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Promoting Health and Wellness Through Peer-Delivered Services: Three Innovative State Examples

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Objective: This article provides examples of the development, implementation, and funding of peer-delivered health and wellness services in three states. Health and wellness services are critical to addressing the health disparities facing people living with mental health and substance use disorders served by the public behavioral health care system. ***Methods:*** Information was compiled from the authors' experiences as champions in three states (Georgia, Michigan, and New Jersey) and the National Association of State Mental Health Program Directors, as well as documents from and discussions with local state and national sources. ***Results:*** Key issues for the implementation and expansion of peer-delivered health and wellness services include defining the model to be disseminated, providing training to prepare the peer workforce, accessing funding for implementation, and establishing clear expectations to sustain the services and maintain quality over time. ***Conclusions and Implications for Practice:*** Peer-delivered health and wellness services can help address the health disparities facing people who are living with mental health and substance use disorders through a variety of innovative models tailored to local needs and circumstances.

Keywords: peer support, whole health, wellness, mental health, recovery

Nearly a decade has passed since the release of the landmark technical report documenting the now well-known findings that people with serious mental illnesses die, on average, 25 years earlier than people in the general population. The evidence that these deaths are the result of preventable causes that are either concomitant with the mental illnesses or side effects of treatment drugs served to mobilize many stakeholders to proactively address this unacceptable health concern. Many people in recovery, care providers, and family members were acutely aware of these physical health concerns, such as obesity and heart disease, and their impact on health, wellness, life span, and quality of life. However, they did not seem to know how to provide or obtain encouragement, access support, set goals for and pursue healthy lifestyles, or access needed treatments. To address this gap, the peer community has adopted, modified, developed, and implemented services to support people in recovery in their efforts to create and sustain a healthy lifestyle centered on wellness.

The passage of the Affordable Care Act (2010), with its heavy focus on prevention, created many opportunities for developing and funding peer-delivered whole health and wellness services. Many states have already initiated successful programs. This article highlights successes in three states and provides examples and ideas that others can draw upon to start, expand, or improve peer-delivered health and wellness services in their own jurisdictions.

Peer-Delivered Health and Wellness Services

The peer movement has a 40-year history of designing and offering alternative supports for and by persons who have personal experiences with the behavioral health system. Peer leaders were quick to embrace the notion of *peer-delivered health and wellness services,* a generic term encompassing a variety of peer-delivered models that have become important components of the most effective recovery-oriented service delivery systems. Peer-delivered health and wellness services are important complements for an integrated care team model working to help a system merge the concepts of recovery with physical well-being and overall recovery (Swarbrick, 2013). Health and wellness services have, in many states, become a subspecialty of peer support, with the development of programs to train and employ peer workers to provide these services in order to enhance quality of life and extend life span. An effort to support and expand these services was the focus

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of the 2011 Pillars of Peer Support Services Summit at the Carter Center in Atlanta, Georgia (Daniels et al., 2012).

Peer-delivered health and wellness services is an umbrella term used here to describe interventions and program models that involve a peer worker with specialized training who may have previously completed a certification program as a peer specialist. The specialized provider role involves assisting an individual with accessing needed care and prevention services, helping set personal health goals to promote recovery and a wellness lifestyle, and providing support for adopting and sustaining healthy habits and behaviors in order to prevent disease onset and/or lessen the impact of existing chronic health conditions (Swarbrick, 2013). In keeping with the philosophy and principles of peer support, the individual served is seen as the director of his or her health. Health engagement or activation and health/illness self-management are key objectives of peer-delivered health and wellness services and are accomplished by facilitating health dialogues; exploring the many options for health and wellness engagement; supporting the individual in overcoming fears and anxiety related to engaging with health care providers and procedures; promoting engagement with health practitioners, including, at a minimum, participating in an annual physical; assisting the individual in finding a compatible primary physician who is trusted; and providing support for engagement in other health and wellness activities as needed. By helping individuals take charge of their own health via adopting simple and practical strategies for making positive changes in their health behaviors, peer-delivered health and wellness services provide an avenue for reversing the disturbing trend toward poor health, shortened life spans, and poor quality of life.

