services: Where is the research taking us, and do we want to go there? *J Ment Health*. 2019;28(4):341–4.
4. Klee A, Chinman M, Kearney L. Peer specialist services: New frontiers and new roles. Vol. 16, *Psychol Services*. 2019. p. 353–9.
5. Puschner B, Reppe J, Mahlke C, Nixdorf R, Basangwa D, Nakku J, et al. Using peer support in developing empowering mental health services (UPSIDES): Background, rationale and methodology. *Ann Glob Health*. 2019;85:53.
6. Gopalan G, Lee SJ, Harris R, Acri MC, Munson MR. Utilization of peers in services for youth with emotional and behavioral challenges: A scoping review. *J Adolesc*. 2017;55:88–115.
7. Hawke LD, Mehra K, Settipani C, Relihan J, Darnay K, Chaim G, et al. What makes mental health and substance use services youth friendly? A scoping review of literature. *BMC Health Serv Res*. 2019;19:1–16.
8. Simmons MB, Cartner S, MacDonald R, Whitson S, Bailey A, Brown E. The effectiveness of peer support from a person with lived experience of mental health challenges for young people with anxiety and depression: A systematic review. *BMC Psychiatry*. 2023;23:1–20.
9. WESTAT. The Mental Health Block Grant Ten Percent Set Aside Study brief report: Peer support in CSC programs. 2019. <http://nri-inc.org/our-work/?focus=First+Episode+Psychosis>. Accessed 5 February 2025.
10. Hopkins L, Pedwell G, Wilson K, Howell-Jay P. Implementing youth peer support in an early psychosis program. *J Ment Health Train Educ Pract*. 2021;16:85–98.
11. WESTAT. The Mental Health Block Grant Ten Percent Set Aside Study brief report: National overview of CSC programs. 2019. <http://nri-inc.org/our-work/?focus=First+Episode+Psychosis>. Accessed 5 Feb 2025.
12. Bellamy C, Schmutte T, Davidson L. An update on the growing evidence base for peer support. *Mental Health and Social Inclusion*. 2017;21:161–7.

13. Smit D, Miguel C, Vrijzen JN, Groeneweg B, Spijker J, Cuijpers P. The effectiveness of peer support for individuals with mental illness: Systematic review and meta-analysis. *Psychol Med*. 2023 Aug 6;53:5332–41.
14. Høgh Egmos C, Heinsvig Poulsen C, Hjorthøj C, Skriver Mundy S, Hellström L, Nørgaard Nielsen M, et al. The effectiveness of peer support in personal and clinical recovery: Systematic review and meta-analysis. *Psychiatr Serv*. 2023;74:847–58.
15. de Beer CRM, Nooteboom LA, van Domburgh L, de Vreugd M, Schoones JW, Vermeiren RRJM. A systematic review exploring youth peer support for young people with mental health problems. *Eur Child Adolesc Psychiatry*. 2024;33:1233
16. Murphy R, Huggard L, Fitzgerald A, Hennessy E, Booth A. A systematic scoping review of peer support interventions in integrated primary youth mental health care. *J Community Psychol*. 2024;52:154–80.
17. Cronise R, Teixeira C, Rogers ES, Harrington S. The peer support workforce: Results of a national survey. Vol. 39, *Psychiatric Rehabilitation Journal*. American Psychological Association Inc.; 2016. p. 211–21.
18. Lloyd-Evans B, Mayo-Wilson E, Harrison B, Istead H, Brown E, Pilling S, et al. A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry*. 2014;14:39.
19. Crane DA, Lepicki T. Unique and common elements of the role of peer support in the context of traditional mental health services. *Psychiatr Rehabil J*. 2016;39:282–8.
20. Simmons MB, Grace D, Fava NJ, Coates D, Dimopoulos-Bick T, Batchelor S, et al. The experiences of youth mental health peer workers over time: A qualitative study with longitudinal analysis. *Community Ment Health J*. 2020;56:906–14.
21. Walker G, Bryant W. Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatr Rehabil J*. 2013 Mar;36:28–34.
22. de Beer CRM, van Domburgh L, Vermeiren RRJM, de Vreugd M, Nooteboom LA. Improving collaboration between youth peer support workers and non-peer colleagues in child and adolescent mental health services. 2023;50:824–33.

