

# **Peer Support and Recovery: Research, Evidence & Best Practice**

**International Recovery Perspectives:  
Implications – Innovations –  
Implementation**

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# Sources:

- *Presentation at The Twenty-First Annual Rosalynn Carter Symposium on Mental Health Policy, Atlanta, GA, November 2, 2005*
  - **Judith A. Cook, Center on Mental Health Services Research & Policy, University of Illinois at Chicago**
- *A Narrative Approach to Developing Standards for Trauma Informed Peer Support*
  - **Cheryl MacNeil and Shery Mead**
- *Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators*
  - **Steven J. Onken, Jeanne M. Dumont, Priscilla Ridgway, Douglas H. Dornan, Ruth O. Ralph**
- *COSP EBP Toolkit Slides*
  - **Jean Campbell, Program in Consumer Studies and Training, Missouri Institute of Mental Health**

# Research-informed Recovery

## Definition:

- Recovery as the ongoing, interactional process/ personal journey and outcome of restoring a positive sense of self and meaningful sense of belonging while actively self-managing psychiatric disorder and rebuilding a life within the community.

# Recovery Practice Framework

- Ecological Structure
  - Elements of the Person
  - Elements of the Environment
  - Elements of the Exchange
    - Emphasis on Interactions and Transactions
- Change Process
  - First Order
  - Second Order

# Peer-to-Peer Looks Like...

- Consumer Operated Services Programs (COSPs)
- Self-Help/Mutual Support Groups (GROW, Depression & Bipolar Support Alliance)
- Peer addiction recovery services (DDA, Double Trouble)
- Intentional Trauma-Informed Peer Support and Peer-Run Crisis Alternatives (Mead & Hansen)
- Peer-to-Peer Services (Georgia Certified Peer Specialists)
- Peer-to-Peer Education (Bridges, Vision for Tomorrow)
- Mental Health Self-Management (WRAP, Taking Charge)
- Self-Directed Care/money follows the person models
- Advance Directives for mental health care
- Employment of people in recovery in 'traditional' programs

# Diversifying Power

*The people that helped me the most in the hospital admitted that yes, they were mental health consumers. They were hired and when they were hired no one knew. (OK)*

# Peer-to-Peer Connection: First Order Change

- Helping one self through helping others, experiential knowledge/self-help, role models, sense of normalcy & understanding
- Counteracting internalized life scripts regarding chronicity/pathology/helplessness with those emphasizing self-responsibility and self-management

# Re-Authoring Process and Practice

- People can be agents of power – can reclaim self-definition
- First Order Externalizing
  - Separating the person from the problem in such a way as to make the problem the problem
  - Challenging the assumptions that locate the problem within the person
  - No longer submitting and monitoring themselves accordingly to “the way to be.”

# Narrative Therapy/Intentional Interviewing

- Understand how people experience and make sense of the world. What are their basic story lines and narratives?
  - **Story** – the stories about their lives, their problems, challenges and issues, telling these in their own way
  - **Positive Asset** – listening for, identifying and uncovering positive strengths and assets - a positive asset search
  - **Restory** – generate new ways to talk about themselves
  - **Action** – bringing new ways of thinking and being into action

(Ivey & Ivey, 2003)

# Referent Power

*Support from others is very important, especially from others who are in the same predicament that you are. They know what you go through. They've been through it, and they survived, which could help you survive. (TX)*

# Peer-to-Peer Connection: Second Order Change

- Consumers empowering consumers through building of community
- Taking of collective action by consumers against the effects of oppressive forces in their lives

**“Revolutions begin when people who are defined as problems achieve the power to redefine the problem.” John McKnight**

- **Building Recovery Capital in CT**
  - **Peer to Peer grant awards**
  - **Trained peers in healthcare settings**
  - **Recovery follow-up telephone calls**
  - **“Citizenship” training**
  - **Elders in Recovery**
  - **Advocacy Unlimited training**
  - **Peer Engagement Specialist initiative**

**What Is the Evidence  
Base for Peer  
Support In  
Behavioral Health  
Care?**

# What do you hear as the “outcome?”

**Elizabeth** (attendee at the peer training): It was uncomfortable at first. Being in this program and being in this training, it's like it's true these things happened, but gearing it to, 'where do you want to go with this?' and moving beyond it... That's really new and it's very uncomfortable. I think it's probably like a toddler learning to take its first steps. He's unstable. I don't mean like I'm going to fall apart. I don't mean like psychologists would mean unstable, its just a little wobbly. It's new ground.

**Cheryl** (evaluator): What's the new ground?

**Elizabeth**: You get comfortable being the victim after a while. It's familiar. Then all of a sudden, someone's challenging you to move beyond that.

