Peer Support Services

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Introduction

Few public institutions are as stereotyped—and even stigmatized—as state psychiatric inpatient hospitals. In movies, print media and the minds of the general public, psychiatric hospitals are viewed as institutions of hopelessness and a one-way ticket to a lifelong journey through mental illness. Individuals and families who have experienced an episode of care in an inpatient psychiatric ward often view their stay as life-saving, however, few are willing to speak about their experience due to the social stigma that continues to follow most people living with serious mental illnesses. Psychiatric hospitals in many ways are the public image of mental illness—tall, dark, and foreboding with barred windows and locked doors.

Surprisingly, to some observers, a quiet revolution has been spreading behind those windows and doors. Rehabilitation and recovery is beginning to replace confinement and control as common descriptors of the state hospital experience. Spurred by improvements in psychiatric medications and therapies over the past dozen years, and emerging best practices in transitions of care between inpatient facilities and community settings, hospital administrators are increasingly testing practices more fully grounded in self-determination, person-centered care and family involvement—practices that are now considered the gold standard of the mental health system.

Among the most interesting and best studied is the introduction of peer and family support services within the inpatient hospital environment. Peer support services are delivered by individuals with their own lived experience of mental health conditions. Peer services are a natural companion to the recovery movement as both are based on similar values and principles. Although peer support services have been offered in community-based mental health agencies and self-help associations for many years, the formal appearance of peer-delivered service programs in hospital settings is a relatively recent development. However, remarkable case studies of positive outcomes attributed to inpatient peer services have accumulated in a very brief period of time, including evidence of reductions in 30-day readmission rates, shorter lengths of stay and improvements in hospital staff attitudes and conduct toward clients.

At the same time the implementation of peer-delivered service programs in the very formal and structured inpatient environment has not been without challenges. Most notably, the

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"medical model" approach to psychiatric care that has historically exemplified the inpatient environment stands in contrast to the emphasis on person/family involvement, voice, and choice that is the hallmark of the mental health recovery movement, posing a natural tension, and resistance to change within the institutional setting. In addition, hospitals are increasingly subject to payer goals for lower costs through briefer lengths of stay and improved transitions to community services—pressures that force a reconfiguration of the clinical workflow and staffing model within psychiatric hospitals. Still, many hospitals have made notable efforts to introduce stronger person-centered and recovery-focused programming, including the introduction of person's with their own lived experience of mental health challenges as a key part of the clinical workforce.

This chapter describes the emergence and impact of peer support services and their role in supporting rehabilitation and recovery outcomes in inpatient psychiatric hospitals. Along the way, peer-delivered services are helping transform the culture of traditional mental health care—and the stigma that accompanies it—within those psychiatric institutions.

Person-Centered Versus Institution Centered Care

While the intended purpose of inpatient psychiatric hospitalization is to secure the safety of the person and the public while medication and other treatments address the symptoms that precipitated the hospitalization, paradoxically for most individuals and their families, an episode of involuntary psychiatric hospitalization is a stressful, if not fundamentally traumatic experience. For some individuals, it may be their only experience with psychiatric hospital, while for others repeated involuntary hospitalization will be a lifelong, recurring theme. Due to the congregate nature of institutional settings, hospitals are highly regimented and require the person to obey set operating rules and protocols such as bedtime, wake up, meal time, medication administration time, phone calls and daily therapies. In this setting, loss of personal freedom limits the opportunity for the person to make any independent decisions. Even with the best intent, many of these practices are extremely difficult to change in order that the institution can safely and efficiently manage several hundred to several thousand inpatient residents each day.

The standard treatment planning process is a good example and an area where the value of adding peer- and family-delivered services has demonstrated immediate positive results. In many hospitals, treatment planning sessions are held with the hospital professional team who make all of the decisions and then invite the person to attend for a few moments at the end of the staffing without giving them any input into the decisions that were made. Another example involves scheduling treatment planning sessions on days or times in which active family members are not available to participate and then discharging the person to the family without any information regarding how they can assist in caring for their family member. Although unintentional, these "standard operating procedures" tend to de-value the person's and family member's own experience of their mental health symptoms, the supports that work for them and how they feel and function when they are well. One of the major themes of the recovery and peer movements is "Nothing about us without us." The treatment planning scenarios above are efficient and expedient for hospital operations, but they are not person-centered or recovery-oriented.

Traditional psychiatric inpatient hospitals generally operate under a "medical model" of care where the team is led by a psychiatrist who is assisted by psychiatric nurses, psychologists, social workers, and direct care staff. The psychiatrist conducts a psychiatric assessment designed to identify a diagnosis that leads to a treatment formulation that guides the team in medication management and other treatment modalities. Other disciples also conduct their specialty assessments and ideally this information is used to create an integrated individual treatment plan. Standards also require that the team develop a discharge plan that identifies the discharge criteria that the person needs to meet in order to leave the hospital setting. The standards require that discharge planning begin upon admission. More forward-thinking hospital settings have been working on developing a psychiatric rehabilitation model that includes the consideration of biological, psychological, and social factors (biopsychosocial model) in order to develop a more holistic approach to care. In this approach, the "medical model" is less evident and the treatment team usually includes the person and family members as well as a variety of professionals and in some cases peer support staff. Many hospitals are in the process of implementing this model and some have succeeded; however, the transformation is a long and challenging process and requires strong administrative support and clinical leadership.

A newer development within inpatient settings is the gradual tightening of length of time a person remains in the hospital. Cost containment goals by payers, enhancements in psychotropic medications, and increased availability of alternative pre-hospital crisis settings have significantly reduced the average length of inpatient stay over time. While this trend has the benefit of not removing the person from the community for extended periods of time, it also requires the inpatient team to act swiftly to assess, diagnose, develop a plan of care, and a discharge plan all typically within 14 days or less. Conducting comprehensive assessments, engaging the person in treatment, and working with the person's natural and professional community supports are put on an accelerated time frame that itself may limit opportunities for person and family involvement in developing the plan of care.

Person-centered care requires the person and their families become active participants in the treatment planning process. As stated earlier, many inpatient hospitals have attempted to implement a person-centered approach with varying degrees of success. The migration and transformation from a "medical model" to a "person-centered' model represents a huge cultural shift for most hospitals. Even with the best intent of the hospital, one of the major challenges is that many individuals who are admitted are significantly impaired and are unable or unwilling to actively participate in their treatment planning process. At the same time, family members are often extremely stressed and have little information on psychiatric symptoms and medications except what they have seen in the media. They also have limited or no information on other aspects of care or the community resources that are available upon discharge. A number of individuals demonstrate what Amador (2000) identified as "Anosognosia," or a lack of insight into their illness. Many individuals with this condition refuse all forms of treatment. Other individuals arrive with unstable living arrangements, homelessness, criminal justice involvement, or orders of protection. Developing an adequate discharge plan involves services beyond the typical scope of a hospital setting.

System Transformation and Peer Support Services

Hospitals are not alone in struggling to address these forces of change. The transformation of traditional mental health system to a person-centered and recovery-oriented approach represents an international challenge. The World Health Organization's (WHO) Quality Rights Tool Kit (2012, p. 1) identified that "in many countries, the quality of care in both inpatient and outpatient facilities is poor or even harmful and can actively hinder recovery. The treatment provided is often intended to keep people and their conditions under control rather than to enhance their autonomy and improve their quality of life. People are seen as 'objects of treatment' rather than human beings with the same rights and entitlements as everybody else. They are not consulted on their care or recovery plans, in many cases receiving treatment against their wishes." While conditions have certainly improved in many developed countries, there is still a long way to go to fulfill the mission of a system that is person-centered and recovery-oriented. Fortunately, there are numerous research findings and evidence-based practices that can serve as a guide to the transformation efforts. An ongoing issue is that the incorporation and translation of research findings to clinical practice continues to be at a very slow pace.

Leamy et al. (2011) identified that orienting mental health services towards recovery will require a system transformation where professionals will need to understand that recovery is a unique personal experience rather than something a system does to the person. Creating a person-centered, recovery-oriented approach to health care requires professional staff to recognize the personal wisdom and experience that the person and their families bring to the table. In addition, the person has the right to self-determination, which includes the right to make informed decisions regarding their care and treatment. It also makes good clinical sense that when the person participates in treatment decisions with support from the professional team, it increases the likelihood that the plan will be followed.