Goldberg and colleagues (2013) conducted a controlled study involving peer participation in health promotion for persons with serious mental illnesses. They created Living Well, which was a modified version of Lorig's Chronic Disease Self-Management Program (Lorig, 1999). Living Well participants demonstrated improvements in self-efficacy, patient activation, illness self-management, overall well-being, and general health functioning outcomes.

Another program, called the Health and Recovery Program (HARP), is a manualized self-management intervention delivered by mental health peer providers to help participants become more effective managers of their chronic illnesses and improve their health-related quality of life (Druss et al., 2010). Physical health-related quality of life, physical activity, and medication adherence improvements have all been shown to be among the positive outcomes in implementing the HARP program (Druss et al., 2010). Peer wellness coaching has also been used to help individuals with serious mental illnesses who are obese or overweight to decrease their overall weight. In a small 6-month pilot study of 10 individuals, over half lost a mean weight of 2.7 kg, showing that peer coaching may be an effective intervention to help individuals with serious mental illnesses to lose weight (Aschbrenner et al., 2015).

On August 15, 2007, a letter was released by the Centers for Medicare & Medicaid Services (CMS), the single largest payer for behavioral health services in the United States (Smith, 2007), identifying mental health peer support services as an evidence-based mental health model of care. This opened the doors for many states across the country to modify state Medicaid mechanisms to add peer support services among those reimbursed by Medicaid.

Also in 2007, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Mental Health Services created the Transformation Transfer Initiative (TTI) to assist and give states the opportunity to increase efforts in transforming their state behavioral health delivery systems to be more consumer and family driven and to break down the silos of state government that impede recovery and resiliency. It began as a demonstration project that sought to provide—on a competitive basis—flexible "tipping point" resources for innovative state projects and has subsequently shown clear evidence of success, sustainability, and positive impact of these projects on state behavioral health systems. The vast majority of the 80 TTI project have been centered on developing, growing, and sustaining peer support programs. Three of the original TTI projects—Georgia, Michigan, and New Jersey—infused whole health and wellness into peer specialist training and created peer-delivered health and wellness services to combat the average 25-year premature death expectancy of consumers served in the public behavioral health care sector (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2014).

In 2007, there were 14 states using Medicaid to fund peer support services, and at the time of this writing, 37 states and the District of Columbia use Medicaid to fund peer support services, although not all of these include specialized peer-delivered health and wellness services.

Examples of Peer-Delivered Health and Wellness Services

As might be expected, implementation of peer-delivered health and wellness services has varied significantly, with different startup processes, interventions and program models, peer provider training programs, and funding for sustainability. Successful peer-delivered health and wellness services efforts in three states are described here and identify key elements for successful implementation. These three states, Georgia, New Jersey, and Michigan, were selected as examples because they (a) were members of the inaugural TTI cycle, and they all have shown great success; (b) have led the way on whole health peer support by adopting curricula that make whole health a tenet in their peer support (specialist) trainings; (c) represent geographic and population diversity; (d)have been models for and given technical assistance to many other states; and (e) have created three separate paths and curricula that other states/territories could adopt/adapt.

Georgia

Startup process. The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) was the first to receive Medicaid fee-for-service reimbursement for peer support in 1999. Since that time, the state has created a workforce of more than 1,400 certified peer specialists (CPSs) who have infused recovery principles into the community behavioral health system. Beginning in 2006, Georgia began to target health improvement by introducing wellness interventions into its peer support services (Agency for Healthcare Research and Quality, 2014). In 2009, Georgia received a TTI grant to create pilot programs for a service called Peer Support Whole Health and Resiliency (PSWHR) and, through this grant, demonstrated the positive impact that CPSs can have when working with individuals on promoting health engage-

ment, developing motivation, setting goals, and achieving positive outcomes (Druss et al., 2010).

The Georgia Mental Health Consumer Network (GMHCN), a peer-run statewide nonprofit organization, has been a partner throughout the development of this policy and has complemented this work using grants providing opportunities for people in recovery to learn about whole health through their annual consumer conferences. Since 2006, the consumer conference has had keynote speakers and learning tracks to promote healthy lifestyles and wellness. GMHCN also has received consumer networking grants that have supported PSWHR.