**Cheryl**: So you're moving out of the victim role?

**Elizabeth**: Exactly. I don't want to be a victim any more. I don't like it. I've been beat enough. I just want to go on. It's going out of there and going on and being someone that's respected. That's the word: Respected. I don't ever feel that I was respected. If I had been, how would someone hurt somebody if they respected them? So I want to be a respected person.

**Cheryl**: And that's a whole different role than wanting to be a victim?

**Elizabeth**: Right. Then I became a victim in the system. 'You take care of me. Okay, doctor, I'll agree with you. I'll take this amount of medicine. Okay, if you say so.' I was victimizing myself all over again. I don't want somebody doing that to me. I don't want somebody just shutting me up. So I like what's offered here. Not to do it alone, because if you come in here you don't have to do it alone. Somebody's willing to sit and go through it with you. (Cheryl MacNeil, Sweetser 2003)

**Knowledge:**

**“The sum of  
what is known”**

**Shorter Oxford English Dictionary**

# Sources of Knowledge:



# Informed knowledge-based decision-making: A more comprehensive approach to evidence-based practice



# U.S. Agency for Healthcare Policy & Research

## 1992 Evidence Rating Guidelines

- |           |   |
|-----------|---|
| Level Ia  | Evidence from meta-analysis of multiple randomized controlled trials  |
| Level Ib  | Evidence from at least 1 randomized controlled trial  |
| Level IIa | at least one well-designed controlled study without randomization   |
| Level IIb | Evidence obtained from at least one other type of non-controlled, well-designed quasi-experimental study                                      |
| Level III | Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, and case studies |
| Level IV  | Expert committee reports or opinions &/or clinical experiences of respected authorities   |

# EBPs in Mental Health: Fundamental Questions

1. What qualifies as evidence of effective practice?

Clinical expertise, scientific research, lived experiences, consumer values & preferences

2. What qualifies as research on which to judge effective practice?

Case studies, single-participant design research, qualitative research, action research, effectiveness research, randomized clinical trials, life narratives

3. What treatment goals and outcome measures should be used to establish EBPs?

Self-report measures, patient reports, quality of life, objective behavioral indices, therapist judgment, external/society decisions

4. Does manualization improve therapy outcomes?
5. Are research participants and clinical trials representative of clinical practice?
6. What should be validated?
7. What else materially influences what is represented and published as evidence?
8. Do empirically supported treatments (EST) for specific disorders produce outcomes superior to non-EST therapies?
9. How well do EBPs satisfactorily address the various dimensions of diversity?
10. Are efficacious laboratory-validated treatments readily transportable to clinical practice?

**Norcross, Beutler, & Levant (eds.) (2005)**

# Valuing Tacit/Implicit Knowledge where Explicit Knowledge holds Sway

- Tacit - 'those things that we know how to do but are unable to explain to someone else'
- *Knowledge Mapping as Flexible Guides*
- Improvisation, Experiential Intuition
- Consumer as Provider
- Explicit - approximates to propositional knowledge (knowledge about)
- *Knowledge Mapping as Standardized Algorithms*
- Outliers, Clinical Judgment
- Professional as Provider

# **Consumer-Operated Mental Health Services: Evidence Base**

**Four Randomized Controlled Trials  
(Paulson et al., 1999; Solomon &  
Draine, 1999; Kaufmann, 1995;  
Edmunson et al., 1982)**

**Multi-site (N=8) COSP Study (Campbell  
et al., 2005)**

**All found COSP services equivalent or  
superior to control services**

**COSP Evidence Base – Level Ib**

# **COSP Multi-Site Study**

- **Overall increase in well-being**
- **Strong relationship between increased well-being and recovery oriented program features**
- **Not limited to one program model type**

# Peer-Run Crisis Alternatives: Evidence Base

## Crisis Hostel Project

### Findings:

- Better healing outcomes
- Greater levels of empowerment
- More timely and useful crisis services (greater service satisfaction)
- Greater healing and promotion of self care
- Shorter hospital stays
- Less expensive crisis costs

Peer Crisis Alternatives Evidence Base –  
Level 1b

## **Other Studies using Randomized Control Trials (Level IB)**

### **Integrated Skill Building and Peer Support in MHT**

- Decreased hospitalizations**
- Functioning without contact with the  
mental health system (helping each  
other in community)**

### **Self Help Employment Center**

- Higher employment**

# **Mental Illness Self-Management: Evidence Base**

**Illness Self-Management: Wellness  
Recovery Action Planning (WRAP)  
(Vermont Recovery Education Project,  
nd; Buffington, 2003)**

**Significant changes in knowledge of  
symptoms, symptom management,  
use of natural supports, hopefulness,  
development of crisis plan**

**Self-Management Evidence Base - Level  
IIb**

# **Seclusion & Restraint Reduction: Evidence Base**

**Seclusion & Restraint Reduction  
(Jonikas et al., 2004; McCue et al.,  
2004)**

**Significant pre-post-reductions in  
rates of seclusion &/or restraint  
following staff/patient training &  
ACM planning**

