

Arthur C. Evans, PhD Response to Honorable Dr. Burgess

April 25, 2014

Question: *Please elaborate on your experience with the introduction of peer specialists.*<sup>1</sup>

The introduction of peer specialists in Philadelphia has been one of the most important developments in improving service delivery and outcomes for individuals with behavioral health needs. Since 2006, the city of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) has supported a statewide initiative to train Certified Peer Specialists (CPS). Over 680 CPS have been trained to date, with approximately 40% of these individuals employed through this training. However, because of their effectiveness, it is now an expectation that behavioral health providers funded by DBHIDS hire at least 2 CPS, so we anticipate that the number of trained CPS employed will rapidly grow in the coming years.

CPS are employed by a wide range of behavioral health providers in Philadelphia including inpatient psychiatric facilities, community mental health centers, psychiatric crisis response centers, residential substance abuse programs, outpatient addictions programs and mobile mental health teams. With the addition of CPS, facilities and agencies have reported improved recovery outcomes for individuals with behavioral health conditions and improved employee satisfaction among professionals as they see significant clinical improvement in individuals in their programs and economic gains for the agency as they improve client retention. One agency in particular has been able to hire 25 full-time CPS solely due to increased fee-for-service revenue resulting from CPS' effectiveness in improving access and retention of individuals in the treatment program.

For the last five years, DBHIDS has also provided other instruction programs to supplement the CPS trainings for individuals with lived experience, their family members, and community members. Over 2,500 individuals have participated in these trainings. DBHIDS is also planning to provide increased support to behavioral health and non-behavioral health agencies to prepare them for

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<sup>1</sup> Original testimony provided on March 26, 2014 at a hearing of the Subcommittee on Oversight and Investigations "Where have all the patients gone? Examining the Psychiatric Bed Shortage."  
<http://energycommerce.house.gov/hearing/where-have-all-patients-gone-examining-psychiatric-bed-shortage>

effectively employing peer specialists. This is to ensure that organizations are equipped to maximize the benefit peers can bring to an agency.

**We would like to thank [Dr. Larry Davidson of Yale University](#) who has collaborated with us in the development of our peer specialist initiative. He has provided some additional background information on peers and their role nationally in behavioral health systems.**

Since the introduction of hiring peers (i.e., persons with histories of mental illness who have recovered or are in recovery) as staff in the early 1990s, peer support practitioners have become the fastest growing component of the mental health workforce. At present, over 30 states have made arrangements with their state Medicaid office to capture reimbursement for the services provided by peer support specialists, and most of the remaining states have developed peer-delivered services based on the use of general fund or SAMHSA block grant dollars. The Veterans Health Administration alone has hired over 1,000 peer specialists over the last several years. As a result of the rapid growth and proliferation of this new profession, a national set of practice guidelines were developed and disseminated in 2014; an ethics statement and set of practitioner competencies are currently under development (Davidson, 2014).

Peers were initially hired to provide conventional mental health services such as case management and residential and employment supports (e.g., job coaches). The first generation of studies on these forms of peer staff showed that peers were able to perform these functions equally as well as existing (non-peer) paraprofessional staff, with no differences in outcomes. The only positive difference for peer specialists was found in one study of outreach and engagement to persons who would have been eligible for mandated outpatient treatment in a state that did not yet have outpatient commitment. To be eligible, participants had to have a serious mental illness, have shown a positive response to acute care during a previous hospitalization, have a pattern of refusing outpatient services once discharged, and have a history of violence or be at risk for violence. Participants were randomly assigned to either an outreach team that had hired peer staff or an outreach team that had not hired peer staff. Those participants who were assigned to peer outreach staff became engaged in treatment more quickly and reported having a better relationship with staff than those who were assigned to non-

peer staff. In this particular study, no adverse events were reported for participants in either study condition over the two-year duration of the project (Sells, Davidson, Jewel, Falzer, & Rowe, 2006).