Interventions and program model. PSWHR is based on a foundation of self-directed, strength-based recovery and the principles and practices of peer support. The process includes person-centered planning that focuses on a person's strengths, interests, and natural supports, while assisting individuals to choose and create new healthy lifestyle habits and disciplines. PSWHR draws from two evidence-based programs (Fricks & Jenkins-Tucker, 2014). These include the relaxation response (Benson & Klipper, 2000), developed at the Benson-Henry Institute for Mind Body Medicine based at Massachusetts General Hospital, and HARP, which was adapted from the Chronic Disease Self-Management Program (CDSMP) based at Stanford University (Druss et al., 2010). With the support of the SAMHSA Health Resource and Services Administration (HRSA) Center for Integrated Health Solutions, this training has evolved into Whole Health Action Management (WHAM; Fricks, Powell, & Swarbrick, 2012), a 10-session program with a participant manual and leader guide available from SAMHSA. The PSWHR pilot led the Georgia state mental health authority to create a statewide service named Peer Support Whole Health and Wellness (Georgia Department of Behavioral Health and Developmental Disabilities, 2015), which is provided by trained CPSs who assist individuals by helping set personal expectations, introducing health objectives as an approach to accomplishing overall life goals, helping identify personal and meaningful motivations, and promoting health/wellness self-management. Individuals served are encouraged to be the directors of their health through identifying incremental, measurable, and personal steps and objectives that make sense to the person and can serve as benchmarks for future success.

The overarching goals of PSWHR and WHAM are promoting health engagement and health self-management, as well as access to health supports. These goals are accomplished by supporting the individual's goals and action steps; providing materials that assist in structuring the individual's path to prevention, health care, and wellness; partnering with the person to navigate the health care system; assisting the person in developing his or her own natural support network to promote personal wellness goals; creating solutions with the person to overcome barriers that prevent health care engagement; and linking the individual with other health and wellness resources.

In Georgia, CPSs are funded to provide this service in traditional community behavioral health service delivery sites, in the community (such as in the person's home and/or work site), and in other health settings such as federally qualified health centers (FQHCs), emergency rooms, and primary health centers. This multisite model allows CPSs to strengthen practices within traditional public behavioral health systems, build bridges to the general health sector, operate within general health settings to increase behavioral health competency, and assist in the accomplishment of critical health engagement goals.

The Georgia model also builds in access to registered nurses for CPSs to consult with on delivering health support, especially in the case of complex health conditions that may require technical support to the CPSs in supporting a person's health goals. This nurse may also provide whole health services when rendering support to the served individual, at the request of the CPS providing PSWHW.

Peer provider training. Initially, and in the absence of a nationally standardized training curriculum for peer-supported health and wellness services, the PSWHR training was developed in collaboration with the GMHCN as part of a TTI grant funded by SAMHSA and administered by the National Association of State Mental Health Program Directors (NASMHPD). This training was provided to a small subset of CPSs who worked to promote whole health along with offering traditional peer support services. Once Georgia decided to move the PSWHW from a pilot to a statewide model, the state selected WHAM to further establish a quality standard for its CPS workforce. Georgia is currently using the WHAM curriculum and training that promotes outcomes of integrated health self-management and preventive resiliency. This curriculum promotes CPS whole health competencies, which are then utilized in the delivery of the PSWHW service.

Funding for sustainability. In June 2012, CMS approved Georgia as the first state to have Medicaid-recognized peer whole health (PWH) services provided by CPSs. As a part of this Medicaid design, peer workers in Georgia must have additional training (SAMHSA HRSA Center for Integrated Health Solutions, 2012) beyond becoming certified as a peer specialist to be able to provide this specialized type of peer support. Since implementation, approximately 400 CPSs have added this specialized training to their competencies.

New Jersey

Startup process. Faculty in the Rutgers School of Health Related Professions and peers at Collaborative Support Programs of New Jersey worked together to create a new workforce role—peer wellness coach (PWC; Swarbrick, Murphy, Zechner, Spagnolo, & Gill, 2011). The initial PWC training, created in 2009, was designed to prepare the peer workforce to address health and wellness needs from a self-management perspective. The curriculum was based on a strength-based eight-dimensional wellness model (Swarbrick, 2006, 2010) and core competencies defined through focus groups with people in recovery, family supporters, and professionals.