23. Delman J, Klodnick V V. Factors supporting the employment of young adult peer providers: perspectives of peers and supervisors. *Community Ment Health J.* 2017;53:811-22.
24. Halsall T, Daley M, Hawke LD, Henderson J, Wilson A, Matheson K. "I think peer support helps to demystify people who have mental health issues and helps to remove that stigma": exploring the defining characteristics and related challenges of youth peer support. *Community Ment Health J.* 2024;60:784-95.
25. Watson E. The mechanisms underpinning peer support: A literature review. *J Ment Health*;28:6,677-688.
26. Byrne L, Roennfeldt H, Wolf J, Linfoot A, Foglesong D, Davidson L, et al. Effective peer employment within multidisciplinary organizations: model for best practice. *Adm Policy Ment Health.* 2022;49:283-97.
27. Firmin RL, Mao S, Bellamy CD, Davidson L. Peer support specialists' experiences of microaggressions. *Psychol Serv.* 2019;16:456-62.
28. Shepardson RL, Johnson EM, Possemato K, Arigo D, Funderburk JS. Perceived barriers and facilitators to implementation of peer support in Veterans Health Administration primary care-mental health integration settings. *Psychol Serv.* 2019;16:433-44.
29. Farkas M, Boevink W. Peer delivered services in mental health care in 2018: Infancy or adolescence? *World Psychiatry.* 2018;17:222-3.
30. Chinman M, McInnes K, Sisen S, Ellison M, Farkas M, Armstrong M, et al. Establishing a research agenda for understanding the role and impact of mental health peer specialists. *Psychiatr Serv.* 2017;68:955-7.
31. Gillard S, Gibson SLL, Holley J, Lucock M. Developing a change model for peer worker interventions in mental health services: a qualitative research study. *Epidemiol Psychiatr Sci.* 2015;24:435-45.
32. King AJ, Simmons MB. A systematic review of the attributes and outcomes of peer work and guidelines for reporting studies of peer interventions. *Psychiatr Serv.* 2018;69:961-71.
33. Mental Health Commission of Canada. Guidelines for the practice and training of peer support. 2013<http://www.mentalhealthcommission.ca>. Accessed 5 Feb 2025.
34. Substance Abuse and Mental Health Services Administration. Core competencies for peer workers in behavioral health services. 2018. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/co-re-competencies_508_12_13_18.pdf. Accessed 5 Feb 2025.