Corrigan (2006) described self-determination as having the freedom to choose the medications and treatment activities they believe will be helpful, regardless of professional recommendations. To date, the evidence that self-determination or informed decision-making is embraced within today's healthcare system is not encouraging. Braddock et al. (1999) audiotaped 1097 encounters with physicians where 3552 clinical decisions were made. Only 9 % of decisions met their definition of completeness for informed decision-making which included the person. Basic decisions were completely informed in only 17.2 % of the cases, no intermediate decisions were completely informed, and only 1 (0.5 %) complex decision was completely informed. An assessment of the person's understanding of the decision was only made in 1.5 % of the observations.

Others have also noted the importance of the person in the decision-making process. Deegan and Drake (2006) as part of medication management and Salyers and Tsemberis (2007) as part of ACT Team protocols have identified the importance of shared decision-making as critical aspect of a person-centered, recovery-oriented approach to care. Shared decision-making is not simply a rights issue, but also critical factor in whether the person and their families or other natural supports will understand and follow the treatment plan when they leave the inpatient setting.

The emergence of formal mental health peer support services and programs over the past 15 years has been a key driver of these changes both within inpatient institutions and community mental health settings. Many states added formal peer support services over the past 20 years as a component of their comprehensive mental health and substance use service delivery system. A significant boost to the development of such programs occurred in 2006 when the Center for Medicaid and Medicare Services authorized the use of peer support service as a reimbursable Medicaid service. The resulting expansion of peer support services throughout the country has been impressive. Today most states have an active consumer movements and peer support programs. Internationally, Canada, Scotland, Australia, and New Zealand all have very active peer support initiatives.

Inpatient facilities; however, significantly lagged in adopting these practices. Oddly, peer support has been occurring naturally in inpatient treatment settings since these settings first existed. Bouchard et al. (2010) studied naturally occurring "peer support" in inpatient psychiatric units. They reported that natural peer support is a thoughtful process that involves observing, reflecting, taking supportive action, and evaluating outcomes. Supportive actions include helping with activities of daily living, sharing material goods, providing information and advice, sharing a social life, and offering emotional support. While hospital staff meticulously documented these developments as "positive social interaction" between patients and evidence of progress, they also serve as an early example of what would eventually be formalized as peer support services. Thus, while peer support has occurred naturally in hospital settings over many years, it has taken considerable time for their clinical value to be recognized and organized into an intentional program of services founded on supportive action.

The Double Revolution: Recovery Movement and Peer Services

In order to understand the emergence of peer support services it is necessary to take a brief excursion into its roots within the recovery movement. The consumer/survivor movement can be traced to 1800s in England where the Alleged Lunatic's Friend Society was established. There were numerous other initiatives over time that developed primarily due to what was perceived as cruel conditions and the lack of the ability of individuals to control any of their care in mental health facilities. In 1908, Clifford Beers wrote an autobiography "A Mind That Found Itself," which led to the creation of the National Committee for Mental Hygiene, known today as Mental Health America. Chamberlin (1978) wrote *On Our Own: Patient Controlled Alternatives to the Mental Health System,* which became the textbook of the consumer/survivors movement. There are many excellent reviews of the consumer movement that go beyond the intended scope of this chapter. Nelson and colleagues conducted some of the most comprehensive reviews of the history of the consumer/survivor movement (Janzen et al. 2006; Nelson et al. 2006a, b, d, 2007). Another excellent review of this information that includes the psychiatric rehabilitation initiative can be found in Corrigan et al. (2008).

In support of the consumer/survivor movement, the U.S. Center for Mental Health Services began funding consumer initiatives and technical assistance centers in the 1980s. While these programs were initially developed to increase consumer voice in the mental health service system, a secondary benefit emerged. By bringing consumers together in forums and on committees, they also created collaborations that resulted in the emergence of a number of consumer-run programs. At this point, many states began creating Offices of Consumer Affairs that often reported directly to the Mental Health Commissioner. These Offices created a variety of opportunities for consumers to become involved in the state planning efforts, including advocating for the addition of more peer self-help support programs to the service array. The expansion resulted in the development of consumer drop-in centers, warm lines, and state supported consumer advisory boards across the country.

Also in the 1980s, a number of studies began to be published that demonstrated that individuals could lead fulfilling lives even with the presence of a serious mental illness. In other words, mental illness was a treatable condition, not a life sentence. The "recovery movement" was launched. On average, research has shown that 60 % of the individuals who were studied had recovered to the point of leading successful lives in their communities with minimal psychiatric symptoms (World Health Organization 1979). One of the most significant studies was a 30-year follow-up of individuals who had long-term hospitalizations in state hospitals in Vermont and Maine in the 1950s (Harding et al. 1987). The Vermont community mental health system at that time was considered to be recovery-oriented, at least as it was understood at the time, and the Maine system was considered traditional care. Using established criteria for "recovery," including having a social life indistinguishable from your neighbor, holding a job for pay or volunteering, no longer experiencing symptoms of mental illness, and no longer taking medication, Harding et al. made a memorable discovery: 63–68 % of individuals in the Vermont group met their criteria for "recovery." In the Maine group, which experienced "traditional" inpatient care, nearly half (47 %) achieved recovery as defined by the researchers. Since their study, numerous other researchers have confirmed Harding et al.'s findings that recovery is an individualized and naturally occurring process that is supported by, but not created by, the mental health treatment system.

The Harding et al. study and the others that followed proved that recovery from mental illness is possible and created the final spark that ignited the recovery movement and the peer support initiative. While many individuals achieve recovery without the assistance of peer support services, most individuals in recovery identify that a social connection with someone, a family member, friend, psychiatrist, or therapist, who believed in and supported them was a vital element in their recovery journey. The ability to provide social support appears to be one of the primary skills that peer support providers possess. Felton et al. (1995) found that individuals who were served by peer support staff reported improved social support, quality of life, a reduction in the number of major life problems, more frequent contact with their case managers and improved self-image. The availability of a social support network is often accompanied by improvements in multiple aspects of life. Hardiman and Segal (2003) examined the characteristics of peer support self-help agencies and concluded that they foster social networks leading to the experience of shared community. Peer staff provide support to the person when others are not available or not willing.

In 2010, the U.S. Substance Abuse Mental Health Service Administration (SAMHSA) launched a national dialogue to define "recovery." The final definition, shaped by advocates, care providers, families, and individuals with lived experience of recovery from mental disorders and/or substance use is as follows: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA 2011, p. 1). SAMHSA (2012, p. 3) listed four dimensions of recovery: "(1) Health—Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem— and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing, (2) Home—A stable and safe place to live, (3) Purpose—Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society, and (4) Community—Relationships and social networks that provide support, friendship, love, and hope." The four dimensions in many ways define the essence of peer support services and in multiple studies peer support has been found to be a major avenue for achieving the four dimensions of recovery.

Peers, Professionals and the Power of Hope

A considerable amount of effort has been devoted to defining what peer support is and what it is not (Repper and Carter 2011). For example, Mead (2003) and Mead and MacNeil (2006) reminded us that peer support is not like clinical support, nor is it just about being friends. Peer support helps people to understand each other because they have been there, shared similar experiences, and can model for each other a willingness to learn and grow.

The President's New Freedom Commission on Mental Health (2003) laid the early foundation for formal peer service programs by emphasizing the strong link between hope and individual recovery, stating "research has validated that hope and self-determination are important factors contributing to recovery" (p.27). Years later, SAMHSA (2011) articulated more forcefully that hope can be intentionally instilled and inspired by caring friends, families and advocates, including peer providers. In their working definition of recovery, SAMHSA (2012, p. 4) stated: "Recovery emerges from hope. The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process." Creating conditions that inspire hope is one of the most powerful skills that peers bring to the table. Campbell and Leaver (2003) stated that hope instilled in people recovering from mental illnesses through the dynamic exchange of peer support has the potential to foster hope and change for the mental health system.

Andresen et al. (2003) suggested that recovery comprises four key components: (1) finding and maintaining hope; (2) reestablishing a positive identity; (3) building a meaningful life, and (4) taking responsibility and control. Stratford et al. (2012) noted that recovery has hope as a keystone. Mental health practitioners have an important role in "holding the hope" for the person with mental illness, until that person is strong enough within themselves to move forward. Hope is not a boundless wish or desire; and in fact, has a probabilistic quality. We do not hope for things that are impossible. We hope for things that have some possibility of occurring. Hope looks for exemplars. Peers in recovery present a concrete exemplar. Clay (2005) reported that one of the qualities of peer support staff is that they act as role models and demonstrate that recovery is possible. If someone who has had similar experience with mental illness and now has achieved recovery, the possibility of recovery is not an unrealistic outcome. Hope is a critical motivator for what has been recently identified as "patient activation" which has been receiving significant attention in healthcare research.

