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UNDER THE MICROSCOPE

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Progress, Problems, and Opportunities for Peer Supports and Peer-Run Services

To get a broad look at how peer supports and peer-run services are advancing across the country, we contacted a number of prominent voices in the peer movement:

- Daniel Fisher, MD, PhD, President of the National Empowerment Center.
- Harvey Rosenthal, CEO of the New York Association of Psychiatric Rehabilitation Services (NYAPRS).
- Lori Ashcraft, PhD, CPRP, Executive Director of Resilience, Inc; whose 40-year career includes work with adult mental health programs in California and Arizona and extensive work in developing and delivering peer training at Recovery Innovations.
- Patty Blum, PhD, CPRP, Executive Vice President of operations at for Crestwood Behavioral Health, whose California-based organization has embraced the use of peers since 1999.

We asked them to comment on the role and contributions of peer support and peer-run services today, the challenges and problems that these services face, and the outlook for the future. Here is what they had to say.

Thoughts on Peer Support

Daniel Fisher

"Things vary a lot from state to state. Georgia, Pennsylvania and Michigan jump to mind as being very highly developed in terms of having 1,000 or more certified peers who can offer reimbursable services. Other states, such as Mississippi, are much less developed, due in large part to an absence of advocacy at the state level. At last count, I believe that 35 states offer Medicaid reimbursement for services provided by certified peers who are operating as independent practitioners, while the rest generally reimburse under rehabilitation services provided by licensed practitioners. Today, 46 states offer peer certification, though our most populous state, California, is not yet one of them."

"Advocacy in Massachusetts and other states has led to legislation that requires state and county departments of mental health to require that CMHCs hire peers, who have proven to be effective in outreach through roles on assertive community treatment teams, community crisis teams, walk-in crisis centers, supported housing programs, and coaching programs." He adds that in some states, peers are also providing support within inpatient psychiatric facilities, including state-run and forensic hospitals, such as

Massachusetts' Bridgewater facility, where peers provide individual and group supports. Peer bridgers then help to transition and place people leaving treatment back into the community.
"Unfortunately, the demand for peers has, in many areas, outstripped the understanding of how best to utilize them. Sometimes, peers find that they're introduced into roles that are poorly defined, working with staff members who don't understand why they are there—and see them not as a help, but as a potential employment threat."

Fisher agrees with other experts that peers are often asked to work in organizations where the recovery culture is weak, leaving them at a disadvantage in terms of the distribution of power. "Traditional models of care are clinical and hierarchical, so the professional always knows best," he notes, adding that despite requirements for "person-centered plans," plans often use the diagnosis-symptom-management language required by insurers, a far cry from the language through which the individual sees and deals with their own condition.

Fisher equates serious mental illness with the loss of one's life. "Often, people experiencing a psychosis feel marginalized, isolated and afraid of people, and separated from community. Yet the system's response is to present program after program, telling them to 'meet this group, meet that group,' when what they need most is someone to act as a bridger, to help them with that process and help them get back into the flow of their life."

According to Fisher, it was the desire to find others that led consumers like him to found drop-in centers, an early precursor of the many peer supports and peer-run services that exist today. He maintains that "a peer's most significant impact is on the 'affect' of the other—brought about by the authentic ability of a peer to appreciate and respond to another individual based on their lived experience. In many peer relationships, this bond starts a virtuous circle where emotional expression expands, together with trust and personal empowerment. In time, individuals become better able to reach out to others and find new purpose and passion in life.

"For a person who's literally trying to recover their life—autonomy, agency, self-determination, empowerment—these are the key factors," says Fisher. And the questions that individuals face aren't clinical, but personal: "Do I have a reason to get up in the morning? Do I know how to make friends? Do I have a sense of meaning and purpose? These questions go much deeper and form the paradigm of the recovery movement. The idea of peer support meshes perfectly with these."

He adds that during the course of recovery from a serious psychiatric event, "people may not benefit greatly from individual therapy, but they really value learning from someone with lived experience about how to obtain Social Security, how to find housing, how to find activities during the day, and other things that clinicians aren't familiar with."

"My dream for the future of peers is that they are trained and reimbursed to be more and more like life coaches," says Fisher. "So, I feel that a life coach – really a social life coach – may be the most important function of a peer."

Harvey Rosenthal

"Peer-delivered services were once considered new innovations that were ahead of their time. Now they're right on time and central to the successful support of individuals with major challenges." Today, according to Rosenthal, "everybody wants a peer, whether they're a managed care plan, a hospital, state and local government, or provider network."