35. National Federation of Families. National Core Competencies 202. <https://www.ffcmh.org/certification-competencies>. Accessed 5 Feb 2025.
36. Mental Health America. Nationally certified peer specialist core competencies. 2016. <https://flcertificationboard.org/wp-content/uploads/MHA-NCPS-Training-and-Test-Self-Assessment-1.pdf>. Accessed 5 Feb 2025.
37. Jivanjee P, Grover L, Thorp K, Masselli B, Bergan J, Brennan EM. Training needs of peer and non-peer transition service providers: results of a national survey. *J Behav Health Serv Res*. 2020;47:4–20.
38. Walker JS, Seibel C, Burnett S, Baird C, Welch MB. Evaluation of a skills enhancement training intervention with remote coaching for young adults providing peer support. *Psychiatr Serv*. 2022;73:1190–2.
39. Walker JS, Klodnick V V., LaPelusa B, Blajeski SM, Freedman AR, Marble S. A theory of change for one-on-one peer support for older adolescents and young adults. *Child Youth Serv Rev*. 2024:107386.
40. Halsall T, Daley M, Hawke L, Henderson J. Exploring peer support services for youth experiencing multiple health and social challenges in Canada: A hybrid realist-participatory evaluation model. *Int J Qual Methods*. 2021;20:1–13.
41. Hiller-Venegas S, Gilmer TP, Jones N, Munson MR, Ojeda VD. Clients' perspectives regarding peer support providers' roles and support for client access to and use of publicly funded mental health programs serving transition-age youth in two Southern California counties. *J Behav Health Serv Res*. 2022;49:364–84.
42. Children's Behavioral Health Knowledge Center. Young adult peer mentoring practice profile. 2017. <https://www.cbhknowledge.center/practice-profiles/young-adult-peer-mentoring/>. Accessed 5 Feb 2025.
43. Mueser KT, Penn DL, Addington J, Brunette MF, Gingerich S, Glynn SM, et al. The NAVIGATE program for first-episode psychosis: Rationale, overview, and description of psychosocial components. *Psychiatr Serv*. 2015;66:680–690.
44. Melton RP, Roush SN, Sale TG, Wolf RM, Usher CT, Rodriguez, CL, McGorry, PD. Early intervention and prevention of long-term disability in youth and adults: The EASA model. In: Yeager KR, Cutler DL, Svendsen D, Sills GM (eds.), *Modern community mental health: An interdisciplinary approach* (256-275). Oxford: Oxford University Press; 2013.

45. Bruns EJ, Walker JS, Bernstein A, Daleiden E, Pullmann MD, Chorpita BF. Family voice with informed choice: Coordinating Wraparound with research-based treatment for children and adolescents. *J. Clin. Child Adolesc. Psychol.* 013 Dec 10;43:256–269.
46. Dresser K, Clark Hewitt BB, Deschênes N. Implementation of a positive development, evidence-supported practice for emerging adults with serious mental health conditions: The Transition to Independence Process (TIP) Model. *J Behav Health Serv Res.* 2015;42:223–37.
47. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;2:77–101.
48. Kiger ME, Varpio L. Thematic analysis of qualitative data: AMEE Guide No. 131. *Med Teach.* 2020;42(8).
49. Braun V, Clarke V. Understanding TA. 2025
<https://www.thematicanalysis.net/understanding-ta/>. Accessed 1 Dec 2025.
50. Braun V, Clarke V. Doing Reflexive TA. 2025
<https://www.thematicanalysis.net/doing-reflexive-ta/>. Accessed 1 Dec 2025.
51. Klodnick V V., Malina C, Fagan MA, Johnson RP, Brenits A, Zeidner E, et al. Meeting the developmental needs of young adults diagnosed with serious mental health challenges: The Emerge model. *J Behav Health Serv Res.* 2021;48:77–92.
52. Arnett JJ. Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist.* 2000;55:469–80.
53. Bandura A. Social learning theory. Englewood Cliffs, NJ: Prentice Hall; 1977.
54. Festinger L. A theory of social comparison processes. *Hum Relat.* 1955;7:117–42.
55. Deci EL, Ryan RM. Self-determination theory: A macrotheory of human motivation, development, and health. *Can Psychol.* 2008;49:182–5.
56. Luhmann N. Trust: Making and breaking cooperative relations. New York: Blackwell; 1988.
57. Lewicki RJ, Tomlinson EC, Gillespie N. Models of interpersonal trust development: Theoretical approaches, empirical evidence, and future directions. *J Manage.* 2006 Dec;32:991–1022.
58. Wampold BE. How important are the common factors in psychotherapy? An update. *World Psychiatry.* 2015 Oct 1;14:270–7.

59. Murphy D, Joseph S. Person-centered therapy: Past, present and future orientations. In Cain DJ, Keenan K, Rubin S (eds.), *Humanistic psychotherapies: Handbook of research and practice* (2nd ed., 185-218). Washington DC: American Psychological Association.

