Welcome to the 18th in a series of webinars for peer supporters.

This webinar series is presented by members of the International Association of Peer Supporters (iNAPS) with generous assistance from Optum, without whom this series would not be possible.

iNAPS is solely responsible for the content of the webinars. The webinar will begin at noon, Eastern. Thank you for your participation!
WHAT DO I MEAN BY PEER SUPPORT?

- Emerged in the 1980s as a result of the Mental Health Consumer/Survivor/Ex-Patient Movement
- Preceded by Recovery, Inc., GROW, and other mutual support groups
- Peer Supporters are people who have experienced a mental illness and are either in or have achieved some degree of recovery. In their role as peer supporters, they use these personal experiences of illness and recovery—along with relevant training and supervision—to facilitate, guide, and mentor another person’s recovery journey by instilling hope, role modeling recovery, and supporting people in their own efforts to reclaim meaningful and self-determined lives in the communities of their choice.
RAPID EXPANSION OF WORKFORCE

- Started in late 1980s
- Over 30 states now provide Medicaid-funded peer services
- Over 1,200 peer specialists hired by the VA system alone
- International Charter workgroup involves 15 countries from 6 continents (all but Antarctica)
- Has led to concerns about co-optation/loss of integrity

BUT NOT REALLY SO NEW AFTER ALL

- History extends back to Philippe Pinel at the end of the 18th Century as a core component of the infrastructure for “moral treatment.”
- Introduced by Jean Baptiste Pussin as a strategy for humanizing asylums.
THE CREATION OF PEER SUPPORT IN THE 1790S IN FRANCE

“In lunatic hospitals, as in despotic governments, it is no doubt possible to maintain, by unlimited confinement and barbarous treatment, the appearance of order and loyalty. The stillness of the grave, and the silence of death, however, are not to be expected in a residence consecrated for the reception of madmen. A degree of liberty, sufficient to maintain order, dictated not by weak but enlightened humanity, and calculated to spread a few charms ever the unhappy existence of maniacs, contributes, in most instances, to diminish the violence of the symptoms, and in some, to remove the complaint altogether.

Such was the system which the governor of Bicetre endeavoured to establish on his entrance upon the duties of his present office. Cruel treatment of every description, and in all departments of the institution, was unequivocally proscribed. No man was allowed to strike a maniac even in his own defence. No concessions however humble, nor complaints nor threats were allowed to interfere with the observance of this law. The guilty was instantly dismissed from the service.

In might be supposed, that to support a system of management so exceedingly rigorous, required no little sagacity and firmness.
The method which he adopted for this purpose was simple, and I can vouch my own experience for its success. His servants were generally chosen from among the convalescents, who were allured to this kind of employment by the prospect of a little gain. Averse from active cruelty from the recollection of what they had themselves experienced;—disposed to those of humanity and kindness from the value, which for the same reason, they could not fail to attach to them; habituated to obedience, and easy to be drilled into any tactics which the nature of the service might require, such men were peculiarly qualified for the situation. As that kind of life contributed to rescue them from the influence of sedentary habits, to dispel the gloom of solitary sadness, and to exercise their own faculties, its advantages to themselves are equally transparent and important” -- Pinel, 1801

JEAN BAPTISTE PUSSIN

Dr. Philippe Pinel at the Salpêtrière, 1795 by Robert Fleury. Pinel removing the chains from patients at the Paris Asylum for insane women.
EARLIER IN THE 20TH CENTURY

Harry Stack Sullivan

People with psychosis are much more fundamentally human than otherwise

Suffered from psychosis himself, and hired recovered and recovering patients to be staff

THERAPEUTIC COMMUNITIES

- Dominant form of institutional care in private and community hospitals from mid-century, which vestiges to this day (e.g., level systems, community meetings)

- Significant role of peers in providing mutual support, role modeling, mentoring, etc.

- Unpaid, considered part of the person’s own treatment (similar to peer support and work-ordered day tasks in Clubhouses)
MAJOR INFLUENCES ON MENTAL HEALTH POLICY IN THE U.S.

