Peer Support in Behavioral Health Services: Theory, Policy, and Research

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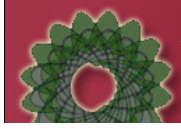


THE TEMPLE UNIVERSITY COLLABORATIVE ON
COMMUNITY INCLUSION
of Individuals with Psychiatric Disabilities

Peer Support: An Evidence-Based and Growing Practice

- Solid theory base
- Solid policy support
- Growing evidence base
- Birth and expansion of a new peer support workforce and discipline

Social Comparison Theory (Festinger, 1954)	1) People seek out interactions with others who have similar experiences. 2) Upward comparisons increase self-improvement (e.g., develop skills) and self-enhancement (e.g., increase sense of hope and decrease fears) efforts. 3) Downward comparisons are ego enhancing and maintain positive affect by providing examples of how bad things could be.
Social Learning Theory (Bandura, 1977)	1) Behavior change is more likely when modeling is provided by peers than non-peers. 2) Peers model coping and health-enhancing behaviors. 3) Peers enhance self-efficacy that one can change behavior.
Social Support Theories	CDS increase support networks, receipt of supportive behaviors, and perceptions of support. There are five types of support: 1) Emotional (someone to confide in, provides esteem, reassurance, attachment and intimacy); 2) Instrumental (services, money, transportation); 3) Informational (advice/guidance, help with problem-solving and evaluation of behavior and alternative actions); 4) Companionship (belonging, socializing, feeling connected to others); and 5) Validation (feedback, social comparison).
Experiential Knowledge (Borkman, 1999)	Experience with an illness leads to an understanding and knowledge base that is different from that acquired through research and observation. Experiential knowledge leads to different intervention approaches.
Helper-Therapy Principle (Riessman, 1965; Skovholt, 1974)	Helping others is beneficial: 1) Increased sense of interpersonal competence as a result of making an impact on another's life; 2) Development of a sense of equality in giving and taking between himself or herself and others; 3) Helper gains new personally relevant knowledge while helping; and 4) Helper receives social approval from the person they help and others.

Salzer et al., (2002) Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines. Psychiatric Rehabilitation Skills.

Federal Recognition of Peer Support

1978: President Carter's Commission on Mental Health offered early federal recognition that "groups composed of individuals with mental or emotional problems" were being formed around the country

1987: Surgeon General's Report recommended strategies for promoting self-help groups

1999: Surgeon General's Report promotes self-help groups and consumer-run services

Pre-2001: Peer support services funded by states and counties

2001: CMS Funding of Peer Support in GA and AZ

2003: The President's New Freedom Commission on Mental Health promotes consumer-operated services

2004: VA strategic plan agenda recommendation "Hire veterans as Peer/Mental Health Para Professionals." (Commission Rec. 2-3.18 &19, Appendix 1).

2007: CMS guidance letter to states on peer support services

2008: *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics* states that "all veterans with SMI [serious mental illnesses] must have access to Peer Support (2, pg. 28)".