ARTICLE IN PRESS

Table 1: Phase 1 Participant Characteristics

Characteristic	n	%
Peer support specialist (PSS)		
First episode psychosis (FEP)	16	45.7
Non-diagnosis-specific (NDS)	19	54.3
Peer support user (PSU)		
First episode psychosis (FEP)	6	35.3
Non-diagnosis-specific (NDS)	11	64.7
Racial/ethnic background		
White	37	71.2
Black	7	13.5
Latino/a/x	6	11.5
Asian	2	3.8
Gender identity		
Male	18	34.6
Female	27	52.9
Non-binary	7	13.5

Table 2: PSS General Skill Areas, Sub-Skills and Related Practice and Contextual Challenges, with Mean Importance Ratings for All Participants, and FEP/NDS Separately

Description	Mean Importance Rating (FEP/NDS)
1) Understanding and Describing the Peer Support Specialist Role	
PSSs are clear about the purpose of the PSS role. They accurately and succinctly describe their role, including issues related to confidentiality and relational boundaries, to PSUs and others (e.g., colleagues, community members).	
Sub-Skills. A PSS...	
a. Understands and can describe the purpose of the PSS role and how skilled practices benefit PSUs.	4.64 (4.69/4.56)
b. Understands and communicates clearly what distinguishes the PSS role from other roles on the treatment team, and what distinguishes the PSS role from that of a friend.	4.68 (4.69/4.67)
c. Understands and explains why they are considered a "peer."	4.45 (4.62/4.22)
d. Introduces their role concisely and provides ongoing role clarification as needed by providing further details or answering questions about their role.	4.59 (4.54/4.67)
e. As part of introducing their role, clearly describes confidentiality between themselves and a PSU, as well as situations such as mandatory reporting when confidentiality may be broken.	4.68 (4.46/5.00)
f. Describes boundaries that limit what they can/cannot do as part of the PSS role.	4.86 (4.85/4.89)
Related Practice Challenges	
a. Understanding and communicating how the PSS role is distinct from other peer-like roles such as mentor, peer mentor, skills trainer, etc.	4.32 (4.38/4.22)
b. Being internally confident about boundaries and clarifying/re-establishing them if a PSU appears to have expectations for the PSS that are outside of the PSS role.	4.64 (4.69/4.56)
c. Determining how much personal information about lived/living experience is helpful to share and comes across as authentic when introducing/describing the role.	4.59 (4.54/4.67)
Related Challenges in the Larger Context	
a. Remaining confident about the PSS role's scope, purpose, practices and skills, even when supervisors or co-workers are unclear or present different views about these.	*
b. Managing situations when family's or other team members' misunderstanding of the PSS role leads them to expect that the PSS will do things that are not part of the role.	*
2) Being a Peer, Being Genuine and Drawing on Personal Experience	
PSSs present themselves and talk about personal experiences with intention, in a way that is genuine and helpful to PSUs.	
Sub-Skills. A PSS...	
a. Cultivates a manner of self-presentation and speaking that is genuine and not overbearing or self-centering.	4.65 (4.65/4.64)
b. Offers knowledge, observations or anecdotes from personal experience for PSUs to consider, without implying that PSUs should believe, feel or act the same way.	4.58 (4.71/4.43)