Once the feasibility of hiring peer staff became established, the peers themselves began to partner with mental health practitioners and researchers to develop and evaluate roles for peers that made more use of their relevant life experiences and talents. One of the reasons given to explain why peer staff initially were not showing superior outcomes over non-peer staff in conventional roles was that the roles they were trained for and hired into did not allow them to make use of the unique strengths they brought to their work. As a result, a number of more properly peer roles have been developed that enable peer staff members to offer a unique form of support (now called *peer support*) that involves them making use of their own recovery stories to instill hope in the persons they serve. They also use the lessons and wisdom they have accrued through their own resilience in the face of adversity—along with relevant training and supervision—to facilitate, guide, and mentor other people's recovery journeys through role modeling and supporting people in their own efforts to reclaim meaningful, self-determined lives in the communities of their choice.

Peers offering this kind of support have found it tremendously gratifying to be allowed to give back to their communities in such valuable and effective ways, and research has begun to show that peer support that is based on the peer staff's own recovery narratives and their role modeling of self-care does in fact produce superior outcomes on a number of important dimensions. Several of these studies also have begun to show cost savings as a result of the introduction of this form of peer support to persons who have histories of using intensive and costly forms of acute care. The roles that peers play vary across these studies offer a beginning list of the diverse ways in which peer support can be provided depending on the specific needs and preferences of specific subpopulations. What follows are examples of this diversity; this is not an exhaustive list of relevant research.

One particularly promising use of peer support has been for persons leaving inpatient care, especially when they have a history of readmissions. A 1998 study found a 72% reduction in readmissions among New York state residents who were offered a peer *bridger*, while a 2010 study found a similar reduction (73%) in hospital days in Tennessee (New York Association for

Psychiatric Rehabilitation Services, 2012)<sup>2</sup>. A more recent *bridger* study found a reduction of 42% in the rate of readmissions and a 48% reduction of days spent in the hospital (Sledge, et al., 2011). A 2013 review commissioned by the National Health Service in England of these and other studies, entitled “Peer support in mental health care: Is it good value for the money?” calculated that, on average, every British pound (£) spent on *peer bridger* services results in the savings of £4.75 due to reductions in hospital use (Trachtenberg et al., 2013). This model is now being extended to help *bridge* the gap between prison and the community for persons with mental illnesses who are being discharged from prisons.

Another strategy for reducing hospital days is that of developing peer-run crisis respite programs that can serve as alternatives to hospital admission (Repper & Carter, 2011; Sledge et al., 2011). A 2010 study of one such diversion program found that 90% of the 227 persons served in that year did not need to be hospitalized in the two years following their stay. The crisis respite program had a cost of \$353 per day compared to the cost of one day in the hospital of \$1,400, resulting in a projected cost savings of over \$1,000 per day for each of the 748 days participants spent in the respite program (for a total savings of \$748,000 in one year) (New York Association for Psychiatric Rehabilitation Services, 2012).

In addition to these kinds of costs savings, peer support has been shown to increase hope, empowerment, well-being, and quality of life, and reduce substance use and depression, among persons with mental illnesses with histories of multiple hospitalizations, criminal justice involvement, and/or co-occurring substance use disorders. Peer support has been used to reduce health disparities for persons with mental illnesses from racial and ethnic minority communities (e.g., people of African and/or Hispanic origin), and to increase the involvement of persons with mental illnesses in their own care. A recent study conducted within the VA system, for example, found that veterans who were randomly assigned to care teams that included peer specialists became significantly more activated for and interested in taking care of themselves (Chinman et al., 2013).<sup>3</sup>

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<sup>2</sup> For more information, see <http://www.nyaprs.org/peer-services/peer-bridger/> (accessed 4/25/2014).

<sup>3</sup> For more information, see <http://www.blogs.va.gov/VAntage/9368/help-fellow-veterans-become-a-va-peer-specialist/> and <http://www.vacareers.va.gov/peer-to-peer/index.asp> (accessed 4/25/2014).

As health care systems aim to improve the quality of services provided to the mentally ill, there will be heightened interest in building on the ability peers have to activate persons with mental illnesses and to teach them self-care skills as members of interdisciplinary health home teams. Peers are particularly well-suited to function as health navigators for exchanges in the Affordable Care Act, and several studies are currently examining the various health and mental health outcomes of peers functioning in this way as Wellness Coaches. Preliminary findings suggest that the use of peers may enhance the timely access of persons with mental illnesses to primary care and specialty medical services and improve their physical and mental health while at the same time reduce their overall Medicaid costs (Chinman, et al., 2014; Davidson, et al., 2012).

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