- Dorothea Dix credited with starting state hospital movement, but wanted quality and effective care available to all in need

- Clifford Beers started mental hygiene movement with Adolf Meyer (today called “mental health”)

PARALLELS IN ADDICTION RECOVERY

“They fully understand each other’s language, thoughts, feelings, sorrows, signs, grips, and passwords, therefore yield to the influence of their reformed brethren much sooner than to the theorists who speak in order that they may receive applause”

--- D. Banks McKenzie, 1875

ADDITIONAL PRECURSORS AND SUCCESSORS IN ADDICTION

- Temperance missionaries (1840s–1890s)
- Aides and managers of inebriate homes (1860s–1900)
- “Friendly visitors” at Emmanuel Clinic in Boston (1906)
- Lay alcoholism psychotherapists (1912–1940s)
- Managers of “AA farms” and “rest homes” (1940s–1950s)
- Halfway house managers (1950s)
- “Para-professional” alcoholism counselors and professional “ex-addicts” (1960s–1970s)

SUMMING UP

- Pinel did not remove the shackles from the inmates at the Bicetre, Pussin did; Pinel observed and described Pussin’s approach
- Pussin’s approach relied heavily on peer workers (convalescing patients, which is what Pussin was when he was hired)
- Dorothea Dix’s crusade was fueled by her own experiences of psychosis as well as her sense of social justice
- Clifford Beers advocacy was fueled by his own treatment in a state hospital
- “Recovery” from addiction was catalyzed by Bill W. based on a hundred years of predecessors providing various kinds of peer support (and more people continue to get recovery by themselves or with peers than through professional treatment)
WHAT IS MY POINT?

- Real life ("lived") experience provides a crucially important and valuable source of "evidence"—both of needed policy changes and of the effectiveness of peer support in promoting recovery from MI and SU.

- History suggests that the lessons learned from these experiences can get separated from the experiences themselves (and the people who had them) and can be appropriated by others for various and sundry purposes.

THE MORAL OF THE STORY?

VIGILANCE

VIGILANCE

VIGILANCE
First generation studies showed that it was feasible to hire people in recovery to serve as mental health staff.

Second generation studies showed that peer staff could generate at least equivalent outcomes to non-peer staff in similar roles; could also engage people into care and reduce readmissions.

Third generation studies are investigating whether or not there are unique contributions that peer support can make; these have thus far been in hope, alcohol & drug use, and activation for involvement in treatment and self-care.

**ENGAGE STUDY**
(NIDA R01 #DA13856)

**Demographics:**
- 134 Participants
  - Standard Care n = 44
  - Skills Training n = 47
  - Engage n = 43
- 83% not employed at baseline (n = 113)
- 56% African American
- 32% Caucasian
- 14% Hispanic (n = 19)
- 66% never married
- 6% married
- 11% participants lived with someone else
- 65% male (n = 88)
- 34% female (n = 46)
- ALL had co-occurring psychosis & substance use disorder
Engage participants demonstrated significantly greater improvement in CCCS scores from baseline to 9-months than Standard Care (est. = -16.36, p = .04) and Skills Training (est. = -19.04, p = .01).

Engage participants have a significantly greater increase in social functioning from baseline to 9-months than Standard Care (est. = -.43, p = .01) and Skills Training (est. = -.31, p = .05).
Engage participants demonstrated a significantly greater reduction in problems with alcohol use in the past 30 days from baseline to 3 months than Standard Care (est. = 8.84, p<.001) and Skills Training (est. = 7.89, p<.001).

Engage have a significantly greater increase in time spent in services from before baseline to the first year after baseline than Standard Care (est. = -765.26, p = .04) and Skills Training (est. = -1183.19, p<.001).
Peer Engagement Study

Randomized, controlled trial of assertive outreach with and without peer specialist staff for people who would be considered eligible for outpatient commitment in other states.

CULTURALLY-RESPONSIVE PERSON-CENTERED CARE FOR PSYCHOSIS

Demographics:

- 278 participants
  - 143 Hispanic origin
  - 135 African origin

Conditions

- IMR = 84
- IMR & Peer Advocate = 94
- IMR & Peer Advocate = 100
- and Connector

Mean age 44
Average education level 11 years
15% employed
57% male (n = 88)
43% female (n = 46)
6-Month Process and Outcome Data

- Peer-Run Community Integration Program
  - ↓ Psychotic Symptoms but ↑ Distress from Symptoms
  - ↑ Satisfaction with Family Life, Positive Feelings about Self & Life, Sense of Belonging, & Social Support
  - ↑ Engagement in Managing Illness & Use of Humor as Coping Strategy

- Peer-Facilitated Person-Centered Care Planning
  - ↑ Sense of Responsiveness & Inclusion of Non-Treatment Issues in Care Planning
  - ↓ in Spiritual Coping
  - ↑ Sense of Control in Life & Power of Anger to Impact Change
  - ↓ Satisfaction with Work Status

- Illness Management & Recovery
  - ↓ Paranoid Ideation & Medical Problems
  - ↑ Social Affiliation & Satisfaction with Finances
  - ↑ Coping & Sense of Participation
  - ↓ Sense of Activism

- Medication Monitoring & Case Management
  - Psychosis
  - African and/or Hispanic Origin
  - Poverty