SAMHSA (2009a, b, p. 10) commented further on the growing recognition of the value and role of peer providers in professional healthcare delivery, "In the medical world of today, there is scarcely a specialty where peer support is not recognized as a valuable adjunct to professional medical and social interventions. Improved outcomes are particularly notable when peer support services are provided to people with chronic conditions that require long-term self-management." In linking peer-delivered services with healthcare's new found focus on chronic disease management under the 2010 Affordable Care Act, SAMHSA (2009a, b) firmly cemented the role of peer providers as essential to healthcare of the future. Operating in a variety of new roles as "health navigators," "health coaches," and "transition specialists," peer support specialists today are leveraging the power of their personal experience to instill hope and produce real-world health outcomes that drive down costs and improve the patient experience of care—otherwise known as the Three Aims of the Affordable Care Act.

The "professionalization" of peer services through formal training, career paths and reimbursement is not without controversy. In many parts of the country, peer support is only believed to retain its "peerness" when supports are dissociated from formal mental health and addiction treatment programs. To add confusion, the growing world of children's mental health services brings with it a new type of "peer": family members of children with mental health and developmental disabilities who work with other family members experiencing challenges in navigating the system or obtaining family-centered care for their children. There is a substantial body of research on peer support and much less on family peer support. Gartner and Riessman (1982, p. 631) provided a succinct and yet complete definition of peer support: "Social emotional support, frequently coupled with instrumental support that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change." Family peer support could be similarly defined as social emotional support, frequently coupled with instrumental support that is offered or provided by family members to other families who share the experience of supporting a family member with a similar mental health condition to bring about a desired social or personal change.

The following core values have been recently ratified by peer supporters across the country as the core ethical guidelines for peer support practice (International Association of Peer Supporters, Inc. 2013): (1) peer support is voluntary; (2) peer supporters are hopeful; (3) peer supporters are open minded; (4) peer supporters are empathic; (5) peer supporters are respectful; (6) peer supporters facilitate change; (7) peer supporters are honest and direct; (8) peer support is mutual and reciprocal; (9) peer support is equally shared power; (10) peer support is strengths-focused; (11) peer support is transparent, and (12) peer support is person-driven.

Outcomes of Peer Services

As with any large-scale system transformation, the introduction of peer professionals—people with their own lived experience as care-givers—sparked a veritable wave of research in studying the effects of this "disruptive innovation" on the outcomes of mental health care. Early work focused on the more obvious outcomes—the ability of peer support staff to engage individuals in their care simply because they shared the same story and experience and have "walked in their shoes." For example, Dixon et al. (1994) noted that peer staff members bring practical knowledge, street smarts, and personal experience with treatment that provide engagement skills. Davidson et al. (2006) reported that peer support workers were highly skilled and effective at engaging and communicating acceptance. They were able to increase treatment participation amongst the more disengaged in case management for consumers with comorbid mental health and alcohol and drug issues. Davidson et al. (2012) wrote that peer staff could be especially effective in engaging people into care and acting as a bridge between clients and other staff.

However to describe the value of peer services as merely the ability of peer staff to share stories and experiences is to seriously under-estimate the value of engagement within the mental healthcare system. With no-show rates hovering between 20-50 % on average at treatment facilities across the country, failure of patients to attend scheduled psychiatric appointments costs millions each year in wasted staff time while increasing the likelihood that the person will not maintain treatment gains and/or be re-hospitalized at 6- to 12-month follow-up (Schmutte et al. 2009; Sledge et al. 2008). Similar studies found that the addition of peer services early in treatment improved patient engagement with non-peer staff as well. For example, Sells et al. (2006) found that unengaged clients had more contacts with their mental health case managers when peers were part of the engagement process, compared with fewer case manager contacts when peer staff were not involved. Sells et al. (2006, p. 1184) concluded that "early in treatment, peer providers may possess distinctive skills in communicating positive regard, understanding, and acceptance to clients and a facility for increasing treatment participation among the most disengaged, leading to greater motivation for further treatment and use of peer-based community services."

Other studies focused on the effectiveness of complementary peer services on the individual's treatment goals. For example, Felton et al. (1995) found that individuals who were served by teams that included peer support specialists demonstrated greater gains in quality of life and an overall reduction in the number of major life problems. They also reported more frequent contact with their case managers and showed the largest gains in the areas of self-image, outlook, and social support.

The first substantial evidence that peer support services can be effective came from studies with peers serving as community case managers. In two studies, Solomon and Drain (1995a, b) in randomized trials of peer case management service found that peer case management teams were equally effective as non-peer teams in terms of reduced symptomology and quality of life outcomes. Chinman et al. (2000) also found that peer case management teams were equally effective as their non-peer counterparts in terms of the clinical outcomes achieved. In a randomized control trial, Clarke et al. (2000) studied assertive community treatment (ACT) teams using peers and ACT teams without peers. The study found that fewer people were hospitalized and the first hospitalization occurred later for individuals who were served by ACT teams with peers.

In a meta-review of randomized controlled studies, Pitt et al. (2013) reported that, when peer-run services were compared to those conducted by non-peer professional staff, the outcomes were equivalent. These outcomes included quality of life, depression, mental health symptoms, satisfaction with treatment, person/professional relationship, use of mental health services, hospital admissions, length of stay, and readmission.

Unique Factors in Inpatient Settings

Psychiatric hospitals have faced a tsunami of change over the past 20 years that have significantly altered daily operations and shifted the role of the hospital within the mental health treatment community. First and foremost is the increased scrutiny paid to admission and readmission rates, as well as changes in the community standards of care that emphasizes alternatives to hospitalization, including the individual's right to self-determination and choice even within the hospital setting. The introduction of new generation antipsychotic medications that are highly effective in remediating psychiatric symptoms for a large percentage of individuals and community-based alternatives to hospitalization, such as ACT teams also played a role in reshaping the purpose of the psychiatric hospital as a short-stay setting for immediate stabilization rather than long-term rehabilitation for most patients.

Nowhere has the scrutiny on the inpatient psychiatric hospital system been more acute than in the admission, discharge and readmission process. The high cost of inpatient services, in particular, has focused the attention of Medicaid, Medicare, and managed care payers on establishing performance standards for readmission and routine monitoring for length of stay. Beginning in 2013, Medicare implemented financial penalties (reductions in per diem payments) for hospitals that exceeded inpatient readmission standards and other quality metrics. Similarly, "transitions in care" (formerly known as "Discharge Planning") has emerged as a sub-specialty area for quality and performance on its own.

The typical inpatient discharge planning process resembles two ships passing in the night. Ship A, the hospital, controls the length of stay in the facility by discharging the person when they determine that hospital services are no longer medically necessary. At the same time the hospital needs to make sure that readmission is not likely to occur by ensuring that the person has sufficient stability and is referred to appropriate community services. Ship B, a community mental health service provider, may or may not be part of the discharge planning process. The hospital needs to prevent readmissions by identifying the community services that are necessary to successfully support the person in the community, but they have no role in ensuring that the person is actually connected to the community resources. Since the hospital does not control the community resources and the community providers do not have any authority in the hospital discharge planning process, there is often significant tension between these two discrete parts of the mental health system.

In addition, mental health service funding is allocated in silos in the United States. Community providers cannot bill for services when the individual is in an inpatient setting and the hospital cannot bill when the person returns to the community. These funding silos significantly inhibit coordination of care between these settings. Organizing discharge planning sessions where the hospital and community staff both participate can be challenging. Needless to say, gaps in services are common. One of the most important predictors of readmission is whether patients attend their first appointment with a community provider. It is not uncommon to find a 30 % or greater rate of failure to appear for the first appointment. While some individuals eventually make a connection with their community providers, a sizable number fail to connect and, without ongoing treatment, remission is often inevitable. These individuals show up in emergency rooms, psychiatric inpatient settings, jails, in homeless shelters and, in some cases as mortalities.