Interventions and program models. In New Jersey, peer wellness coaching is an emerging practice based on the wellness model developed to address physical comorbidities. PWCs work within the context of existing services such as supportive housing, residential intensive support, and community wellness centers. PWCs are qualified by the New Jersey licensed Integrated Care Centers to provide integrated behavioral health and primary care services.

A key task of the PWC is to help a person in recovery explore eight wellness dimensions, which leads each individual to better understand his or her own experiences, motives, and needs. There is a specific focus on physical wellness, since that sometimes

represents a challenge, including addressing low levels of physical activity (a sedentary lifestyle); limited access to medical screenings; poor management of medical conditions; inadequate nutrition, low knowledge of a healthy diet, and a need for education on glucose monitoring; oral hygiene and dental health practices; sleep and rest; reduction or elimination of tobacco use and other addictive substances; and prevention or management of HIV/AIDS (Swarbrick et al., 2011). In the PWC model, peers apply the principles and processes of coaching, effective communication skills, and motivational enhancement strategies to help individuals achieve the goal of a healthy lifestyle. Peer workers are taught to collaborate and act as coaches, helping to guide people toward successful and long-lasting behavioral changes (Swarbrick, Hutchinson, & Gill, 2008). PWCs provide ongoing individualized support and reinforcement by helping the people they serve with setting and achieving their goals. The PWC helps each participant find personal solutions by asking questions that promote insight into the participant's situation and guide him or her toward successful and durable behavioral change (Swarbrick et al., 2011). PWCs are trained and employed to promote health and wellness through approaches based on empowerment, self-direction, and mutual relationships. In this way, PWCs can intervene in areas where there are modifiable risk factors, such as diet and exercise, and can support better access to primary care. The PWC generally helps the participant focus on physical wellness domains that can help contribute to overall balance and health, addressing priority areas that the person identifies as important. A person with a co-occurring medical condition, for example, may be assisted by his or her PWC to address high-risk behaviors and health risk factors such as smoking, poor medical self-management, infrequent use of primary care, inadequate diet, and infrequent exercise (Swarbrick et al., 2011).

Peer provider training. The PWC training, initially offered through Rutgers University for six academic college credits, was updated and refined in 2014 based on the evaluation of implementation efforts throughout New Jersey and other states. The training now leads to an academic Certificate in Wellness Coaching for Physical Mental and Addictive Illnesses offered by the Rutgers School of Health Related Professions. The certificate requires nine academic credits over two semesters, and graduates can apply those credits to associate's or bachelor's degree programs offered by Rutgers University within the School of Health Related Professions, or they can transfer the credits into other academic programs.

Funding for sustainability. The peer wellness coaching service is billable through the New Jersey Community Support Services supportive housing regulations. Mental health services in New Jersey are funded through agency contracts, rather than through fee-for-service, so the peer-delivered health and wellness services do not add an expense or income stream but instead are a component of how services are designed. Although initially developed as a peer-provided service, wellness coaching is being adapted to train nonpeer service providers, who then incorporate wellness coaching into their roles and, as desired by people using services, include wellness goals and plans in the larger service planning process. The PWC training also has been adapted to address different job roles, including the peer workforce (Brice, Swarbrick, & Gill, 2014), and addressing the needs of older adults and youth. This model of incorporating health and wellness into existing services is being adopted in other states by government authorities (Missouri, Oklahoma), the City University of New York (Nelson & Shockley, 2013), the New York Peer Bridger training, and through managed care (Pennsylvania). PWC training also has been provided for integrated health projects in Tennessee and Rhode Island.

Michigan

Startup process. Michigan has a rich history of supporting the role of certified peer support specialists (CPSSs) in providing Medicaid-reimbursable services that include health, wellness, self-management, and the integration of behavioral health and primary care. CPSS requirements listed in the state Medicaid provider manual have included wellness activities as a covered service since 2006. CMS approved reimbursement for services provided by CPSSs in April 2006 under Section 1915 (b)(3) of the Social Security Act, which allows a state to make available services that are in addition to the Medicaid state plan services. Peer-delivered services provided under the Medicaid waiver are based on the medical necessity criteria of community inclusion and participation, independence, and productivity.