RECOVERY MENTOR STUDY

- Randomized controlled design
- Inpatients 18 years and older, with a diagnosis of:
  - Schizophrenia
  - Schizoaffective disorder
  - Major depression
  - Bipolar disorder
- Follow up
  - 3 and 9 months
**EXPERIMENTAL CONDITION**

"Usual care" plus: Community-based interactions with recovery mentor as desired by participant

Mentors were trained in

- Engaging people in trusting relationships
- Using positive self-disclosure to instill hope
- Role modeling of adaptive problem solving

**DEMOGRAPHICS**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Experimental (n=38)</th>
<th>Control (n=36)</th>
<th>P (two-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>42.37 (11.47)</td>
<td>38.69 (8.35)</td>
<td>.12</td>
</tr>
<tr>
<td>Male Gender</td>
<td>17 (44.7%)</td>
<td>21 (55.3%)</td>
<td>.24</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td>.37</td>
</tr>
<tr>
<td>African-American</td>
<td>12 (32.4%)</td>
<td>9 (25.0%)</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>18 (51.4%)</td>
<td>24 (66.7%)</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>4 (10.8%)</td>
<td>3 (8.3%)</td>
<td></td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>2 (5.4%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Currently Married (yes)</td>
<td>8 (21.1%)</td>
<td>1 (2.8%)</td>
<td>.02</td>
</tr>
<tr>
<td>Number of Hospitalizations in Prior 18 months</td>
<td>3.76 (1.08)</td>
<td>3.94 (1.31)</td>
<td>.52</td>
</tr>
<tr>
<td>Number of Hospitalization Days in Prior 18 months</td>
<td>40.0 (20.70)</td>
<td>42.31 (19.69)</td>
<td>.63</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td>.92</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>12 (31.6%)</td>
<td>11 (30.6%)</td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>26 (68.4%)</td>
<td>25 (69.4%)</td>
<td></td>
</tr>
</tbody>
</table>
### ADMISSIONS & DAYS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Peer Mentor</th>
<th>Usual Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>38</td>
<td>36</td>
</tr>
<tr>
<td>Hospitalizations Mean (SD)</td>
<td>0.89 (1.35)</td>
<td>1.53 (1.54)</td>
</tr>
</tbody>
</table>

**Significance:** $F = 2.90$, df = 1, $p = .05$ (one tailed)  
Partial Eta Squared = .04

| Hospital Days Mean (SD) | 10.08 (17.31) | 19.08 (21.63) |

**Significance:** $F = 3.63$, df = 1, $p = .03$ (one tailed)  
Partial Eta Squared = .05

### ADMISSIONS & DAYS BY DIAGNOSIS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Average Hospitalizations</th>
<th>Average Days in Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mentor</td>
<td>Usual Care</td>
</tr>
<tr>
<td></td>
<td>N Events</td>
<td>N Events</td>
</tr>
<tr>
<td>Psychotic</td>
<td>26 (.92 (1.41))</td>
<td>24 (1.80 (1.68))</td>
</tr>
<tr>
<td>Non-psychotic</td>
<td>8 (.83 (1.27))</td>
<td>6 (.91 (.94))</td>
</tr>
</tbody>
</table>

**Significance:** ANCOVA, $p$ (one tailed)  
Condition: $F = 1.47$, $p = .12$  
Partial eta squared=.03  
Diagnosis: $F = 2.22$, $p = .07$  
Cond. X Dx: $F = 1.28$, $p = .13$  
Cond. F = 1.51, $p = .12$  
Dx. F = 3.96, $p = .025$  
Cond. X Dx: F = 1.23, $p = .14$
**History of the Peer Support Movement - Larry Davidson**

**3/20/2015**

iNAPS/Optum Webinar 19

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### Significant Differences Between Conditions Over Time for Intervening Variables

<table>
<thead>
<tr>
<th>Condition</th>
<th>Drug Use</th>
<th>Hope</th>
<th>Depressed</th>
<th>Poor Self-Care</th>
<th>Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual Care</td>
<td>.54 (.23)</td>
<td>.53 (1.17)</td>
<td>39.03 (11.45)</td>
<td>38.63 (7.75)</td>
<td>4.21 (2.06)</td>
</tr>
<tr>
<td>Mentor</td>
<td>.85 (1.52)</td>
<td>.05 (21)</td>
<td>43.467 (12.52)</td>
<td>45.68 (10.59)</td>
<td>4.03 (2.28)</td>
</tr>
</tbody>
</table>

**Significance**
- p = .004
- p = .04
- p = .002
- p = .02
- p = .016

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### Peer Support Has Been Found So Far To…

- reduce readmissions by 42%
- reduce days in hospital by 48%
- decrease substance use
- decrease depression
- increase hopefulness
- increase engagement with care
- increase activation and self-care
- increase sense of well-being
- improve relationship with providers

Recent review by Chinman et al in psych services
CURRENT SITUATION

- Peers hired into a variety of roles with a variety of names
- Hired by outside and inside of mental health agencies
- Hired into agencies with varying degrees of understanding and acceptance of peer role
- Tension is more the norm than not at this point

HOW CAN YOU TELL THE DIFFERENCE?