c. Is open and genuine about personal experiences without distressing PSUs or themselves.	4.68 (4.76/4.57)
d. Serves as an example of a young adult who has experienced—and may continue to experience—mental health challenges, and who has had success—and setbacks—in navigating life and employment while managing their mental health and wellness.	4.70 (4.69/4.71)
Related Practice Challenges	
a. Recognizing and managing if oversharing personal experience, for example, i. as a way to prove worthiness as a peer; ii. in a way that overwhelms a PSU, diminishes the PSU's own experiences, or distresses the PSS; or iii. to serve the PSS's own purposes, such as venting, or prompting a PSU to provide emotional support.	4.58 (4.47/4.71)
b. Feeling comfortable discussing past, current or ongoing struggles or setbacks with PSUs in a way that is genuine but also does not discourage or distress the PSS or PSU.	4.56 (4.71/4.45)
c. Being internally aware about when and how much lived/living experience to share with PSUs, and managing situations when a PSU presses a PSS to share more about their experiences than the PSS is comfortable with.	4.41 (4.46/4.33)
d. Managing situations when a PSS does not share key aspects of identity or experience with a PSU (e.g., difference in gender or sexual orientation, race/ethnicity, socioeconomic status), so that it may be difficult for a PSS to understand a PSU or for a PSU to feel understood. Being comfortable acknowledging differences and talking about them with PSUs when they come up.	4.61 (4.76/4.43)
Related Challenges in the Larger Context	
a. Managing situations where managers, supervisors or non-peer colleagues i. ask the PSS to share their lived/living experiences in settings or in ways that the PSS is not comfortable with; ii. share PSS lived experience with PSUs, colleagues, and/or community members; or iii. ask PSS inappropriate questions about their mental health and treatment.	*
3) Drawing Out and Supporting PSUs' Preferences, Perspectives and Ideas PSSs support PSUs to explore their own values, preferences, thoughts and ideas. PSSs do this in a way that is non-judgmental and shows genuine curiosity and interest in what PSUs express. PSSs do not try to convince PSUs what to do, say or think. PSSs follow PSUs' lead regarding if and when to meet, and what to do or talk about.	
Sub-Skills. A PSS...	
a. Maintains a non-judgmental attitude, using active listening skills to support PSUs in sharing and exploring their experiences, values, ideas, preferences and perspectives.	4.94 (5.00/4.87)
b. Makes reflections that fit well within the conversation and accurately restates or summarizes key content that PSUs bring up.	4.56 (4.59/4.53)
c. Gauges when a PSU doesn't want to participate in certain activities or talk about certain things, or when they do not want to talk at all.	4.63 (4.82/4.40)
d. Makes observations and offers ideas for a PSU to consider, without putting pressure on them to agree.	4.56 (4.65/4.47)
e. Identifies and remembers key content from conversations or interactions with PSUs, and bring this into later conversations when relevant.	4.50 (4.65/4.33)
f. Is comfortable acknowledging when they have misunderstood what a PSU is communicating. Acknowledges misunderstandings as needed and then returns the focus of the conversation to the PSU's thoughts and ideas.	4.91 (4.88/4.93)