Peer Support Research Evidence Base

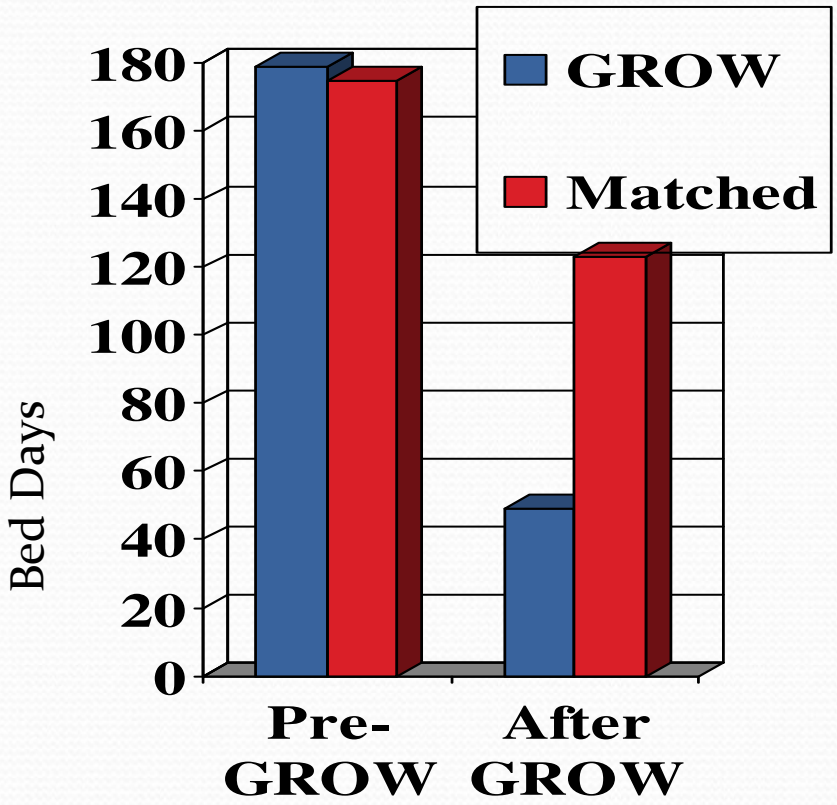
- Humphreys (1997) Individual and social benefits of mutual-aid self-help groups. *Social Policy*
- Davidson et al. (1999) Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*
- Van Tosh & del Vecchio (2000) Consumer-operated self-help programs: A technical report. *CMHS*
- Solomon & Draine (2001) The state of knowledge of the effectiveness of consumer-provided services. *Psychiatric Rehabilitation Journal*

Self-help/Mutual-Help Groups

- Recovery Inc. (Galanter, 1988)
  - improved psychopathology, increased coping skills, and increased life satisfaction among long-term members versus short-term members
- GROW
  - commitment to GROW associated with more positive changes and (Luke, 1989)
  - greater group attendance was associated with lower levels of isolation and brooding, and increased support seeking (Reischl & Rappaport, 1988)

Cost Savings

Kennedy (1989) Used IL. DMH database to match GROW members to non-members on 12 variables, including rates of hospitalization and length of stay for a 3 year period prior to joining GROW



Self-help/Mutual-Help Groups

- Double-Trouble in Recovery (DTR)
  - Greater participation in this self-help group associated with increased medication adherence (Magura et al., 2002)
  - Greater participation in DTR associated with greater perceived social support. Greater support associated with less substance use. (Laudet et al., 2000)