**Seclusion & Restraint Reduction  
Evidence Base - Level IIb**

# Advance Directives for Psychiatric Care: Evidence Base

Psychiatric Advance Directives (AD-Maker) – (Backlar, 2000; Southerby et al., 1999; Srebnik et al., 2004, 2005)

Significant increases in perceived control over mental health problems, involvement in care, and ability to express treatment preferences

Advance Directives Evidence Base - Level IIb

# Other Quasi Experimental (Level II)

- Canadian Consumer/Survivor Initiatives
  - Increased instrumental roles (e.g., work)
  - Reduced psychiatric symptoms and hospitalizations
- Effects Noted in Other Studies:
  - Increased Interpersonal Transactions of Giving and Receiving Help
    - Helper's Principle
  - Recovery of Social Functioning and Increased COSP Participation
    - Improved psychological and social adjustment
    - Encouraged goal advancement
    - Improved quality of life

# Self-Directed Care: Evidence Base

Self-Directed Care for Mental Health Recovery  
(Teague & Boaz, 2003; Cook & Russell,  
2005)

Significantly greater satisfaction than comparison group with ability to obtain needed services & with progress toward goal attainment; significant increases in level of functioning & days in the community compared to pre-program levels

Self-Directed Care Evidence Base - Level III

# Other Well-Designed Descriptive (Level III)

- **Member Benefits**
  - **Improvements in quality of life**
  - **Problem solving**
  - **Satisfaction**
  - **Social support**
  - **Hospitalization reduction**
  - **Coping skills**
- **Drop In Centers**
  - **Improved social support**
  - **Shared problem solving**
  - **More confident in making decisions about life situations**
  - **Stay out of the hospital**
  - **More freedom, caring, and less structure**
  - **Improved quality of life**
- **Comparison With Clinical Setting**
  - **Greater self esteem, locus of control, and hope for the future**
- **Mutual Support Groups**
  - **Better medication adherence**

# Expert/Respected Authorities Reports, Opinions, Experiences; First Person Accounts (Level IV)

- Reaching Across, On our Own, Etc.
  - Describing COSP Processes
  - Identifying consumer defined outcomes (role modeling, helping ourselves, empowerment)
- Well Being Project
  - Reducing psychiatric problems
  - Building empowerment, personhood and social connectedness

# Peer Support

- Standards
- Use
- Funding
- Expansion

# Narrative-Informed Standards and Indicators

- **Achieving Difference**
  - Shifting worldview
  - Restorying my life
  - Moving with Support towards what I want
- **Critical Learning**
  - Learning how we've come to know what we know
  - Thinking about 'what happened to me instead of what's wrong with me.'

# Standards and Indicators (cont.)

- **Mutuality: Redefining help**
  - More than reciprocity, it's a two way process
  - Both people taking both roles, helper and helpee
- **Mutual Responsibility: Creating Community Relationships**
  - Both people figure out the rules of the relationship
  - Negotiating power as equals

# Standards and Indicators (cont.)

- **Language Use**
  - Using language that supports a different kind of conversation
  - Getting away from illness/behavioral health language
- **Redefining Safety: Sharing Risk**
  - Seeing safety in the context of mutually responsible relationships
  - Being honest about our discomfort
  - Sharing risk and practicing alternative ways of being together

# The Use of Peer Support – Growing

- ECA study (early 1980s) - 4.1% of individuals with a mental disorder used voluntary support in past year
- MIDUS study (1996) - 18% of ppl with severe mental illness used formal mental health self-help/mutual aid group in past year
- In a national survey of states, 40 funded consumer-operated peer/mutual support programs, 38 funded consumer advocacy programs, 32 states reported offering self-help programs in state hospitals, & 32 funded drop-in centers (Shaw, 2004).

# While Peer Support is Growing the Amount of State Funding is Fairly Minimal

- In 2002-2003, most states spent less than one percent of their total annual mental health budgets on COSP.
- Of 41 states reporting, 1/3 provided less than \$500,000/year and 1/4 spent \$200,000 or less/ year. (NASMHPD, 2004).

# Enhancing Peer Support: Modest Proposal

- ✓ Increase level of funding for peer support and consumer-operated services
- ✓ Encourage development of new models of peer support and consumer-operated services
- ✓ Develop, encourage & fund standards and fidelity models of peer support
- ✓ Encourage & fund more and more rigorous research on the effectiveness of peer support
- ✓ Train professionals in these models & require that they collaborate effectively with consumers & consumer-providers
- ✓ Increase **paid** consumers' involvement in all levels of behavioral health care "transformation"
  - ✓ **Living Wage and Career Ladders**