Peer Support Among Those With Serious Mental Illnesses: Empirical Evidence and Program Implications

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Recovery & Rehabilitation of the Client with Psychosis: Evidence-based Practices
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Peer support an increasing priority

PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH

Recommendation	**2.2 Involve consumers and families fully in orienting the mental health system toward recovery.**

Peer Support

- sharing similar life experiences with others
- a structured process of social interaction
- an intentional process which includes standard procedures, routines, and prescriptions for addressing problems
- offer worldviews and ideologies to assist persons in making sense of their experiences
- enhance person-environment fit

Types of peer support

		Control	
		Consumer	**Non-Consumer**
Aim	**Service**	Consumer run services	Consumers as providers
	Peer Support	Peer support groups	Consumer Initiatives

Mowbray CT & Moxley DP (1997). A framework for organizing consumer roles as providers of psychiatric rehabilitation. In Mowbray CT, Moxley DP, Jasper CA, Howell LL. Consumers As Providers in Psychiatric Rehabilitation. Columbia, MD: IAPRS

But Why Peer Support?

- Peer support has the potential to specifically address key challenges in public sector mental health

Peer Support & Patient Factors

Social isolation	Disconnection with ongoing outpatient treatment	Powerlessness & demoralization regarding illness
How Peer Support helps		
Enhance social networks by ■role modeling ■facilitating peer support activities		

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How Peer Support helps		
Enhance social networks by ■role modeling ■facilitating peer support activities	Engages patients; makes treatment more relevant	Activates patients to participate in their own care

Peer Support & System Factors

Overburdened providers	Fragmented services	Lack emphasis on recovery, rehabilitation, empowerment
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How Peer Support helps		
Supplement existing treatment; increase access	Provide case management/ system navigation to increase access	Emphasize recovery, rehabilitation, empowerment

Benefits of peer support groups

- Improved psychiatric symptomatology
- increased coping skills, & life satisfaction for members
- decrease in the number of hospitalization days compared to matched group
- helping others within group was positively related to increased social adjustment

Kaufmann, Schulberg & Schooler, 1994; Raiff, 1984; Galanter, 1988; Luke, 1989; Reischl & Rappaport, 1988; Rappaport, Seidman, Toro, et al. 1985; Kennedy, 1989

Benefits of peer support groups

- Continued group membership has been associated with
  - increased perceptions of self-esteem
  - better decision-making skills
  - improved social functioning pursuing educational goals and finding employment
  - stronger feelings of cohesion
  - increased life satisfaction
  - increased perceptions of security
  - broadened sense of spirituality more similar to those of the general population than persons with psychiatric disturbance
  - larger social networks

(Carpinello, Knight & Janis, 1991; Galanter, 1988; Kaufman, Schulberg & Schooler, 1994; Markowitz, DeMasi, Carpinello, et al., 1996; Humphreys, 1997; Kennedy, 1995

Utilization

- 17% of persons who were invited to attend a self-help group did so (Kaufmann, Schulberg & Schooler, 1994)
- One-third of persons who came to a GROW meeting did not continue after one or two meetings (Luke, Roberts & Rappaport, 1993)
- Professional referral rates to Recovery Inc. range from 2% to 39% (Galanter, 1990; Grosz, 1973; Lee, 1993; Raiff, 1978)
- Survey of CT providers showed that there was moderate familiarity, and frequency of referral - less than 12 step groups (Chinman et al, In press)

Utilization

Paired Sample T-tests among Connecticut State Providers

Question	Group Comparisons	Mean	N	SD
How helpful are ___?*	peer groups	4.04	388	0.79
	12 step	4.31	388	0.77
How likely would you refer to___?*	peer groups	3.18	379	1.21
	12 step	3.61	379	1.24
How much value do___ have for your clients?*	peer groups	4.02	378	0.91
	12 step	4.27	378	0.89
How familiar are you with___?*	peer groups	3.38	418	1.06
	12 step groups	3.89	418	1.01

5= highest in being helpful/referral frequency/value/familiarity
1=lowest in being helpful/referral frequency/value/familiarity

*p=.000

Expand peer support opportunities

Consumer-Run Services

- Not entirely mutual
- More structured

Expand peer support opportunities

Consumer-Run Services

- Feasible, but not proven
- More minority involvement
- More viable when linked to traditional mental health settings
- More informal referrals
- Have fidelity criteria (structure, beliefs, role structures, supports)

Davidson L, Chinman M, Kloos B, Weingarten R, Stayner DA, & Tebes JK (1999). Peer support among individuals with severe mental illness: A review of the evidence. Clinical Psychology: Science and Practice, 6, 2, 165-187.
Holter MC et al (2004). Critical ingredients of consumer run services: Results of a national study. Community Mental Health Journal, 40, 1, 47-63

Expand peer support opportunities

Consumer Providers

- More common than consumer-run services
- Mutuality is different - traditional context
- Provider roles:
  - advocacy,mediation, mentoring, role modeling,education, counseling, assistance with meeting needs of daily living (housing and work)