These payers are finding that peer services, including many services delivered through peer-run agencies, have evolved into robust, mature models that include:

- Peer bridgers and other forms of transitional support from hospitals, adult homes and criminal justice facilities to the community,
- Peer wellness coaches
- Peer warm line and crisis line supporters
- Peer crisis respite programs
- Peer homeless outreach programs
- Peer mentors who provide assistance around housing, finances and employment
- Vet2Vet support
- Online, text and tele-peer support

Peer staff typically are highly trained in a variety of skills and values and are engaged in careers that are compensated appropriately, usually at a minimum of $40,000 annually.

However, Rosenthal cautions that, wherever peers are deployed, it is essential to make sure that they are knowledgeably supported to provide the right kind of support in the right way and with the right kind of supervision.

“Very few payers and providers actually understand what peers do—and the way that we have to do it to meet fidelity standards—so it’s all too easy for peers to end up in an unsupportive culture and the wrong role,” he says. (Sample standards can be found in the downloadable Fidelity Assessment Common Ingredients Tool (FACIT), which is available from SAMHSA.)

For example, peer organizations are frequently approached by hospitals and health plans to satisfy HEDIS behavioral health measures, most notably the one that focuses on seeing that people who leave hospitals see a clinician within seven days of discharge. “But that’s not why we’re here,” he explains. Peer support is not a seven-day relationship that begins with diagnosis and treatment.

“A key tenet of peer support is that each person decides what their goals are, what they need, how they want to be helped and where. It all starts with who the person is.

“If you let a peer relationship happen organically, an individual may ultimately choose to go to the doctor, and even ask the peer to help them get there. But that relationship begins with asking the individual, ‘what’s most important to you right now?’ And, often enough, the individuals’ greater concerns are about feeling safe, understood and connected; securing housing, finances, and food; or dealing with isolation and trauma rather than managing their symptoms.”

“The system has to be patient with the process of peer support, to allow a true engagement and a real alliance to develop. We often say, we are not here to get folks to the doctor after a hospitalization, but if we’re allowed to do what we do best, there will be far fewer crises and admissions in the first place.”

“Peer support is always voluntary, it is never coercive yet at the same time, we never give up on anybody. We keep coming back to see if there’s a way we can best be of help,” says Rosenthal. He points to the INSET model that is being piloted in Westchester County, New York to provide immediate, intensive and sustained support to individuals with major challenges for whom previous care and supports have been unengaging or ineffective.

Rosenthal says that INSET has an 85% rate of success in engaging and assisting individuals who would otherwise be subject to involuntary outpatient treatment, sometimes called Assisted Outpatient Treatment (AOT), which he considers to be evidence of system—not personal—failure.

As an example, "a community agency CEO once asked me for recommendations about what to do after they had sent out a worker on numerous occasions offering a specific package of services without success. Rather than dismissing the individual as 'noncompliant' and seeking a court order, I suggested he send out someone else and offer something better. Very often that 'something better' comes out of a trusted relationship with a peer supporter."

"I see a future where peer wellness coaches help individuals with a high level of medical as well as mental health related needs and who are not engaged or helped by their doctors, leading all too often to high instances of preventable medical crises and hospitalizations or early death. The message to doctors and healthcare systems is 'there are a lot of people you're attempting to treat who are not feeling heard, well engaged or supported, who are not clear about what you're recommending and why and who all too often get sicker and in frequent crisis."

"In some ways, peer support came out of providing more humane alternatives to traditional clinical and medical treatment. Peers working *with* doctors? Ironic, isn't it? Rosenthal laughs, but asserts, "If it can be done with fidelity, it will be a major win for all involved. Doctors will be helped to better understand and communicate with the folks they serve, people will experience improved health and reductions in preventable illnesses, ER use and hospital admissions and provider and state systems will improve care and reduce avoidable costs."

"But this will only happen where agencies and service settings feature a recovery culture and roles and supervision that advance true peer support."

Lori Ashcraft

For the past 20 years of her 40-year career, Lori Ashcraft has played a significant role in the recovery movement, in part by creating peer support specialist training and also by developing many current peers in Arizona, California, other states, and many other countries as well. Two of biggest issues that she and her colleagues have faced are 1) the challenge of introducing peers and recovery culture into behavioral health organizations that are hesitant to change, and 2) helping peers and their supervisors to survive the often-bumpy transition.