Factors in hospital readmissions have been closely studied across multiple states and payer systems. The available research indicates that the reasons for readmission include all of the following factors: the person may be discharged prematurely without achieving functional stability; the community resources needed to support the person are either not available, not sufficient or not responsive; the person does not understand what they need to do to remain healthy; the person lacks capacity or desire to adhere to the discharge instructions upon leaving the more regimented inpatient setting; the person has an unaddressed or refuses to address a substance abuse issue; or the person's living environment does not support recovery (Hemminger 2012).

One issue that comes into play is that people who are frequently readmitted often receive discharge plans that contain the exact same locations and services that have repeatedly failed to support them in the community. Due to the rapid time frame in which the inpatient team must complete a discharge plan, the causative factors that drove the readmission are often not identified or considered when new discharge plan is developed. Even when the reasons are obvious, the hospital often has few community options to choose from that are capable of addressing the issues. If the person needs to move to a more supportive environment, those settings are often not readily available. If an ACT Team is needed to support the person, there may be a wait list for the program. Nevertheless, any approach to reduce readmissions and to support a successful community placement must address all of the factors that led to the person's initial admission and any subsequent readmission. The problem of gaps in the service array needs to be addressed by the administrators of the system of care. Inpatient hospitals and community providers need to unite to bring these gaps in care forward or the gaps and consequently high rates of readmission will continue to occur.

The discharge planning process itself has a fundamental flaw in that the person is not just leaving one level of care, but entering another. Rather than simply concluding a service, the person is transitioning between services. Research has shown that the most effective ways to reduce readmission is to provide education while the person resides in the inpatient setting, develop a discharge plan that effectively deals with the factors in the prior readmissions and provide transitional support in the community to ensure that the discharge plan is followed and readjusted if needed (Forchuk et al. 2007a, b). The goal is to connect the person with community services and supports necessary to succeed, and in each of these areas, peer services have been shown to play a beneficial role.

Connecting the Dots: Peer Models in Inpatient Settings

Across the country many inpatient settings have begun to see the value of adding peer support and family support to their services; however, only a few have done it to the degree necessary to have the type of significant impact reported in the few randomized controlled trials that have been conducted. McGill and Patterson (1990) reported one of the earliest examples of peer support program in an inpatient setting. In this program, former patients were trained to be peer counselors in a large public sector acute psychiatric inpatient program. Due to their positive impact over a four-year period, staff that were originally skeptical changed their attitudes and began requesting that peer-run groups and services be expanded.

Several other studies have examined the role and outcomes of peers serving in inpatient settings (Chinman et al. 2001; Lawn et al. 2008; Sledge 2011). The most promising target identified issues that are the most challenging within hospital environments: the need for rapid engagement into treatment during increasingly shorter lengths of stay, effective discharge and transition planning, and readmission prevention. Others focus on education and support directed to assist the person and their family in caring through on treatment recommendations once they leave the hospital. Programs implemented to target these factors utilize peer staff that work with individuals while they are in the inpatient settings while others link the person with peer support upon discharge. Another approach attempts to bridge the inpatient-community transition process by introducing peer support services while the person is in the hospital and continuing the service when the person returns to community. Methods employed to test the effectiveness and outcomes of these interventions include randomly controlled trials, case studies, program reports, and personal accounts by peer staff and persons receiving services.

In a study that examined peer support staff who were introduced after discharge, Chinman, Weingarten, Stayner and Davidson (2001) compared peer support outpatient programs with traditional care and found a 50 % reduction in readmissions when compared to the programs where support services were not in place peer. The results support the conclusion that when individuals return to the community and receive peer support services it can reduce hospital readmissions.

Sledge et al. (2011) found that individuals who were assigned a peer support staff member had fewer hospital admissions and hospital days over a 9-month period than patients who were not assigned a peer support staff member. The average length of stay for individuals who received inpatient peer support services was 10 days as opposed to 19 days for participants without peer support and hospital admissions for individuals that received outpatient peer support were 53 % less than those without peer support.

Another group of studies examined peer supports who acted as "Bridger's" between the hospital and the community. Lawn, Smith and Hunter (2008) found that individuals who received peer support services in the hospital and when they returned to the community showed reduced admission rates and more stable community placements, fewer readmissions and reduced lengths of stay. Individuals who took part in group peer support services had a readmission rate of only 17 % compared with an expected rate of 30 %. The data suggested that peer support staff are able to connect individuals with resources both inside and outside the hospital and provide the type of hopeful engagement that maximizes treatment returns.

One of the most promising lines of research is the work of Cheryl Forchuk and her colleagues in Ontario, Canada who developed a transitional discharge model (TDM). The model strategically targets discharge planning issues and the gap between hospital and community services. Known as the "Bridge to Discharge" program, her model addressed the traditional boundaries between hospital and community settings that impede care transitions by assigning an inpatient team of professional and peer support staff work with the individual while they are in the hospital and then remain with them in the community until a therapeutic relationship (Forchuk et al. 2002) is formed with a community mental health provider. Canada does not have the same funding silos that exist in the American system, allowing for more seamless care transitions. Forchuk et al. (2005) reported that using peer support as part of the discharge process significantly reduced readmission rates and increased discharge rates. The model was tested in a randomized clinical trial involving either peer support for one year, or ongoing support from hospital staff until a therapeutic relationship was established with a community care provider. The peer group was discharged 116 days sooner than the traditional care group. The study authors also reported that individuals who received peer support demonstrated improved social support, enhanced social skills and improved social functioning.

Forchuk and Brown (1989) based the TDM model on early work on nurse–patient relationship that emphasized the importance of directed relationships in promoting health and healing (Peplau 1952). This research defined nursing as "a significant, therapeutic, interpersonal process that aims to promote a patient's health in the direction of creative, constructive, productive, personal, and community living." Forchuk and Brown expanded on Peplau's definition to include all professional staff involved with the person and then added peer support to the formulation.

Using the relationship as her framework, Forchuk et al. (2012) identified three essential elements that underlie the effectiveness of the TDM model: (1) people heal in relationships (including staff and peer relationships); (2) transitions in care are vulnerable periods for individuals with mental illness and services should be front-loaded to bridge the transition process; and (3) a network of relationships provided during transitional periods assists in sustained recovery. Forchuk et al. (2012, p. 585) summarized their findings on design components that are key to the success of the TDM approach: "… the availability of on-ward educational opportunities, presence of an accessible 'champion' for the intervention, perceived administrative support, belief in the usefulness of the intervention and in the ease of use of the intervention, and willingness to partner with outside groups. In general, active engagement and participation by staff throughout the process was critical."

Implementing the TDM involves a significant change in the relationship between hospital and community care providers as well as hospital operations. Specific strategies that facilitated the implementation of TDM within the inpatient environment include: (1) the use of educational modules for on-ward hospital staff training and peer training; (2) presence of on-site champions; and (3) supportive documentation systems. Issues identified as barriers to implementation included: (1) feeling drowned, swamped and overwhelmed; (2) death by process; (3) team dynamics; and (4) changes in champions. (Forchuk et al. (2012). In addition, they identified several actions that are critical to ensuring the person establishes a therapeutic relationship with a hospital clinical staff member before discharge and that hospital staff communicates properly, continuously, and understands their roles in the discharge process.

To emphasize the foundational role of relationships during transition, Forchuk et al. (2007a) changed the title of the TDM to transitional relationship model (TRM). To Forchuk et al. (2007a, p. 80) "therapeutic relationships include not only the nurse–client relationship but also other staff relationships, family relationships, and peer relationships. Each person needs a safety net of relationships because people are believed to heal in supportive relationships. However, traditional models of care terminate relationships at the point of hospital discharge, which is a time of vulnerability for many clients."

Forchuk et al. (2007b) also studied the transferability of the model to a facility in Scotland. Reynolds et al. (2004) implemented and evaluated the TDM on acute care psychiatric wards there and reported that the group that did not participate in the TDM model was more than two times as likely to be readmitted in the subsequent 5 months when compared to the TDM discharge group.

Hanrahan et al. (2014) used an adapted version of the TDM for older adults being released from acute care hospitals for patients with serious mental illness and medical comorbidities. The "Transitional Care Model" was delivered by a psychiatric nurse practitioner assigned within the acute setting who continued to see patients in the community. The study found that patients with immediate and pressing physical health problems were most receptive and actively utilized the service. A number of barriers were identified including communication and privacy issues making it difficult to remain engaged with persons in community mental health facilities. While the nurse practitioner was accepted and valued in the physical health arena, the psychosocial needs and relationship issues were too demanding for a single staff. The researchers concluded that a team approach including a social worker, peer provider, and consulting psychiatrist were needed for severely mentally ill patients being released from an acute physical health hospital (Solomon et al. 2014).