Related Practice Challenges	
a. Resisting a desire to fix things for the PSU, or steer them towards what the PSS thinks they should think or do.	4.31 (4.18/4.47)
b. Remaining patient, empathic and non-directive when a PSU is reluctant or unable to share their thoughts, ideas or preferences.	4.28 (4.24/4.33)
c. Remaining empathic and non-directive when PSUs raise topics that the PSS finds difficult or uncomfortable, or when they do not share ideas or opinions expressed by a PSU (e.g., topics connected to sexuality, privilege/oppression, substance use, political views, religious beliefs).	4.66 (4.76/4.53)
d. Handling situations when a PSS has concerns that a PSU's thinking or reasoning may lead them to do something that is risky or harmful—including suicidality or self-harm—or that sets them back from their own goals. Knowing when it's appropriate to break confidentiality to ensure safety.	4.34 (4.29/4.40)
Related Challenges in the Larger Context	
a. Navigating situations when clinicians or family members put pressure on a PSS to "make" a PSU change their thinking or behavior.	*
4) Providing Empathy and Validation PSSs attend to, empathize with and validate PSUs' emotional expression and tone—positive, negative and mixed. Across their interactions and communication together, PSSs create opportunities for PSUs to explore topics or ideas that are important or meaningful to them.	
Sub-Skills. A PSS...	
a. Provides validation and empathy that is rooted in the PSU's perspective.	4.74 (4.82/4.64)
b. Recognizes and validates when PSUs indicate things that are important or meaningful to them. Creates opportunities them to explore these topics if they want to.	4.77 (4.76/4.79)
c. Recognizes and responds to emotional content PSUs express—including positive, negative and mixed emotions in conversations or actions.	4.71 (4.76/4.64)
d. Assesses and/or asks when it would be helpful to go deeper into emotionally significant topics and help PSUs explore further.	4.61 (4.71/4.50)
e. Normalizes PSUs' experiences appropriately through reflections, observations, etc.	4.84 (4.88/4.79)
f. Is comfortable discussing safety concerns and developing safety strategies, and confident about when and how to contact other providers due to safety concerns.	4.57 (4.63/4.50)
g. Manages their own reactions to what PSUs may disclose, including vicarious trauma and distress. Knows how to seek support for themselves in processing these experiences and creating boundaries.	4.77 (4.76/4.79)
Related Practice Challenges	
a. Responding and managing (and knowing how to seek supervision/support) when feeling overwhelmed or unable to genuinely understand or validate emotional experiences or ideas that PSUs talk about, such as those connected to trauma; racism, sexism, homophobia, transphobia or other forms of oppression; and extreme or unusual experiences related to mental health.	4.58 (4.65/4.50)
b. Offering a normalizing perspective when appropriate, without discounting a PSU's experiences.	**
c. Knowing how to avoid making reflections or responses that come across as inauthentic, exaggerated or misaligned with what PSUs are communicating, including over-empathizing or being excessively enthusiastic or positive.	4.35 (4.53/4.14)

d. Handling situations when a PSU thinks (or appears to think) that the PSS can't really understand them due to different styles of communication, personal experiences, identities, cultures and values, socio-economic status, etc.	4.42 (4.59/4.21)
e. Recognizing when topics may be too activating or unhelpful to explore with PSUs in peer support, and knowing when and how to assist a PSU in getting additional support from other providers.	4.58 (4.65/4.50)
Related Challenges in the Larger Context	
a. Navigating differences in perceptions between young people (i.e., PSSs/PSUs) and older adults (supervisors, co-workers, PSUs' family members) regarding statements, behavior or activity that is normal, versus what is dangerous, threatening or risky.	*
b. Navigating clinical staff's lack of clarity about whether the empathy and validation provided by PSSs is therapeutic, and how this differs from providing psychotherapy.	*
5) Supporting Motivation and Activity PSSs are attentive to things PSUs say and do that provide information about what motivates them, including values, commitments and passions, as well as relationships and activities that bring satisfaction or joy. PSSs support PSUs in exploring these motivators from their own perspectives. When PSUs show interest, PSSs partner with PSUs to develop plans or goals based on what emerges, and to carry out activities in the community with PSS support if desired.	
Sub-Skills. A PSS...	
a. During conversations and activities with a PSU, notices and offers openings for PSUs to recognize and explore their motivators, including i. aspirations, interests and passions; ii...personal, family and cultural values and commitments; and iii. activities and relationships that bring joy, satisfaction, pleasure, or a sense of accomplishment or achievement.	4.73 (4.62/4.89)
b. During conversations and activities with a PSU, notices and offers openings for PSUs to recognize and explore their ideas and preferences related to wellbeing, including self-care, wellness, personal safety and harm reduction.	4.59 (4.46/4.78)
c. During conversations and activities with a PSU, notices and offers openings for PSUs to build recognition about the people, groups and organizations that support their aspirations, values and wellbeing, or that could do so.	4.59 (4.62/4.56)
d. When PSUs show interest, works with them to plan and engage in activities together in the community that reflect PSU motivators and preferences (i.e., as explored in conversations described above).	4.40 (4.25/4.67)
e. Uses opportunities that arise during conversations, interactions or activities to reflect PSUs' awareness of their personal growth, learning, progress and success, even when changes, progress or accomplishments are small.	4.73 (4.77/4.67)
Related Practice Challenges	
a. Managing any desire to "get" a PSU to pursue goals or activities when they are not internally motivated to do this.	4.59 (4.62/4.56)
b. Knowing how to respond when a PSU has passions, goals or sources of pleasure that the PSS sees as harmful, unrealistic or undesirable.	4.50 (4.31/4.78)
c. Remaining patient, empathic and non-directive when a PSU does not talk much, does not bring up motivators, values, commitments and activities, and/or generally does not seem to express interest, joy, excitement or motivation.	4.32 (4.31/4.33)