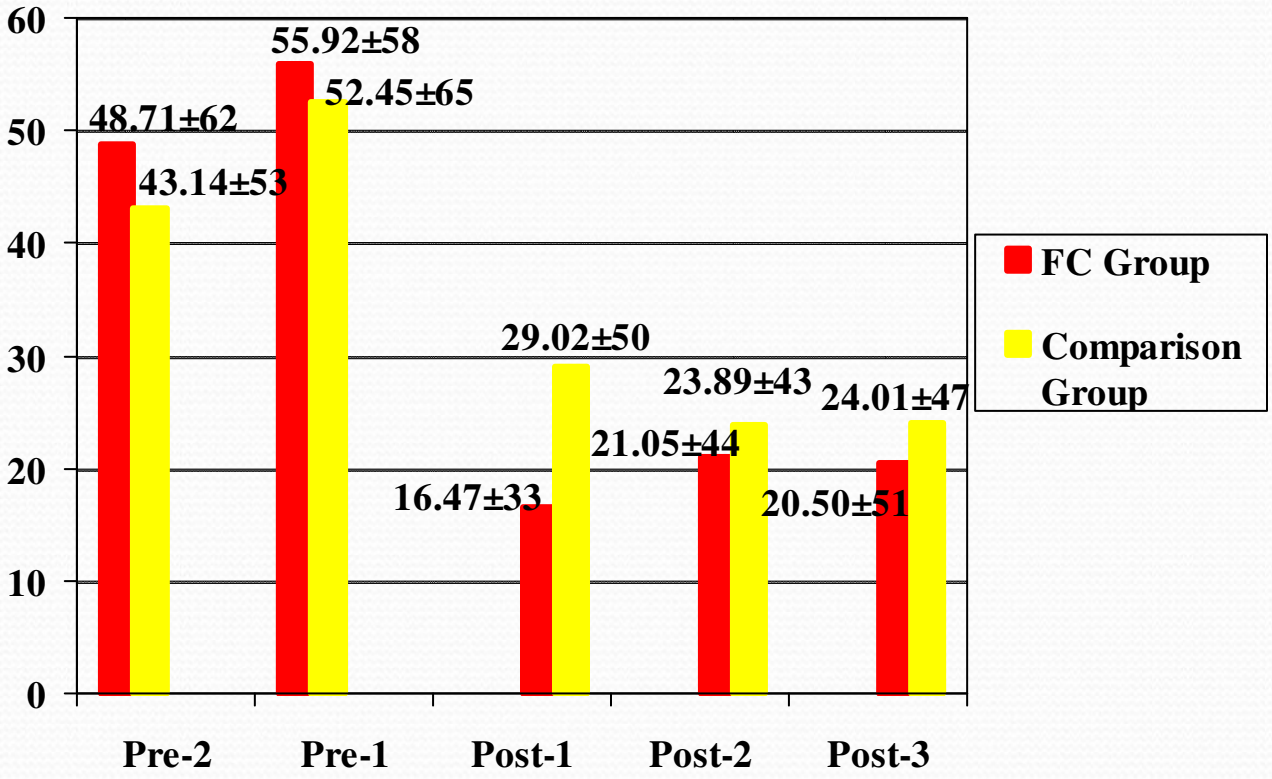
Drop-In Centers

- Peer-Run Drop-in Centers
  - High satisfaction and increased quality of life, enhanced social support and problem solving (Chamberlin, Rogers, & Ellison, 1996; Mowbray & Tan, 1992).

Peer Support Services

- Peer added to case management services
  - enhanced quality of life, fewer major life problems, and greater gains in social support than those receiving case management services without a PSC (Felton and colleagues, 1995)
- Friends Connection 1:1 support program as adjunct to case management
  - fewer crisis events and hospitalizations, improved social functioning, greater reduction in substance use, and improvements in quality of life compared to a non-matched comparison group (Klein, Cnaan, & Whitecraft, 1998)