Similar models have been promoted in a number of locations. M-Power Advocates reported to the Massachusetts Inpatient Study Commission (2009) regarding the need to implement peer support programs designed to transition individuals from inpatient facilities. Their report stated, "One type of support for individuals transitioning out of the hospital used very successfully in New York State is a Peer Bridger Project in which a trained peer specialist provides one-to-one support to a person ready to be discharged. This relationship begins several months before the discharge date and continues for several months after discharge. This is an excellent way to address the concerns and fears a person who has been in the hospital for months or years may have about being able to make it on the outside. The Genesis Club in Worcester and the Lighthouse Clubhouse in Springfield run Peer Bridger projects under a DMH contract entitled "Peer Support in After Care." Such programs need to be expanded throughout the state" (p. 2).

Marc Community Resources has implemented a Community Transition Program utilizing trained peer support navigators to assist individuals who are being discharged from a community psychiatric inpatient setting. The peer staff engages the individual while they are in the hospital and assist them while they transition to the community using a critical time intervention model shortened to a 90 day period. The results to date (Thomas and Anderson 2015) have been encouraging. Preliminary findings from the first 75 individuals served include the following:

(1) The vast majority (65) remained in the community during the period in which they were supported, (2) a large percent of the individuals (41 % or 31 participants) were either homeless or could not return their original living environment (33 participants). (3) Many individuals have co-occurring mental health and substance abuse disorders (42.6 or 32 participants). (4) Coordination with the person's outpatient clinical team can be challenging in some cases and individuals reported that the lack of responsiveness by their teams was the main reason for their hospitalizations. (5) While the hospital staff were initially unsure how peer supports could be helpful, their attitude changed rapidly and they now see peer supports as a valuable resource.

The six participants who were re-hospitalized disengaged from both the Community Transition Program and their PNO teams soon after initial discharge and ceased all contact with both entities until they were either re-engaged upon re-hospitalization, or were located after rigorous outreach efforts. Other interesting information that has been obtained from this group is that approximately one-third of the readmissions began with a medical hospitalization. In a significant number of cases the substance abuse challenges that were prominent reason for re-hospitalization. Approximately, one-third experienced challenges with medication, i.e., some people did not want to take their medication. Approximately one-third self-discharged from the hospital and went to motels or similarly unsupportive settings whereby they soon became homeless and symptomatic.

An interesting application of the peer support model was conducted by Vijayalakshmy et al. (2006). In long-term psychiatric hospitals a small percentage of individuals resist discharge. The study described a peer support intervention that specifically addressed individuals who were reluctant to return to the community. The group utilized standard methods of rehabilitation and training with strong emphasis on validating individual needs and feelings using peer support. After 18 months of the group intervention, five of the seven group members had achieved discharge and community success.

Bringing Peer Support to Scale in Inpatient Programs

Bluebird (2008) described a model of a peer support inpatient program that was implemented in a State Hospital setting in Delaware. In this program, the peers were not hospital employees, but were managed by an external peer-run organization that also provided the peer staff supervision. The roles of peer staff included providing support during hospitalization, providing low-level advocacy to ensure that the person's voice was heard with professional teams and that persons were treated with dignity and respect. As part of the overall plan to introduce peer services in this environment, the peer support staff were involved in all aspects of client care and operations of the hospital, ensuring that consumer voice was reflected in hospital operations and policies.

The duties assigned to peer support staff in the Delaware program were many and varied, reflecting the wide range of job functions and valued roles that peers can deliver to support effective hospital services. Staff provided one-to-one and group support, facilitated recovery groups, developed personal safety plans, provided transportation, conducted debriefings, assisted with resolving complaints, attended treatment team and admission meetings, supported crisis intervention and ran drop-in centers ("comfort rooms") as part of the hospital program.

Other facilities have developed their own approaches, such as the "Passport to Health" used at Kings County Hospital in Brooklyn, New York (Perrazo and Rodriguez 2014). Their approach employed a peer counselor who assisted the person in identifying the members of their clinical team, their diagnosis, symptoms, medications, the purpose of the medications, their daily treatment groups, their recovery goals, life goals, natural supports, and emergency contacts. Delivering instrumental support is a large component of the peer counselor job function. The counselor works with individuals by attending treatment team meetings with the person and assisting them in describing their personal goals and service preferences. The peer counselor also conducts individual and group recovery sessions designed to assist the person in developing recovery and self-management skills.

Most programs that use peer support staff in inpatient settings have similar features. Peer staff typically attempt to engage the person shortly after admission using their shared experience to establish rapport, illustrating the emotional support component of peer services. Informational support is then provided and depending on the person's response to engagement, the peer support worker can assist the person in understanding and participating in the treatment planning process and describing the services they will receive at the hospital and how they can participate in the process.

Many peer support staff who work in inpatient settings assist patients in developing a "Wellness Recovery Action Plan" or WRAP plan. WRAP is personal planning tool where individuals develop their own goals and strategies for reducing and preventing symptoms. Copeland (2007) developed the WRAP plan and it is now a widely used tool that supports person-centered and recovery-oriented planning. In a study of 519 individuals with a serious mental illness who were provided WRAP Training, Cook et al. (2011) reported that WRAP participants experienced (1) significantly greater reduction in symptom severity, (2) significantly greater improvement over time in hopefulness as assessed by the Hope Scale, and (3) enhanced improvement over time in quality of life as assessed by the World Health Organization's Quality of Life environment subscale. These results indicate that peer-delivered mental illness self-management training reduces psychiatric symptoms, enhances participants' hopefulness, and improves their quality of life over time. On psychosocial measures of hopefulness and quality of life, WRAP recipients reported not only greater improvements relative to controls, but this advantage appeared to grow over time.

Sadaaki et al. (2011) compared the results obtained between individuals who received WRAP training and a control group, and found statistically significant improvements for the WRAP trained group in psychiatric symptoms and hope after the intervention, while non-significant changes occurred in the comparison group. Their conclusion was that the evidence was promising that WRAP participation had a positive effect on psychiatric symptoms and feelings of hopefulness.

WRAP has also been found to have a dose-response relationship. Greater exposure to WRAP is predictive of improvement on psychiatric symptom severity and hopefulness for their futures when compared to individuals with less exposure (Cook et al. 2009). This study concluded that individuals need to have adequate exposure for WRAP to have a measurable impact, with participants who attended six or more recovery-oriented group sessions showing greater improvement than those attending fewer sessions. Similarly, Starnino et al. (2010) reported positive effects of their WRAP intervention with at least 75 % participation in the program. This can be challenging in inpatient settings where the lengths of stay are typically very short. Taking the analysis a step further, Falzer (2011) noted that the effectiveness of recovery-oriented programs such as WRAP might depend more on the level of participation than simply attendance.

Benefits and Challenges

Adding peer support staff to inpatient settings has produced both positive results and identified several challenges for program implementation. For example, Salzer and Shear-Liptzin (2002) conducted thematic interviews with peer support providers and reported that peer staff themselves benefit from their roles as helpers. They noted a number of positive outcomes including improvement in their own recovery, increased feelings of social approval and self-efficacy, professional development skills and stable employment. Bradstreet and Pratt found that when peer support staff were placed on traditional clinical teams, it enhanced the team's commitment to recovery. Clinical staff reported being more aware of their use of language and becoming more aware of recovery-oriented principles. O'Hagan (2011) noted that based on interviews of staff, a significant percentage of professional staff reported that presence of peer support staff helped to create a culture change through role modeling, informal dialogue, education, and creating the conditions where some professionals felt safe to "come out" as consumers. Walker and Bryant (2013) also reported that traditional clinical staff developed increased empathy and understanding toward people in recovery as a result of working with peer support workers.

Bluebird (2008) reported that over time staff attitudes toward peer support staff became more positive, they develop more respect for patient input, began to see peer specialists as a valued role on the treatment team and became more open about sharing their own personal recovery stories. The impact on the peer specialist staff was the development of a better understanding of mental illness, higher awareness of issues people face, learning to speak up for themselves, greater confidence in speaking to medical professionals, changing their perception of some client populations and a deeper valuing of their own recovery journey.