- Do peer staff view service users as their peers? (as seen in language, attitude, and relationships)
- Are peer staff encouraged to disclose their own recovery stories and to bring their life experiences with them to the table?
- Is there clarity in roles or does the peer staff role overlap with existing staff roles?
HOW YOU CAN TELL, PART 2

- Do peer staff spend the majority of their time doing things (i.e., solving problems) or listening?
- Do peer support staff have a “champion” in a senior leadership position to endorse and ensure the integrity of peer support?
- Are peer staff viewed as one element of a broader agency-wide transformation to a recovery orientation?

HOW TO TELL, PART 3

- Is inevitable discrimination addressed within the work place? Is it understood to be discrimination?
- Are peer staff trained and supervised for the roles they are being asked to perform?
- Are peer staff supervised by someone who understands the value of life experience?
- Are there opportunities for upward mobility?
HOW TO TELL, PART 4

Is there at least a tension between …

- Engaging people into existing system of services and supports by encouraging attendance and adherence (e.g., “helping people stay on their meds”)
- Advocating for the system itself to change in order to become more responsive to the needs of the people it serves (e.g., peer facilitator in person-centered care planning)

MANAGING/EDUCATING “UP”

- Usually, when someone is hired for a job, their supervisor or other higher up in the organization orients them to the role and tasks
- In peer support, peer staff are often in the position of needing to manage or educate up the line in an organization in which leaders do not know much about what the person has been hired for
- The training peer staff receive typically has not addressed how to handle this unfortunate inevitability in an effective fashion
- As a result, micro-aggressions frequently go unaddressed
TURNING TO THE FUTURE

Health Care Reform:
- Focuses on health care homes (including person-centered care, shared decision-making, & self-management)
- Includes role of patient navigators ("community members who are trained in strategies to connect individuals to care, to help them overcome barriers to receiving care, and to assist them in various other ways through their course of treatment")

“NAVIGATION” INVOLVES
- scheduling appointments
- arranging for child care
- reminding people of appointments
- providing transportation to and/or accompanying people to appointments
- providing information, education, support, and encouragement
- trouble shooting system issues and barriers
Navigation services have targeted underserved populations, and have led to increased rates of engagement and retention, as well as improved trust and communication between patients and health care providers, both of which have contributed to improved adherence and self-care.

**EXAMPLES**

- Decrease in high-risk behaviors for HIV
- Decreased infant mortality
- Decreased psychiatric symptoms
- Significant decreases in HbA1c, body mass index, total cholesterol, LDL cholesterol, and systolic and diastolic blood pressure among persons with diabetes
IN BEHAVIORAL HEALTH, THERE IS ALSO A NEED FOR ACTIVATION

- helping people prepare for health care visits and ask questions;
- identifying and setting health-related goals;
- planning specific action steps to achieve goals;
- encouraging exercise and good nutrition;
- assisting in daily management tasks;
- problem solving (broader than system navigation);
- providing social and emotional support and feedback;
- and following up with people over time

TWO TYPES OF ENGAGEMENT AND ACTIVATION IN BEHAVIORAL HEALTH

- Engagement in care historically has meant connecting persons with mental illnesses and/or addictions to needed behavioral health services and supports (i.e., getting people ‘into treatment’)

- Self engagement means activating persons with behavioral health conditions to manage their own conditions and their own care (this is not the same thing)
CURRENT SITUATION

- Moving away from symptom management that has (falsely) accepted long-term disability as inevitable
- Moving toward promoting the recovery, social inclusion, and citizenship of persons with mental health conditions and addictions through the use of community-based supports, including peer-based support
- CMS shifting to self-management of health care conditions, including behavioral health
- Who better to promote self-management than peers?

Questions? Comments?
Please use the chat box.
Special thanks...

Special thanks to Optum for their ongoing support of this series and their dedication to quality in the practice of peer support.

To receive a certificate of participation, go to the iNAPS website: www.inaops.org and click on the link for a brief quiz.

Please be certain to complete your contact information completely and correctly. A certificate will be mailed to you in 3-4 weeks.
On behalf of the International Association of Peer Supporters (iNAPS) and Optum

Thank you!