Friends Connection Associated with Faster Recovery



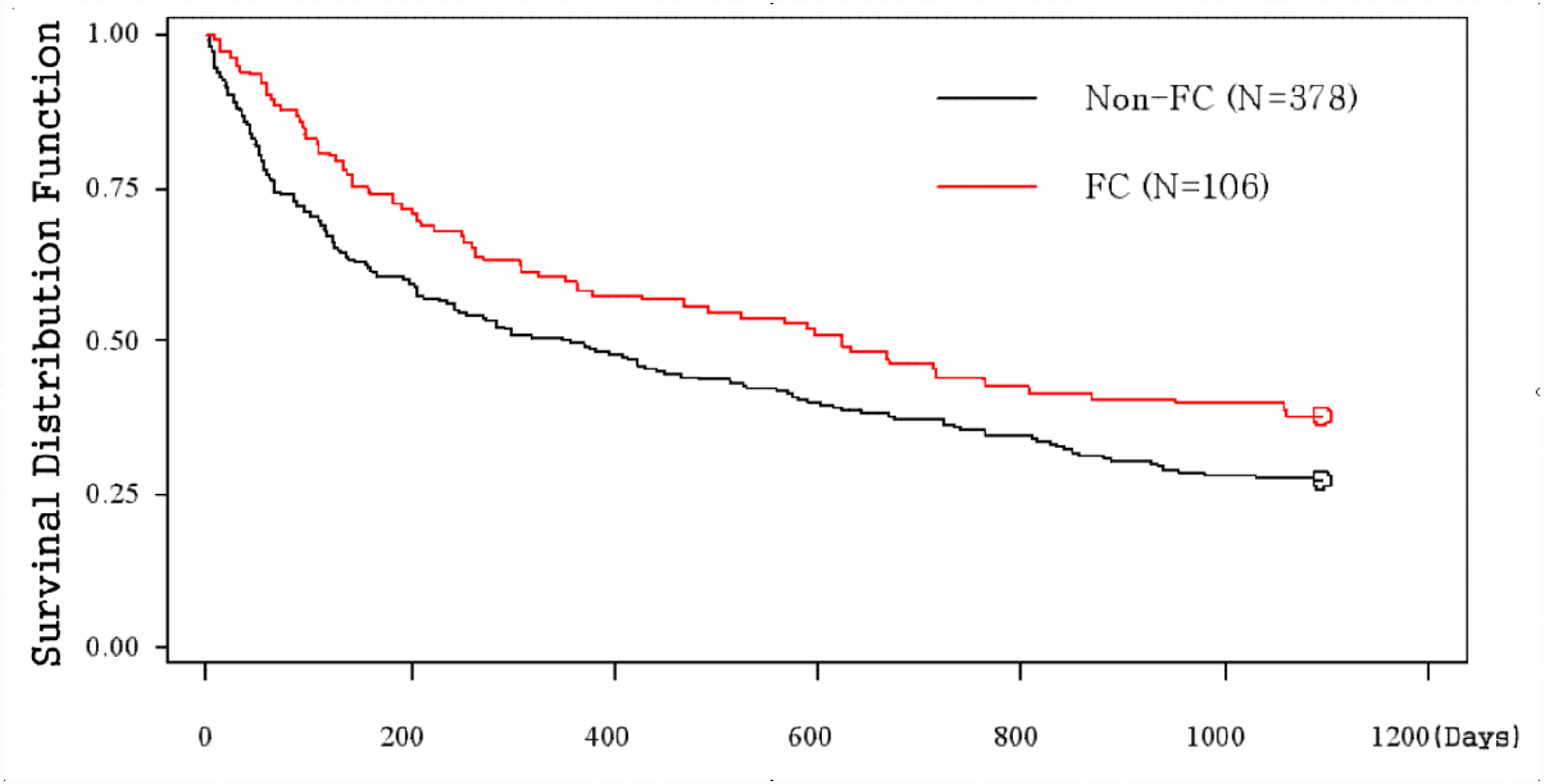
•Individuals in Friends Connection had 1549 fewer hospital days than we would have expected if they were not in the program

Hospitalizations During Three-Year Post-FC/Index Date

	FC (N=106)	Non-FC (N=378)	
	N(%)	N(%)	
Not Hospitalized during post period	40(37.7%)	103(27.3%)	X^2=4.374 (p=.036)
Hospitalized During Post Period	66(62.3%)	275(72.7%)	