Campbell and Leaver (2003) and Clay (2005) concurred, reporting that peer support services had the potential to be a force for positive change. Campbell and Leaver (2003) identified "Four significant forces have converged over the past century to foster peer-run support programs as they exist today for people with psychiatric problems: (1) the growth of self-help groups to address a wide range of conditions; (2) the movement of people with special needs from institutions to communities; (3) the mobilization of the consumer/survivor movement; and (4) the growing support of consumer inclusion and concepts of recovery (p. 9).

Implementing peer support within traditional psychiatric inpatient settings requires careful planning and support by agency administrators. Key challenges identified in less successful implementations tend to focus on lack of planning or clear vision of the purpose and goals of the program. When peers were introduced into inpatient settings without detailed job descriptions, clearly defined roles and without adequate staff preparation regarding the peer support function, conflict and confusion occurred. For example, Jacobson et al. (2012) conducted a review of the literature and identified that in the absence of adequately defined job descriptions and clear roles, it became challenging for peer support staff to play a meaningful role on inpatient teams. Dixon et al. (1994) found similar problems when imprecise job descriptions and inadequate structure of the peer function resulted in peer staff not being able to identify their roles. Gates and Akabas (2007) also reported role conflict and confusion when clinical and medical staff were not sufficiently prepared to work with peer support staff. Manning and Suire (1996) concluded that the lack of a clearly defined job description or role expectations was a serious impediment to realizing the full value of this service.

Meehen et al. (2002) conducted interviews with peers working in inpatient settings and identified a menu of issues that should shape planning and implementation of effective peer programs. In their review, (1) staff were not adequately trained regarding the role of peers, (2) staff used peers as tokens and discounted their contributions, (3) peers filled traditional work roles, not recovery roles, (4) staff were afraid that peers would become ill, (5) peers were overworked, and (6) peers had boundary issues. Gordon (2005) reported that the integration of peers into the workforce could be compromised by the attitudes of some mental health professionals. Hodges and Hardiman (2006) reported that some professionals, particularly those who are trained in a medical model of care, are often pessimistic about the value of peer support and are reluctant to refer or encourage consumers to participate in peer-run services.

With respect to the issue of peer staff experiencing relapse due to contact with individuals who are symptomatic, Nikkel et al. (1992) examined whether the stress and anxiety associated with exposing former consumers to patients currently receiving treatment in a hospital could cause relapse and found no evidence to suggest that the psychological wellbeing of the peer support staff suffered as a result of interacting with patients in hospital. Bluebird (2008) reported the following issues in their implementation of peer support in the Delaware state hospital program: Getting "buy-in" from staff, staff fears that peers would tell them how to do their job, some staff viewed peers as "mental patients with keys" and did not want consumers working in the hospital, boundary issues, access to some information and areas of the hospital that are restricted, pay comparison, rumors and negative comments, professional respect, power differentials, medical model of treatment, staff fears that they would let clients out of the building, and that peers would get sick and would support the person's symptoms of illness. They reported that major challenges included moving too fast, developing infrastructure, balancing training needs with work needs, getting buy-in from all staff (most are very supportive), peers conducting themselves as decision makers on treatment teams and challenging authorities.

On a positive note, peer support staff provide other traditional mental health staff the opportunity to see peers successfully functioning in productive social roles. Ockwell (2012) described how models of inpatient peer support need to be flexible to both the individual talents of peer support workers and the cultures in which they work.

Peer Support Training

In 2007, the U.S. Center for Medicaid and Medicare Services (CMS) released a historic letter to State Medicaid Directors (Smith 2007) that authorized peer support as a reimbursable Medicaid service. Required components necessary to deliver and bill the service included a strong focus on training and clinical oversight of peer positions: "Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function." This development was initially viewed with trepidation in some settings, but in fact has resulted in a significant enhancement of the peer workforce. Early on, Campbell (1990) noted that while many consumer groups demonstrated a desire to participate in the planning and delivery of services, the literature indicates that such involvement with vulnerable populations requires knowledge and skills that consumers may not already possess. While being a peer with lived experience is a basic requirement, it does not necessarily mean that the person is capable of assisting another person in their recovery process.

In our experience in Arizona (Thomas and Anderson 2015), peer supports can play many roles in the behavioral health system but there is specialized knowledge regarding accessing resources, stages of change, ethics, evidence-based practices, HIPAA, maintaining boundaries and other skills that are necessary in order to provide effective and ethical support to another person. Some individuals believe that providing additional training to peers causes them to lose their "peerness"; however, peer support staff have benefited significantly from additional education and frequently seek out advanced educational opportunities on their own. The peer support staff that we have worked with have not lost their fundamental orientation as a peer, but in fact have added additional skills to their repertoire.

When peer staff begin to work as part of a clinical team they are often confronted with rules, regulations, billing procedures and other requirements that are not familiar. For all staff entering a new position, there is an acknowledged learning curve, but eventually peers are expected to perform like all staff with respect to standard work behaviors. This requires that peer staff complete facility orientation programs and all training required by licensing, credentialing, and accrediting organizations. In some cases peer staff need to request ADA accommodations so that they can continue their own recovery process by attending services that may only occur during their work hours.

Ingredients of Peer Support Services

What makes peer support such a unique contribution within the healthcare delivery system? SAMHSA (2009a, b), citing the work of Cobb

(1976) and Salzer (2002a), identified four types of support offered by peers: emotional, informational, instrumental, and affiliational. *Emotional support* includes demonstrating empathy, caring, or concern in order to bolster person's self-esteem and confidence. *Informational support* involves sharing knowledge and information and/or providing life or vocational skills training. *Instrumental support* includes providing concrete assistance to help others accomplish tasks. *Affiliational support* involves facilitating contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging. Peer staff may exhibit each type of support within the context of their work roles, or focus on a specific type in a targeted program.

In our experience in working with peer support staff since 2001, there are several aspects of support that have special relevance in supporting recovery. Within the emotional domain peers play a special role in providing the person with hope that there can be a brighter future. Hope is a primary motivator for patient activation, which has been identified as a critical element in self-management. Ultimately, self-management is necessary to maintain recovery. No matter how often a person sees the psychiatrist, counselor, case manager, primary care provider, or peer support provider, what happens when they are not in the presence of professionals and support staff determines whether a person is living a healthy lifestyle. Decisions made on a daily basis—where to eat, whether to watch television or take a walk, whether to take prescribed medications on time and in the correct amounts—are ultimately more important than the decisions made during a treatment planning session.

Another important element of peer support services is the assistance they provide in improving a person's health literacy. Jorm (2000) hypothesized that people's symptom-management activities are influenced by their mental health literacy. This perspective is important because it leads to a greater emphasis on increasing personal vs. professional knowledge and skills about mental health, and on empowering the person experiencing disabling symptoms. Many individuals lack an understanding of their diagnosis, the available treatment options and what they have to do to remain healthy. This is as true of people managing chronic diabetes or heart conditions as those learning to live with schizophrenia.

Two of the key elements of peer support services are hope and social connectedness. Many scholars and peer professionals believe that hope is the keystone of recovery. Reynolds et al. (2004) reported that the expression and maintenance of hope for a future outside of the hospital was the central theme for many participants. They reported, "Hope was commonly found throughout many clients' comments, particularly during the early stages of the project" (p. 496).

The ability to build social support appears to be one of the primary skills that peer support providers possess. Felton et al. (1995) found that individuals who were served by peer support staff reported improved social support, quality of life, a reduction in the number of major life problems, more frequent contact with their case managers and improved self-image. The availability of a social support network is often accompanied by improvements in multiple aspects of life. Hardiman and Segal (2003) examined the characteristics of peer support self-help agencies and concluded that they foster social networks leading to the experience of shared community.

Kaplan et al. (2012) reported that those peers who participated in community activities such as parenting, employment, volunteering, college student, group membership, civic engagement, peer support, friendships, intimate relationships, and engagement in religious/spiritual activities had higher scores on the recovery, quality of life, and meaning of life measures. Younger adults had the most significant results. Coatsworth-Puspoky et al. (2006) discussed the importance of expanding the person's social network. One poignant quote from an informant clearly articulated the value added by peer support, "They've seen me at my best and at my worst and they're still my friends" (p. 496).