"I don't think anyone gets supervised particularly well in behavioral health," says Ashcraft, noting that "supervisory issues with peers are no different, but the effects show up more strongly for them, because they're often fresh out of training and have little work history. They get trained in the right stuff, but their work ends up a lot different from what thought, because the organization is not really recovery oriented." Often, part of the problem is in the attitude of the supervisor: "Think about a supervisor, observing work and giving an individual feedback about it. There are still a lot of people who believe that peers are 'too fragile' to take input. But without it, they are left wondering what to do, and trying to figure it out." She believes that supervisors can improve their feedback skills, while ensuring that peers know that they have permission to ask for help.

To help minimize future supervisory problems, numerous organizations are implementing changes in training models used in new programs. In a program being developed for Crestwood Behavioral Health in California, Ashcraft says that peer support training will start first with staff, then add supervisors, then peers—and maybe customers, too—before the entire team comes together in the workplace. The new

training model will be used to prepare peer support specialists for working with individuals admitted to involuntary treatment.

"Our work with Crestwood in San Diego County will, we hope, prepare people to have a shorter stay in the locked facility due to the help that they'll receive. The people involved are non-forensic (95%) admissions who are subject to admission under California's 5150 law. This law places people found by a judge to be "gravely disabled" and "a threat to themselves or others" into involuntary treatment where they may be held until their court-appointed conservator deems that they are competent to leave. (California's state hospitals accept the involuntary forensic admissions.)

The program will place trained peer support specialists at Crestwood's mental health rehabilitation center and adult residential program in San Diego. Having peer specialists work in locked environments is a first for Crestwood, which operates 33 locations in California. However, peer supporters, sometimes recruited from the ranks of its voluntary mental health patients, have been part of the company's approach since the late 1990s. Peers also actively assist in Crestwood's community-transition programs, which offer clients educational and vocational training through its "Dreamcatchers" pre-employment programs.

Patty Blum

Patty Blum, Crestwood's longtime VP of Operations, explains: "We looked at peers getting directly involved in supporting and providing services in the late 1990s. And we quickly realized that that was a great key to transformation. Then we took another step beyond peers in direct services and in 2003, began involving peers in the executive level of our organization. And, today, although California does not yet have peer certification, we operate a range of pilot peer certification projects.

Beyond those trained as peers, Crestwood recruits professional staff and employees "in all positions who are willing to use their lived experience to model of success and resilience for the people that we treat. So for us, the presence of peers has been very transformational."

"The other thing that occurred, something that behavioral health people often don't want to talk about, is how the presence of peers advances the no-force-first model and gets you organizationally away from coercive forms of treatment. We've really moved the needle on that. When you have peers doing services, you find that you no longer have a need for seclusion and restraint. You also find a reduction in Workmen's comp, and a lot of other significant savings as well as higher client satisfaction and outcomes."

Thoughts on Peer-Run Programs

Daniel Fisher

"Until we have a world free from stigma and discrimination due to psychiatric labels, there will be a need for peer-run programs. There is great appeal for persons in distress being in the presence of others who have been through a similar experience. Peers can interact in a much more authentic and accepting manner with persons in severe distress because they have been there too. Furthermore, persons with lived experience can gain hope from being with people who are the evidence that people can and do recover from severe mental health conditions. Peer-run respites are the best example of an alternative to traditional mental health services. Peer-run respites meet the person where they are without imposing a value judgement upon their distress."

Harvey Rosenthal

"Whether you have a peer-run agency, or a peer-run division of a larger agency, those are the best places to go to ensure that you're going to get true, fidelity peer services. Peer-run agencies today have matured so much in the past few decades that they represent the cutting edge of system transformation and recovery outcomes. There are peer-run organizations here in New York that offer extensive ranges of service and enforce strong training and fidelity requirements that, to me, represent the "gold standard" for this type of work. These peer agencies provide bridging and transitional supports, coaching, mentoring and others. And all of it starts with the individual's needs and goals."

Lori Ashcraft

"Peer run programs are often underfunded. For many, their biggest opportunity is in gaining business skills, learning how to document, bill, and survive doing what everyone else is doing. They need to have strong people on their boards, and in their staff, who can understand them and their work and can be accountable. It is easy for peer-run programs to be overly dependent on local funding, but they must recognize that local dollars alone aren't typically a strong enough base of support. So, it is essential that they have the capabilities to reach out and look for Medicaid-matched dollars and insurance dollars. That ability will help to protect their organizations over the longer term. Another concern is that too few peer-run programs take the time and make the effort to show that they are making a difference in outcomes."

Researched and Written by Dennis Grantham