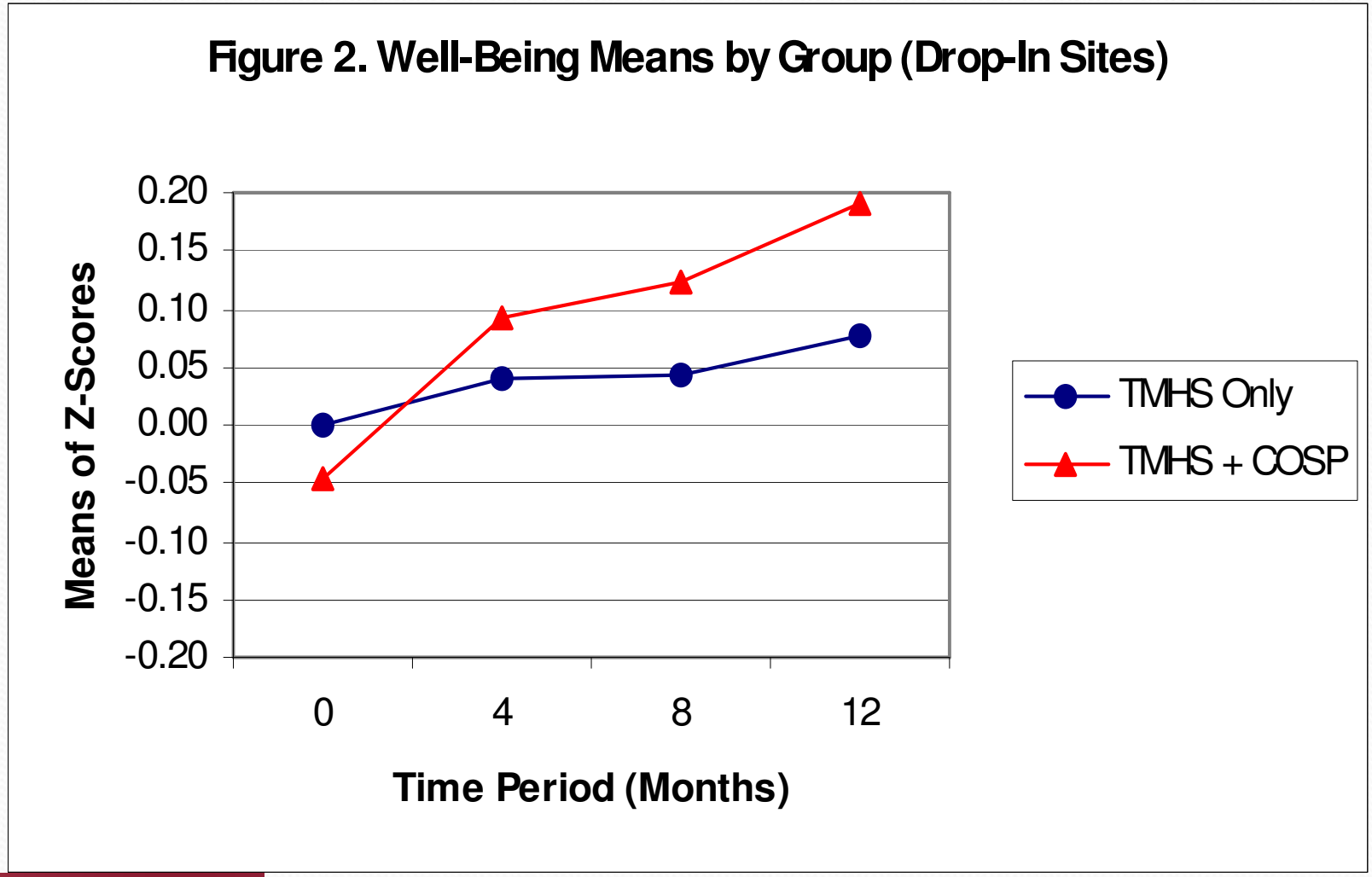
Min et al., (2007)

Survival Analysis: First hospitalization during 3 years post-program



Min et al., (2007)