In 2009, and again in 2012, Michigan received a TTI grant from SAMHSA and NASMHPD.[1] Funding was used to provide a foundation for CPSSs to gain skills and training in a variety of whole health initiatives. In 2009, several CPSSs were employed in five community mental health centers to implement health, wellness, and prevention activities that included leading classes such as Wellness Recovery Action Planning (WRAP; Copeland, 2002), smoking cessation, and the evidence-based CDSMP (Lorig, Ritter, Pifer, & Werner, 2014), which also influenced the Georgia curriculum.

Interventions and program models. The Michigan Mental Health Code requires that each individual plan of service be completed using a person-centered planning process. This mandate supports individuals in identifying self-management goals and developing individualized plans to address health and wellness. In addition, a contract requirement mandates that the state's 10 regional Prepaid Inpatient Health Plans must offer arrangements to support self-determination when requested by an individual. Individuals have exercised choices to hire wellness coaches, purchase fitness memberships, and attend community classes using their individual budgets.

In the Michigan Medicaid manual,[2] a detailed provider description includes a variety of peer duties, many of which emphasize health, wellness, and prevention activities. The list of covered services outlines the essential job functions of peers across the state. The explicit language for integrated behavioral health and primary care includes developing health and wellness plans; developing, implementing, and providing health and wellness classes to address preventable risk factors for medical conditions; and integrating physical and mental health care. Additional covered CPSS services that enhance and complement health and wellness include providing vocational and housing assistance, assistance

[1] The Michigan program is described at https://innovations.ahrq.gov/profiles/peer-specialists-federally-qualified-health-centers-enhance-access-behavioral-and-physical%20#diw

[2] http://www.michigan.gov/mdch/0,1607,7-132--87572--,00.html

and facilitation of the person-centered planning process, and developing advance directives.

A new and emerging model began in 2012 with the second round of TTI funding, which began placing two full-time and two part-time CPSSs in all FQHCs. These peers work with medical practitioners, physician assistants, doctors, midwives, nurses, and diabetes educators to assist individuals who are there for a physical health concern but also have a mental health and/or substance use disorder. The goal is to support people in self-managing their chronic conditions by providing them with health and wellness classes, as well as support in navigating complex health systems to improve their quality of life. Activities associated with navigation include help with accessing such community resources as housing, employment, gym memberships, and support group meetings. The work that the CPSSs provide in the clinics has been supported and recognized by medical staff as an enhancement to the medical services that are routinely provided. Family practice physicians have made referrals to the smoking cessation groups and provided information on the peer-to-peer model.

Peer provider training. The initial core training curriculum for peer-delivered health and wellness services in Michigan includes health and wellness information and mindfulness exercises. In addition, state requirements for the enhanced training provide a significant amount of instruction devoted to SAMHSA wellness initiatives, self-management activities for preventable risk factors, and tobacco recovery. Continuing education activities related to wellness include WRAP, WHAM, CDSMP, and motivational interviewing. A large initiative was implemented as part of the Michigan TTI grant to train CPSSs in leading CDSMP classes. In addition, 20 peer specialists were certified as master-level CDSMP trainers, which increased the state's capacity to train additional leaders to facilitate classes. In approximately 1 year, over 180 CPSSs were trained to run 6-week classes, with positive outcomes (Lorig et al., 2014).

Funding for sustainability. The Michigan Primary Care Association continues to be a strong partner in employing CPSSs on a much larger scale in FQHCs. Discussions on capturing peer services at the FQHCs with a designated encounter code have been ongoing. Currently, individuals and advocates have met with the state Medicaid office on providing reimbursement for community health workers (CHWs). Several state-level grants have funded positions, and local community health centers are seeking additional opportunities. Job duties and professional responsibilities of CPSSs allow them to be recognized as CHWs, expanding the job opportunities for CPSS in integrated care settings. Discussions with the Michigan Association of Community Health Workers are under way to create a train-the-trainer initiative, with CPSSs serving as trainers for certification of CHWs, which will expand the opportunities for CPSSs to be employed in dual roles.