d. Understanding the difference between reflecting/supporting a PSU's own perceptions of their strengths, growth, learning and progress, versus giving praise or affirmation from the point of view of the PSS or other people.	**
Related Challenges in the Larger Context	
a. Responding to supervisors, other treatment team members or family members when they expect or direct a PSS to pursue goals or activities that are not in alignment with a PSU's preferences or motivators.	*
b. Negotiating situations when organizational rules or culture dictate what sorts of PSU activities are meaningful or important, thereby limiting the support that PSSs can offer when PSUs are motivated to engage in other kinds of activities.	*
6) Supporting Personal Agency and Empowerment PSSs are attentive to opportunities to support PSUs in exploring options and making choices about mental health treatment and other aspects of their lives.	
Sub-Skills. A PSS...	
a. Is attuned when a PSU expresses thoughts related to having a mental health diagnosis and mental or emotional experiences that are unusual and/or stigmatized, and provides an opportunity for them to explore these thoughts further if they wish. This includes exploring the meanings and values that PSUs attach to their experiences.	4.82 (4.77/4.89)
b. Is attuned when a PSU touches on topics related to mental health treatment and other strategies for improving/maintaining wellness and mental health, and provides an opportunity for them to explore these thoughts further if they wish.	4.68 (4.62/4.78)
c. Is attentive when a PSU is considering a decision or change, helps them to recognize options, explore choices and take action that is aligned with their values and goals.	4.82 (4.85/4.78)
d. Models and offers strategies for accessing sources and information about various options and choices.	4.55 (4.54/4.56)
e. Offers strategies that can help a PSU effectively advocate for their own choices, preferences and goals.	4.59 (4.54/4.67)
f. Assists PSUs in understanding power differentials (e.g., between individuals with different identities or roles, or between individuals and organizations, institutions or systems) and how these may impact their ability to make progress on their goals. Provides PSUs with information and strategies on how to work with, negotiate with or confront power structures as they pursue activities and goals.	4.73 (4.69/4.78)
Related Practice Challenges	
a. Remaining comfortable, empathic and non-judgmental when a PSU's interpretation of their mental health experiences or choices regarding treatment are difficult for a PSS to understand or accept.	4.68 (4.54/4.89)
b. Being able to talk with PSUs—and manage own reactions—about situations in which a lack of power and/or resources poses significant barriers to PSUs' efforts towards their goals.	4.64 (4.54/4.78)
c. Supporting a PSU in situations in which other treatment team members, or other key people in a PSU's life, may be pressuring a PSU to accept a specific interpretation of their mental experiences, or to accept specific treatment recommendations.	4.64 (4.69/4.56)
d. Keeping what a PSU says confidential, unless the PSU specifically provides permission to share; and making sure PSUs understand any exceptions when confidentiality might be broken.	4.75 (4.94/4.53)
Related Challenges in the Larger Context	

a. Responding appropriately when treatment team members or family members expect a PSS to speak for a PSU about topics or issues that the PSU has not given permission for the PSS to discuss with others.	*
b. Managing and responding to situations when treatment team members or family members pressure a PSS to undercut a PSU's agency, for example by asking the PSS to "get" a PSU to comply with the team's/family's view of treatment or medication.	*

* These key challenges in the organizational context were not included on the survey and were thus not rated by respondents.

** These items were substantially changed from their original forms, so the ratings provided in the survey do not apply to the revised items.