Family Peer Support

There has been increased recognition that family members play a critical role in providing natural supports to individuals who experience inpatient hospitalization. Most individuals who are discharged from inpatient settings return to their family homes. The short length of the typical inpatient stay makes it challenging to involve families in formal interventions. The first priority is to provide a period of respite for the family who are typically emotionally exhausted by their efforts to care for their loved ones during the crisis that resulted in hospitalization.

The SAMHSA National Registry of Evidenced-Based Programs and Practices (2006a, b) identified family interventions as an evidence-based practice. The intervention focuses on informing families and support people about mental illness, developing coping skills, solving problems, creating social supports, and developing an alliance among consumers, practitioners, and their families or other support people. Practitioners invite five to six consumers and their families to participate in a psychoeducational group that typically meets every other week for at least 6 months. McFarlane et al. (2003) reported positive outcomes for employment, lower relapse and hospitalization rates, lower rates of negative symptoms of schizophrenia and reduced family stress. Solomon (1996) reported that when families participate in family intervention activities they gain knowledge and feel greater satisfaction with mental health treatment, experience a reduction in burden, distress, and anxiety, and improved self-efficacy and coping behaviors. Dixon et al. (2004) reported that peer support programs for families could improve their knowledge about the illness, increase confidence, and reduce caregiver burden.

Solomon (1996) described the difference between psychosocial interventions and family education programs. Psychoeducational interventions combine educational and therapeutic objectives, offering didactic material about the ill relative's disorder and therapeutic strategies to enhance the family's communication and coping skills with the goal of reducing the patient's rate of relapse. Family education differs from psychoeducation in that its primary goals are didactic and supportive rather than therapeutic. Interventions are focused on improving family members' quality of life by reducing stress and burden, and only secondarily on benefiting the ill relative.

Cuijpers (1999) conducted a meta-analysis of the impact of family interventions on the burden of relatives of psychiatric patients. Based on a review of 16 studies, family interventions were found to have a positive impact on relatives' burden, psychological distress, relationship between patient and relative, and family functioning. The analysis also revealed that, when the families participated in 12 sessions or more, the interventions had larger effects than shorter interventions. These interventions could be started while the person is in the hospital, but due to the length of the intervention, it would have to be continued after discharge.

Gingrich and Bellack (1995) reviewed a number of randomly controlled studies of formal family interventions programs and concluded that there were numerous positive effects on the course of the illness when families are included in these intervention programs. These included reductions in relapse rates, increased remission of symptoms, and reduced number of hospitalizations. The interventions included the following shared components: (1) Education was provided to patients and families about the biological nature of the illness and the principles for treatment (especially medication compliance, attention to early warning signs, reducing stress, and providing a supportive environment). (2) The family is treated as an ally by the treatment team and is discouraged from feeling guilty or to blame for the patient's illness or its course. (3) A psychoeducational workshop is conducted at the beginning of the program. (4) Regular meetings are then held with the family, ranging from weekly to monthly. (5) Support is provided by clinicians and, in most cases, by other families in a group format. (6) Families are assisted in improving their coping methods and their communication with each other. (7) Treatment teams are multidisciplinary and team members coordinate frequently with each other and outside agencies, and (8) Medication is followed closely, with rigorous attempts made to maximize compliance. In some cases family peer members played a role in these interventions, but in most cases it was a minor role.

The SAMHSA (2010a, b) Family Psychoeducation (FPE) program is an approach for partnering with consumers and families to treat serious mental illnesses. It is not a family therapy program, but rather a family support and education program where practitioners, consumers, and families work together to support recovery. Dixon et al. (2000) identified the critical ingredients of effective FPE to be (1) education about serious mental illnesses, (2) information resources, especially during periods of crises, (3) skills training and ongoing guidance about managing mental illnesses, (4) problem solving, and (5) social and emotional support.

Caplan and Caplan (2000) reported that family psychoeducation programs have the potential to extend the impact of care provision well beyond the immediate situation by activating and reinforcing both formal and informal support systems. Lukens and Mcfarlane (2004) predicted that psychoeducational interventions have far-reaching application for acute and chronic illness and other life challenges across levels of the public health, social and civic services, and/or educational systems.

There are a number of formal family psychosocial interventions that are typically conducted by professional staff and in some cases peers assist in the interventions; however, there is only one formal pure family education program that was developed by National Alliance on Mental Illness (NAMI), titled the Family to Family Program (FTF). The FTF program is a 12-week course offered by family members of adults with mental illness. Dixon et al. (2011) evaluated the effectiveness of the FTF program RTC, with one group receiving the FTF compared to a waiting list control group. The participants were interviewed at enrollment, at 3 months or after the FTF training. The study measured problem- and emotion-focused coping, subjective illness burden, and distress. The results indicated that the FTF participants had significantly greater improvements in problem-focused coping as measured by empowerment and illness knowledge. FTF participants also had significantly enhanced emotion-focused coping as measured by increased acceptance of their family member's illness, as well as reduced distress and improved problem solving.

Anderson et al. (1986) compared the satisfaction of family members participating in process versus psychoeducational groups. Families were randomly assigned to a traditional multiple family groups with a process orientation that emphasized support, destigmatization, and self-help about common problems; or to a psychoeducational multiple family groups that emphasized the provision of information about the mental illness and methods of coping with it effectively. They found a number of differences in knowledge, attitude and dyadic adjustment in the participants of both groups immediately following their respective group sessions, but there were only a few statistically significant differences between the two groups. Those who attended the psychoeducational session, however, reported significantly more satisfaction with the experience.

Pollio et al. (1998) examined the relationship between professionally prepared psychoeducation materials and the needs of the family members as identified and ranked by importance. The findings suggested that input from the family, the ill family member, and mental health providers is necessary for developing psychoeducation curricula that will meet families' needs. Professionals who design multifamily psychoeducation curricula are encouraged to incorporate enough flexibility to accommodate the specific needs of members of particular groups and to provide general information that is useful for all groups.

The Adaptive Family Tool Kit is a program that provides families with education and support (Perrazo and Rodriguez 2014). The program includes information on mental illness and diagnosis, effective treatments, the range of services available in the hospital and the community, common family reactions to illness, how these reactions are quite normal, what can be done to change the reaction, how the family can help, communicating with your loved one, how to handle crisis, aggression, identifying signs of relapse, benefits and financial support, how to care for yourself, support groups, and NAMI Programs and other resources. When working with families it is often necessary to assist them in resolving their immediate problems before educational resources and training can be attempted. Like peer support, family peer support involves family members who have lived experience in dealing with loved with mental illness. Family support partners who have this experience and have learned how to deal with and navigate what is often a very complicated and fragmented system of care, have become an extremely valuable resource. When the person leaves the hospital the family is connected with community-based agencies to continue the supports.

Financial Impact of Peer Support Services

Given the consistency of the findings of decreased hospitalization or shortened length of hospital stay for both peer provided services and peer providers themselves, there should be financial savings to the system, as hospitalization is one of the most expensive of mental health services. There is substantial research evidence that when peer support services are combined with traditional services superior outcomes are achieved when compared to traditional mental health services only (Chinman et al. 2001; Klein et al. 1998; Lawn et al. 2008; Sledge et al. 2011).

While a number of studies have reported cost savings when peer supports deliver services in inpatient settings, at least one study that compared the total costs of both inpatient and community services found that the total cost of services decreases. Forchuk et al. (1998a, b) demonstrated savings in hospital costs of approximately $0.5M for the 14 individuals served over 1 year. In a follow-up study, Forchuk et al. (2005) reported that the intervention group left the inpatient setting an average of 116 days earlier, reducing the cost of hospitalization by $12M compared to the control group. Sledge et al. (2011) found that participants who were assigned a peer support staff member when discharged had fewer hospital admissions and hospital days over a nine-month period than patients who were not assigned a peer support staff member. There was no dollar value assigned to the cost savings.

Trachtenberg et al. (2013) reviewed six studies that reported cost savings with respect to inpatient hospital bed days. Four of the six studies (Chinman et al. 2001; Klein et al. 1998; Lawn et al. 2008; Sledge et al. 2011) showed a cost benefit in excess of the additional costs of providing peer support services. In one study, a cost benefit was positive, but was not positive when peer support services costs were added. In another study, Rivera et al. (2007) there was an increase in the costs of bed days when peers supports were added. On the basis of this evidence, they concluded that the use of peer support workers is justified on the basis of financial cost versus benefit received by the service recipients.