Lessons Learned

Peers are uniquely qualified as supports for health and wellness for other peers. As the peer specialist role in supporting mental health becomes more established (and accepted) in a state, it then may be easier to add whole health and wellness services after the initial value of peer support is shown. The details of how peer-delivered health and wellness services are designed and implemented in the behavioral health system will necessarily vary across states, given differences in local needs or persons served, service requirements, and funding mechanisms. Providing specialized services by including peer wellness coaches on service delivery teams is just one way to structure services. Specially trained peers can serve as bridgers or navigators between behavioral health and medical/dental service systems, or they can be embedded within traditional health models, such as health homes, FQHCs, medical hospitals, and emergency rooms. Alternatively, peers may be just one of the service providers focused on health and wellness. Thus, the focus on health and wellness becomes part of the existing array of services, such as through incorporating health goals into all behavioral health service plans and placing health and wellness in the forefront of services, rather than as ancillary work with a designated specialist. The service-wide focus on health and wellness, although intuitively appealing given the current push toward integrated care, requires a significant investment in training for all service providers, which may make this approach prohibitively expensive for some mental health authorities.

Based on the experiences in the three states described here, public mental authorities need to address a number of key issues related to implementation and expansion of peer-delivered health and wellness services, including defining the model to be disseminated, providing the necessary training to prepare the peer workforce for delivering the new service, accessing funding for implementation, and establishing clear expectations from funders to enhance and maintain quality while sustaining programs and staffing over time. Addressing these issues before implementation will facilitate a smooth rollout of services and ensure consistent quality.

Similar to peer support services in general, peer-delivered health and wellness services have the potential to alleviate some of the workforce shortage concerns that many states and regions of the country are experiencing. Peer health coaches will not replace trained medical staff, of course, but their work with peers on more basic issues such as healthy eating and self-care could reduce the burden on medical personnel of addressing these areas and free up their time to focus on other concerns and needs.

For states that already have a peer workforce but no peer-delivered health and wellness, this could provide an area of specialization for peer specialists who wish to advance and/or enhance their careers. Although peers are usually happy to get a job providing support to other peers, as addressed in the 2012 Pillars of Peer Support Services Summit, there is an increasing awareness of the need to develop opportunities for career development and advancement for peer specialists. As with any profession, as it grows and becomes more established, there is a need to create new opportunities to take advantage of existing expertise, while keeping individuals in the profession interested and feeling like they are advancing their careers (Daniels et al., 2013).

One important area to expand upon in research is the savings that might be generated by the implementation and use of peer-delivered health and wellness services in a state. As with any new service, there is the need for political will and funding to make it happen. Many states are missing one or both as they consider developing and implementing basic peer support services. Peers in the mental health and addictions fields are typically very mutually

supportive in that if peers find something that works for themselves, they like to see it made available to others. Even states that already have the political and economic will to implement peer-delivered health and wellness services could strengthen their cause by being able to demonstrate positive cost savings. Data on positive outcomes such as the substantial cost savings claimed by the Missouri Behavioral Health Homes (http://www.mocoalition.org/#!health-homes/c14fu) could both strengthen the sustainability of programs in their own states and provide needed incentives for other states to create and sustain peer-delivered health and wellness services. For states with established peer-delivered health and wellness services, there is always the risk that political will could shift, running the risk that such services would be cut in a tight budget year. Having data to demonstrate cost savings would help alleviate that possibility.

Areas to capture when evaluating cost benefits include not only the obvious possible benefits, such as decreased hospitalizations and medical expenses, but also more abstract benefits, such as how improved physical health might enhance peers' abilities to accelerate their recoveries from mental illnesses and improve their quality of life. Advancing recovery may result in additional cost-benefits to a state, as people gain greater independence in housing, work, and life management.

Additional areas of future research include examining whether peers are more effective than nonpeers, defining personally meaningful outcomes valued by peers (not just the financial outcomes valued by funders), examining what outcomes are achieved, and developing fidelity scales for the different models of peer-delivered health and wellness services.

Conclusion

Peer-delivered health and wellness services help address the health disparities facing people who are living with mental health and substance use disorders. A variety of innovative models tailored to local needs and circumstances are now being implemented using different funding sources. These varied service models share common features in their structure, such as being peer delivered and focused on improving health and wellness as desired by the person served, increasing knowledge about preventing disease, lessening the effects of the chronic medical conditions that affect many people with mental disorders, and promoting change to adopt and maintain healthy lifestyle habits. Given the urgency evident in the prevalence of medical comorbidity and the reduced life span for people with mental disorders, the need to expand and replicate health and wellness services is compelling, with specialized peer-delivered services providing an effective and feasible method for launching this expansion.

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