Consumer Providers: Feasibility

Consumer providers more able to:

- empathize
- access social services
- appreciate clients' strengths
- be tolerant, flexible, patient, and persistent
- be aware of and responsive to clients' desires

Consumer providers spend more time:

- In supervision
- Doing face-to-face contact and outreach
- Higher turnover

Davidson L, Chinman M, Kloos B, Weingarten R, Stayner DA, & Tebes JK (1999). Peer support among individuals with severe mental illness: A review of the evidence. Clinical Psychology: Science and Practice, 6, 2, 165-187.
Simpson EL & House AO (2002). Involving users in delivery and evaluation of mental health services: Systematic Review. BMJ, 325, 1265-67

Consumer Providers: Effectiveness

Compared to non-consumer treatment

- No detrimental effects (equivalent outcomes)
- Less life problems
- Improved social functioning
- Improved quality of life
- Less family burden*
- Less; Longer time between, hospitalizations*

*RCT study result

ACCESS Program

- Initiated in 1994 by the Center for Mental Health Services (CMHS)
- 5 year demonstration program that provides outreach and intensive case management to 100 homeless people with SMI at each site, each year
- 18 sites in 15 US cities

ACCESS Study

- Case managers consumers vs case managers non-consumers on client outcomes
- Addresses two shortcomings:
  - low power, lack of client outcome assessments
- First two cohorts of ACCESS program
- 6 sites with at least 10 clients served by a consumer provider

Chinman M, Rosenheck R, Lam JA, Davidson L (2000). Comparing consumer and non-consumer provided case management services for homeless persons with serious mental illness. The Journal of Nervous and Mental Disease, 188, 446-453.

Consumer Providers

- Received treatment similar to the clients
- Received equivalent pay
- Performed the same duties as the non-consumer staff
- "consumer outreach worker/case managers"
- "outreach worker/case managers"
- Saw clients as often as non-consumer providers (M=7x/month)

Consumer/Non-consumer providers

Demographic	Consumers	Non-Consumers
Gender*	Male=73%	Male=43%
Age*	M=46.69, SD=19.73	M=36.16, SD=7.71
Race*:		
White	52%	47%
African-Am.	48%	44%
Hispanic	0%	7%
Asian-Am.	0%	2%

*p=.000

Consumer/Non-consumer providers

Education Level	Consumers	Non-Consumers
Ph.D./MD	0%	7%
MA	18%	21%
BA	43%	53%
High School	39%	19%

Consumer vs Non Consumer sites

Clients at consumer sites:

- more depressed
- more psychotic (observed & self-reported)
- had less social support
- spent more days homeless
- had more days of drug use
- more drug dependence and major depression
- similar on other DXs and demographics

Consumer sites sample

- average age = 38.4±9.4
- 67% = males
- 49% = African American, 9% = Latino, 42%=White
- Dx (SCID): any psychotic disorder (66%), major depression (55%), personality disorder (21%), anxiety disorder (20%), bipolar disorder (17%), alcohol abuse disorders (45%), drug abuse disorders(44%)
- intoxicated an average of 2.2±5.9 days/month and used illegal drugs a total of 3.5±10.3 days
- homeless an average of 38.4±20.9 days in past 60

Outcome Measures

- Depression (DIS)
- Client-reported symptoms of psychosis
- General psychiatric problems (ASI)
- Alcohol use (ASI)
- Drug use (ASI)
- Overall quality of life (QOL)
- Days homelessness out of 60
- Level of social support (# of people…)
- Days of paid employment out of 30
- Therapeutic alliance (TAS)

Outcome Measures

- No baseline differences
- Effect of Time on almost all measures (all improved)
- No Time x Group effects

Implications

- Creates additional avenues of employment for people who have a SMI (Fisk et al., 1999)
- Provides additional mode of service within the traditional treatment system
- Offers additional opportunities for participation in a mutual support-based intervention

Other Peer Support Examples

Example 1: The Breakfast Club

- **Who:** CMHC clients and clinicians of Dual Diagnosis Team
- **What:** Peer Support in addition to
  - Clinical engagement,
  - Psychoeducation,
  - Medication management,
  - Access to community resources
- **When:** Daily (M-F), 8:00AM to 9:00 AM
- **Where:** CMHC cafeteria and group room