COSP Finding



Benefits to the Peer-Provider

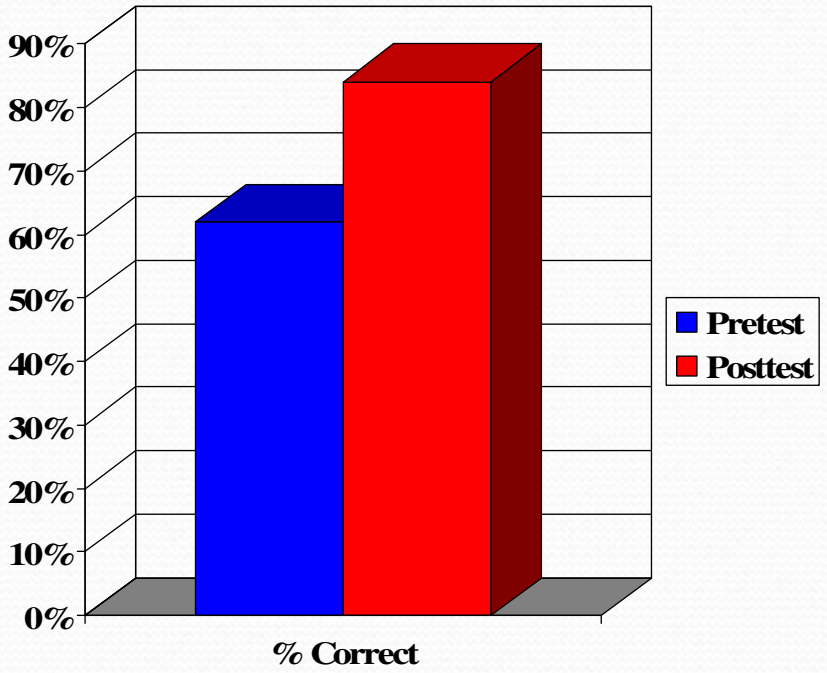
- Consumer case managers had fewer hospital days after working in their positions than before (Sherman & Porter, 1991)
- Salzer & Liptzin-Shear (2002) found that peer supporters reported benefits from
  - Facilitating other's recovery
  - Greater perceived interpersonal competence
  - Facilitating own recovery
  - Social approval
  - Professional growth
  - Job-related benefits
  - Job-related recovery
  - Mutual support

CPS Training Outcomes: Graduation

- All 141 individuals (100%) who enrolled successfully completed the Meta Services Peer Provider program (Hutchinson et al, 2006)
- 69 out of the 73 (95%) individuals accepted in the Recovery Support Specialist Institute graduated (Stoneking & McGuffin, 2007)
- 72 out of 74 (97%) individuals enrolled in training provided by the Institute on Recovery and Community Integration successfully completed the program (Salzer et al., 2009)
- 100 out of 137 (73%) of the peers who were accepted and attended the intensive Kansas Consumers as Providers program graduated (Ratzlaff et al., 2006)

CPS Training Outcomes

- Training associated with positive psychological outcomes and personal growth (Hutchinson et al., 2006; Ratzlaff et al., 2006).