Simpson et al. (2014) found no significant differences between those receiving peer support and those receiving care-as-usual on two of the three main outcome measures of costs: hopelessness and loneliness. However, hope increased in both conditions with a near significant change on Beck's Hopelessness Scale in those receiving peer support. There were fewer readmissions in the peer support arm of the study, but no conclusions could be drawn from such a small sample and short follow-up period. There was also considerable attrition in this study.

In an analysis of costs across all mental service, Landers and colleagues (Landers and Zhou

2014, 2011) examined the 2003–2004 inpatient and outpatient payment claims data for 1910 individuals in Georgia who received peer support services and a randomly sampled comparison group of 3820 individuals who did not receive peer support services. The average Medicaid prescription and outpatient care costs for Georgia Medicaid beneficiaries with mental illness who received peer support services in 2003 and 2004 was higher than costs for a comparison group with mental illness who received traditional care. However, the average costs for inpatient psychiatric services, which are not covered by Georgia Medicaid, were lower among the beneficiaries receiving peer support. Overall, the average per person Medicaid and non-Medicaid costs for those who received Medicaid peer support were about $5991 higher than costs for those who did not receive peer support services.

The Georgia researchers also noted that while the overall state spending was higher for those who received peer support services, given the lack of community-based services during 2003–2004, inpatient and facility-based crisis services were the only available options. The researchers noted the finding that peer support was a significant predictor of lower nonpsychiatric inpatient costs, even after controlling for illness severity, was unexpected. They recommended further study of the connection between peer support and overall Medicaid inpatient utilization.

The caveat regarding the available array of community services in 2003–2004 makes the Georgia findings unique to that context. Since the Georgia study did not attempt to measure the quality of care or other outcomes such as quality of life or satisfaction with services for the two groups, it difficult to determine whether the costs increases are justifiable. Since one of the roles of peer support staff is to ensure that individuals are made aware of all of the resources they may need to support recovery, it would be expected that more community services would at least initially be accessed by individuals who receive peer support.

Trachtenberg et al. (2013) examined the TDM Model financial data and reported that the financial benefits of employing peer support workers do indeed exceed the costs, in some cases by a substantial margin. They also indicated, “The introduction of peer workers is a powerful way of driving a more recovery-focused approach within organizations. Just as peer workers provide hope and inspiration for services users, so they can challenge negative attitudes of staff and provide an inspiration for all members of the team. Their example demonstrates to everyone that people with mental health problems can make a valued contribution to their own and others’ recovery if they are given the opportunity” (p. 5).

Given the equivocal results of the various cost-benefit analyses, future studies need to include the costs of both inpatient and outpatient services and other financial categories that are impacted by untreated mental illness, including homelessness and criminal justice. Since significant medical comorbidity also exists within the population, the scope of the review should go beyond costs of mental health services and include physical health care costs as well.

Re-engineering the Workforce Through Peer Providers

While many observers of healthcare systems shake their heads over the 20-year gap between innovation and implementation of new practices, adoption of peer services has moved quickly to become the standard of care in most community mental health systems in the country today. Inpatient psychiatric hospitals are also beginning to test the water of peer-delivered services in larger numbers, following the success stories and implementation recommendations from early adopters of the practice. Prompted by advocates, researchers, family members and patients themselves, hospital settings are moving to embrace recovery and peer-delivered care as much for its potential to inspire hope during life’s most challenging times as the clear evidence of positive outcomes produced by the service. What started as a quiet revolution in a few state hospitals is quickly becoming a movement all its own.

Georgia and Arizona were the first two states to act on the New Freedom Commission recommendations and began developing formal peer support programs in 2001. In both Georgia and Arizona, forward-thinking system administrators and legislators redesigned their state's Medicaid benefit package to allow for more recovery and rehabilitation services to be provided under the State Plan Waiver, including peer and family support services. By making peer service reimbursable, both states launched a workforce expansion and transformation that placed peer professionals in a variety of mental healthcare programs across the state.

An important first step in both Georgia and Arizona was developing formal training programs designed to give peers an understanding of the recovery process and how they can use their personal experience and "story" to assist a person in their personal recovery journey. Both states significantly expanded their peer support programs and subsequently developed peer supports to address the comorbid physical health and substance abuse issues that often co-occur with mental illness. More recently in Arizona, the Arizona Department of Health, Office of Individual and Family affairs launched a Peer Career Academy—a professional development program for the peer workforce with the goal of expanding and diversifying the roles that peers can play. By including roles within the healthcare arena, such as peer health coaching, the Academy holds promise for creating a true career path for peer providers and a vast number of different roles and job opportunities within the healthcare system (Bashor 2014).

The Future of Health

Increasingly, the use of nontraditional peer roles is aligning mental health systems with the powerful new vision of twenty-first century healthcare articulated through the National Quality Strategy. (The U.S. Department of Health and Human Services (2011a, b, c) Report to Congress) The so-called Triple Aims of the Quality Strategy describe a future of health for the American population:

1. *Better Care*: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
2. *Healthy People/Healthy Communities*: Improve the health of the US population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher quality care.
3. *Affordable Care*: Reduce the cost of quality health care for individuals, families, employers, and government.

To advance these aims, the National Quality Strategy focused on six priorities: (1) making care safer by reducing harm caused in the delivery of care; (2) ensuring that each person and family is engaged as partners in their care; (3) promoting effective communication and coordination of care; (4) promoting the most effective prevention and treatment practices for the leading causes of mortality; (5) working with communities to promote wide use of best practices to enable healthy living; and (6) making quality care more affordable through new health care delivery models.

Peer support services have proven to be a method that aligns with and supports the National Quality Strategies. The research is clear that peer support services have enhanced person-centered care not only by their direct application of this approach by peer support staff, but also in their ability to influence the behavior of other staff in the settings in which they work. Peer support staff have improved accessibility of care by increasing both the workforce and the types of services available in the community. The availability of Peer Respite, crisis services, drop-in centers and other options has expanded the array of options available.

Peer supports services have been able to address the behavioral, social and environmental determinants of health by using a holistic approach that not only addresses symptomatology, but also the other factors which are necessary to support recovery and resilience. Peer support services are also cost effective. However, peers need to be paid a wage that is commensurate with their education, experience and duties. Whereas peer support staff do not require advanced degrees or credentials, they often earn less than staff who are required to have these credentials. The research is undisputed in the finding that peer support staff produce outcomes that are equivalent to those of staff employed as case managers who in many cases require academic credentials. Another cost implication is that as peers become employed, they become tax-paying citizens, and reduce their reliance on SSI and SSDI funds.

Peer support services are also in line with the six priorities of the National Quality Strategies of health care. Peer supports have improved safety in inpatient settings by reducing the use of restraints in those settings. Both peer and family peer services have increased the level of person and family involvement in health care decision-making. Peer supports are often involved in spanning boundaries between providers and promote communication and coordination of care. A recent development in peer support services involves health coaching and chronic disease self-management. The expansion of peer support programs and their use in many of the new health care delivery models have made them a vital element in most healthcare systems. In fact, The Association for Behavioral Health and Wellness (2013) released a report that described several opportunities for behavioral health organizations to expand peer support services to new settings or to new responsibilities. Examples included placing peer support specialists in hospital emergency rooms to assist emergency staff in their interactions with mental health patients. Expanding the role of peer transition coaches for psychiatric hospital discharges and expanding the number of Whole Health Coaches are two additional promising strategies.

The President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America (2003) states that successfully transforming the mental health service delivery system rests on two principles. First, services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers. Second, care must focus on enhancing a person's ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, and not just on managing symptoms.

In each area, peer services have demonstrated their effectiveness while supplementing more traditional models of psychiatric care. Peer support services have been effective in involving individuals and their families in their health care both by their advocacy and improvement of health literacy. These aspects of peer support have played a major role in improving what has been called "patient activation," a critical aspect of recovery and resilience. They have also significantly expanded the array of service options adding drop-in centers, working in inpatients settings, creating crisis stabilization programs and respite services. Their role in assisting the person in the recovery process by providing the necessary social supports for individuals to regain hope that life can improve, assisting the person in developing social networks and providing the guidance to obtain the necessary resources to support recovery is a significant accomplishment. The contribution of the peer workforce transcends mental health and serves as a model for the health workforce of the future.

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