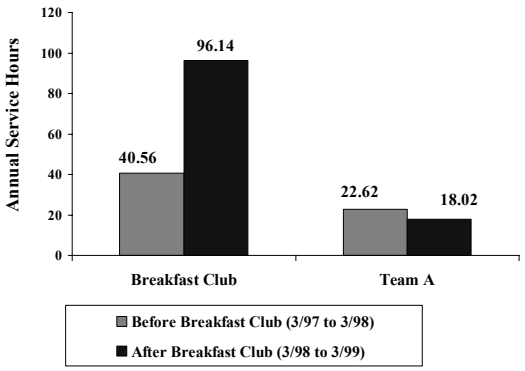
CMHC vs Breakfast Club: Demographics

Demographic	Category	CMHC: (N = 1891)	Breakfast Club (N = 32)
SEX	Male	45.3	62.5
	Female	52.4	37.5
RACE	White	44.6	28.1
	Black	26.7	62.5
	Mixed Race	25.4	9.4
	American Indian	.4	0
	Asian	.4	0
ETHNICITY	Not Hispanic	72.6	90.6
	Hispanic	25.0	9.4
MARITAL	Never married	44.0	71.9
	Separated/divorced/annulled/widowed	28.0	18.8
	Married/cohabitating	10.1	3.1
EDUCATION	None - 8th grade	15.6	12.5
	Some High School	17.2	28.1
	High School Grad/GED	27.8	34.4
	Some College/Voc School	19.2	18.7
AGE		44.76	39.67

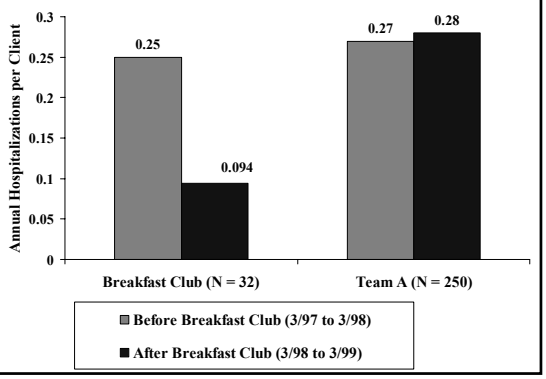
Note: All figures expressed above are PERCENT demographics with the exception of the MEAN age.

Annual Outpatient Service Utilization

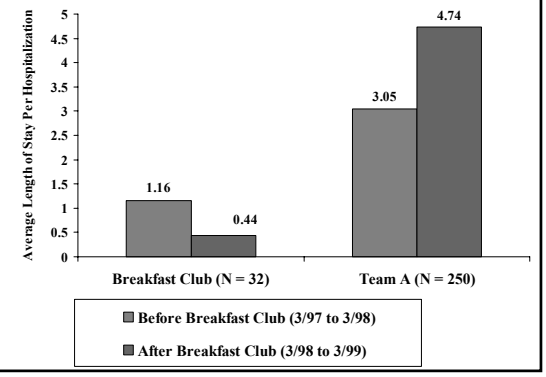
Breakfast Club (N = 32) vs. Team A (N = 250)



Annual Hospitalizations Per Client



Average Length of Stay Per Hospitalization



Example 2: Welcome Basket

- Engage in hospital
- Visit post-discharge w/ basket
- Follow-up visits (interest survey)
- Outings
- Advocacy
- Peer support groups
- 3 months, three consumer staff (15hrs/week)

Preliminary Outcomes: Demographics

Demographic and Diagnostic Characteristics for Participants by Condition

Demographic/ Diagnostic Category	Demographic/ Diagnostic Subtype	Welcome Basket (N=79)	CMHC Outpatients (N=79)
Gender	Male	50.6%	44.3%
	Female	49.4%	55.7%
Age	Range	19-62	19-70
	Mean	37.7	41.0
Race/Ethnicity	Caucasian	39.2%	50.6%
	African-American	51.9%	39.2%
	Hispanic Origin	8.9%	10.1%
Diagnosis	Psychosis	44.3%	44.3%
	Major Affective Disorder	39.2%	39.2%
	Substance Abuse Disorder	10.1%	10.1%
	Anxiety	2.5%	2.5%
	Other Disorder	3.8%	3.8%

Preliminary Outcomes: Hospitalizations

Service Utilization for 6 Months Prior to and After Welcome Basket Participation

	6 months prior to start		6 months after start	
Variables	Welcome Basket (N=79)	CMHC Outpatients (N=79)	Welcome Basket (N=79)	CMHC Outpatients (N=79)
(Re) Admissions	46	37	21	16
Mean Admissions per Person (SD)	.58 (.90)	.47 (.71)	.27 (.69)	.20 (.49)
Days Inpatient	965	592	245	549
Mean Days Inpatient per Person (SD)	12.22 (38.03)	7.50 (13.29)	3.10 (10.10)	6.95 (25.92)

Conclusions

- More and better research – what is in the black box?
- Offer a variety of types
- Spontaneity by design

Exploring the Use of Consumer Providers in the VA

- HSR&D Grant
- Focus groups & interviews with providers, consumers in Long Beach, Los Angeles, San Diego, Little Rock, New Haven
- Recommendations for Consumer Providers in the VA

Consumer Providers in the VA?

Stakeholder analysis in Southern CA, the challenges:

- CPs lack skills or are too ill
- CPs would cause harm to themselves, their patients, or would cause conflict and be a burden to the system
- CPs would reduce pt. satisfaction or simply be done to reduce cost