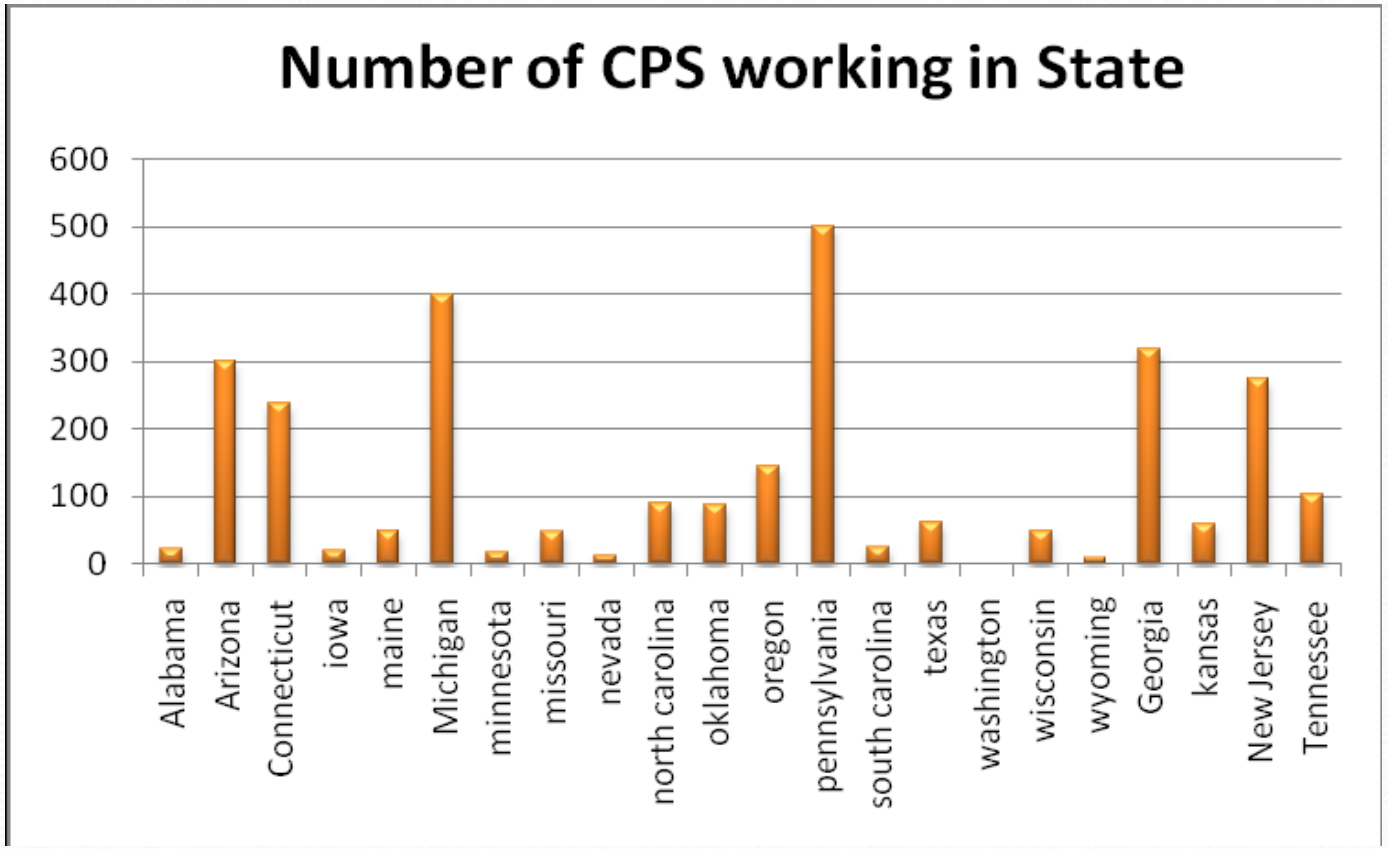


Increased knowledge* (Salzer et al., 2009)

- Statistically significant at p<.001.
- 32% scored >70% correct on pretest.
- 96% scored >70% correct on posttest.

CPS Training Employment Outcomes

- 89% of participants were employed 1-year after completing CPS training (Hutchinson et al., 2006).
- 77% working as a CPS 1-year post-training (Salzer et al., 2009)



Daniels, A., Grant, E., Filson, B., Powell, I., Fricks, L., Goodale, L. (Ed), Pillars of Peer Support: Transforming Mental Health Systems of Care Through Peer Support Services, www.pillarsofpeersupport.org; January, 2010.

National Survey of CPS*

- 291 respondents (6/08 – 3/09)
- 33% male, 66% female, and 1% transgender.

Race	N	%
Asian/Pacific Islander/Hawaiian Native	3	1%
Black/African American	29	12%
Hispanic/Latino	8	3%
Multiracial	8	4%
Native American/American Indian	3	1%
White/Caucasian	198	79%

* Survey conducted by Salzer, Brusilovskiy, and Schwenk

Agencies and Programs

- Participants came from 27 states and more than 190 different agencies

- Pennsylvania and Michigan had the greatest number of participants (70 and 51, respectively)

- The highest number of participants from any one agency was 10.

Employment

- CPS respondents employed an average of 23.8 months
  - The range in months is from 1 month to 126 months (10.5 years)
- Hours worked per week
  - Average of 29.6 hours/week
  - Range from 3 to 50 hours
  - 111 peer specialists (58%) worked full-time (35 hours or more per week)

What do CPS Do?

- The primary responsibility of the certified peer specialist is to (Georgia Division of Mental Health as cited in Sabin & Daniels, 2003):
  - "…assist consumers in regaining control over their own lives and control over their recovery processes"
  - ".model competence and the possibility of recovery…"
  - "….assist consumers in developing the perspective and skills that facilitate recovery"

National Survey Results: Types of Programs

Employed in 8 types of programs:

- Independent peer support (N=70)
- Case management (N=57)
- Partial hospital/day program, inpatient or crisis (N=31)
- Vocational rehabilitation/clubhouse programs (N=23)
- Drop-in centers (N=21)
- Education/advocacy (N=15)
- Residential (N=12)
- Therapeutic recreation/socialization or psychiatric rehabilitation (N=10)

Program	% time at agency/ on phone	% of time in the community
Average Across All Programs	59%	33%
Case Management	42%	53%
Partial Hospital/Day Program, Inpatient, or CRISIS	76%	13%
VR or Clubhouse	75%	17%
Therapeutic Recreation or Psych. Rehab.	49%	39%
Residential	49%	40%
Drop-In Center	80%	12%
Education/Advocacy	65%	19%
Independent Peer Support Program	56%	37%
Other/Could not be Coded	58%	36%

Salzer, M.S., Schwenk, E., & Brusilovskiy, E. (2010). Certified Peer Specialist Roles and Activities: Results from a National Survey. Psychiatric Services, 61, 520-523.

Program	% Time Groups	% Time Individuals
Average Across All Programs	25%	48%
Case Management	15%	61%
Partial Hospital/Day Program, Inpatient, or CRISIS	38%	43%
VR or Clubhouse	32%	47%
Therapeutic Recreation or Psych. Rehab.	36%	44%
Residential	4%	75%
Drop-In Center	41%	37%
Education/Advocacy	27%	26%
Independent Peer Support Program	22%	51%
Other/Could not be Coded	22%	38%

Salzer, M.S., Schwenk, E., & Brusilovskiy, E. (2010). Certified Peer Specialist Roles and Activities: Results from a National Survey. Psychiatric Services, 61, 520-523.

Please tell us how often you support your peers in…	Mean Score 1 = "Never" 5 = "Always"	Type of Support
peer support	4.48	Core Supports
encouraging self-determination and personal responsibility	4.26	
health and wellness	3.87	
hopelessness	3.84	
communication with providers	3.68	
illness management	3.62	
stigma in the community	3.56	
family relationships (e.g., with parents, siblings, cousins, etc.)	2.95	Intimacy Supports
spirituality/religion	2.74	
parenting	2.14	
dating	1.74	
developing friendships	3.51	Leisure/ Social Supports
leisure/recreation (e.g., exercise, hobby groups, movies)	3.25	
transportation	3.06	
citizenship (e.g., voting, volunteering, advocacy)	2.83	
education	3.16	Career Supports
employment	2.94	
developing WRAP plans	3.04	WRAP/ PADS
developing psychiatric advanced directives	2.27	

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Salzer, M.S. (2010). Certified peer specialists in the United States Behavioral Health System: An emerging workforce. Brown, L.D. & Wituk, S. (Eds.). Mental health self-help: Consumer and family initiatives (pp. 169-191). New York: Springer.

Barriers to Implementation of Peer Support Services

- Non-peer professional's have negative beliefs about peers
- Concerns about competence and peers being able to act professionally (e.g., maintain confidentiality)
- Non-peer professional lack of understanding of peer support theory and research
  - View peer support as inherently less helpful than "professional" services
- Lack of clarity about peer specialist roles and activities
  - Hiring problems
  - Peers assigned ancillary roles, treated as "junior staff," and given inadequate resources
- Concerns about using personal disclosure and role modeling in service delivery
- Inadequate supervision
- Concerns about dual relationships and job-induced relapse
- Limited opportunities for networking and support with other peer specialists